BEHAVIORAL ENGAGEMENT WITH PURE PRESENCE™
IN PATIENT-PROVIDER RELATIONSHIPS:
COMMUNICATION AND THE EFFECT ON PATIENTS AND PROVIDERS

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A dissertation submitted in partial fulfillment of
the requirements for the degree of
Doctor of Health Administration

School of Health Sciences

Central Michigan University
Mount Pleasant, Michigan
February 2015
Grant that we may not so much seek to be understood as to understand.

~ Saint Francis of Assisi
This is dedicated to society, as everyone should have an opportunity to live their best life.

This is dedicated to all those who dedicate their lives as health professionals who aim to treat the “Whole Patient” as opposed to the disease.

This is dedicated to the individuals in my life who have shared my vision, provided unwavering support and remained committed to the fortitude I have demonstrated. In all to fulfill my purpose, will hold the same in future endeavors.
I would like to extend my sincere appreciation to my committee members for their direction during my dissertation process: Dr. Steven Berkshire, Program Director for the Doctor of Health Administration Program and the chair of my committee, for his guidance and insight that directed me in all facets of my research; Dr. John Lopes for support in joining my committee and his valuable recommendations; and Dr. Saleh Aldasouqi for his immeasurable contributions, words cannot suffice, and commitment in support of me, my purpose and shared vision.

I would to thank Dr. Opada Alzohaili, who welcomed me into his endocrinology practice, Alzohaili Medical Consultants, permitting me to conduct my research; for his dedication to train and apply the study’s intervention with his patients; and to make available his research team and medical staff, Dr. Ahmad Yusuf Solaiman and Majed Kattan. I am thankful for the insight they provided to enhance the viability of my research and the commitment to assist me over the several months of preparation, patient recruitment and data collection.

I wish to thank Dr. Georgianna Donadio for her life’s work, her knowledge bestowed, her unwavering commitment in support of all I have worked to accomplish and aspire yet to achieve. I am forever grateful we have been brought together and am honored to carry forward your work.

Evan Carmichael said, “Life isn’t about finding yourself, it’s about discovering who God created you to be.” I envision a life with clarity in its purpose, a life that is meant to make a significant impact in the lives of others on an immeasurable scale. It takes not one person but a strategic alliance of many to affect such change. This doctoral program has served as an integral vehicle in aligning my mission with the exceptional individuals named and others I have established purposeful relationships with throughout this journey. I am forever grateful to all.
ABSTRACT

BEHAVIORAL ENGAGEMENT WITH PURE PRESENCE™ IN PATIENT-PROVIDER RELATIONSHIPS:
COMMUNICATION AND THE EFFECT ON PATIENTS AND PROVIDERS

by Christie L. Clipper

Effective communication is the basis of the patient-provider relationship impacting satisfaction among both patients and providers. In today’s patient-centered healthcare environment a behavior change model formulated to provide communication-skills training for providers to effectively engage and empower patients for sustained behavior change, improved patient-provider satisfaction and patient outcomes is needed.

The purpose of this study is to explore the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships. The behavioral change model applies an integrated approach to interpersonal communication while engaging both patients and providers, facilitating emotional shifting essential to sustained behavior change (Donadio, 2011).

The research is a pre-experimental, one-group pretest-posttest study limited to a purposive sample of participating practice sites. A random sample of 40 adult patients was recruited from a physician’s private endocrinology practice with two locations in Southeastern Michigan. One participating provider was trained to implement the intervention.

The research design comprised a quantitative analysis utilizing a self-administered, pre- and post-intervention Consultation and Relational Empathy (CARE) Measure Survey to participants measuring their perspective of relational empathy in the patient-provider relationship. Parametric and nonparametric statistical tests were performed on dependent
variables against exposure to the intervention, the independent variable. Patient demographic and medical information were indicated as covariates and tested as independent variables. Provider pre- and post-intervention survey results on the model’s effect on provider satisfaction in the patient-provider relationship and workplace were reported. The research study demonstrated statistical significance to reject the null hypothesis in favor of the alternate hypothesis: Patients who participate in Behavioral Engagement with Pure Presence™ will experience improved psychological effects.

Results of this research will attempt to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in clinical practice across diverse health delivery systems. Implications include increased patient-provider satisfaction, improved self-directed patient-provider compliance, sustained patient behavior change, improved patient outcomes and an increase in provider job satisfaction; all of which may contribute to a decrease in healthcare costs. Further research will provide greater insight into the effects of behavior modification and disease management models for sustainability in lifestyle changes.
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CHAPTER I  
INTRODUCTION  

Background  

The patient-provider relationship is an essential element of quality medical care. The dialogue between a patient and his or her physician can significantly affect health care outcomes (Sibille, Greene, & Bush, 2010) influencing the patient’s ability to self-manage a chronic condition and adopt preventive health behaviors (Institute for Healthcare Communication [IHC], 2011). Further, effective communication among providers enhances the quality of working relationships, job satisfaction and has a profound effect on patient safety (IHC, 2011). Research reveals a direct correlation between provider satisfaction and patient satisfaction (Donadio, 2004; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011) with communication being one of the major drivers in satisfaction among healthcare providers (Downs & Adrian, 2004; Volunteer Hospitals for America [VHA], 2002).

Improving patient adherence and outcomes through healthier lifestyles will require a deeper understanding of how to effectively engage patients through the patient-provider relationship. As traditional, provider-focused practices shift to patient-centered care, providers must develop communication skills that empower patients by seeing health from the patient’s perspective and motivating and educating patients in health-related self-management (World Health Organization [WHO], 2005).

Many behavior modification models demonstrate initial enhancement to behavioral change; however, they do not identify tools that produce sustainable change (Donadio, 2011). A behavioral change model that is whole person focused and applies an integrated approach to...
interpersonal communication, engaging both patients and providers, is essential to facilitating emotional shifting for sustained behavior change (Donadio, 2011).

The research is a pre-experimental pilot study. In experimental research the researcher uses an intervention, manipulating the independent variable(s) to observe how it affects the dependent variable(s) (Cooper & Schindler, 2008). The intervention consists of incorporating Behavioral Engagement with Pure Presence™ in patient-provider relationships. The study comprises a one-group pretest-posttest design. In pre-experimental research a control group is not used (Cooper & Schindler, 2008).

The researcher collected quantitative survey data of participants measuring the effects of the intervention on participants in the patient-provider relationship. The surveys compared the perspectives of patients and providers pre- and post-intervention. The knowledge gained from this research may demonstrate the significance of Behavioral Engagement with Pure Presence™ in communication-skills training of providers to improve the patient-provider encounter for implementation in clinical practice.

Scope of Research Study

The research was initially an experimental pilot study limited to a purposive sample of providers (i.e., physicians, physician assistants, nurse practitioners, and nurses) of various areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.) and their patients recruited from outpatient medical centers in the state of Michigan. Grant funding opportunities over a twelve-month period were exhausted in an attempt to conduct a larger scale, randomized controlled clinical trial. A pre-experimental research design using a purposive sample of participants was then determined to be conducive to the time and budgetary constraints. Upon
commencement of the study a reduction in the number of participating practice sites resulted in a limited sample of patient participants derived from a single participating provider. A detailed explanation is presented in Chapter IV.

**Statement of Problem**

**Health Risk Behaviors and Chronic Disease**

The prevalence of behavior-related diseases is on the rise as unhealthy lifestyle behaviors account for over 50% of the morbidity and mortality in the United States (Sibille, Greene & Bush, 2010). Health risk behaviors are unhealthy behaviors that Americans can change. Unhealthy lifestyle practices such as physical inactivity, poor nutrition, tobacco use, and excessive alcohol consumption account for much of the illness and premature deaths related to chronic diseases and conditions (Centers for Disease Control and Prevention [CDC], 2014).

**Patient-Provider Communications**

Research reveals only one in seven patients who were told by their physicians they will die if they do not make lifestyle changes are actually able to make the recommended changes, even with the desire to live (Kegan & Lahey, 2009). The University of Michigan reports our opinions are based on our emotions, beliefs and world views and when presented with contradictory facts, we adhere even more strongly to our original beliefs deep rooted in our emotions (Donadio, 2011). Emotional shifting with new information that surrounds the patient’s world view must occur for sustained change. Many behavior modification and disease management models demonstrate initial enhancement to behavioral change; however, they do
not identify tools, such as emotional shifting, that produce sustainable, long-term behavior change (Donadio, 2011).

Patients do not want to be controlled or told what they must do. They want to know how they can take control of their own condition or concern. Research shows patients are more likely to make lifestyle changes when they have been authentically engaged by their provider and their self knowledge has been valued (Donadio, 2011). The provider’s intention to help or heal can often produce communications that offer information or feedback quite different from what patients are asking for.

The Institute of Medicine (IOM) Report on Health Professions and Training has reported providers lack adequate training in providing high quality, patient-centered care (IHC, 2011). Physicians rely more on objective test results than subjective information from his or her patient (Goold & Lipkin, 1999), yet most diagnostic decisions arise from the history taken upon an initial visit (IHC, 2011). Research reveals in this patient-provider encounter the patient is often not provided the opportunity or time to convey their history due to interruptions (IHC, 2011). The provider’s clinical decisions are then based upon incomplete information. Patients perceive what they are saying is not important resulting in the patient restraining from offering additional information which in turn hinders the patient-provider relationship.

There have been numerous studies measuring patient-provider communication in a variety of ways. A commonalty evident is that poor communication frequently occurs (Chesser, 2013). Research shows a breakdown in the patient-provider relationship is most often manifested as unsatisfactory patient-provider communication. This is evidenced by the perception physicians were not listening to their patients or talking openly, attempting to mislead
their patients or not warm them of long-term problems, devaluing their patients’ or patients’
family views, delivering information poorly and failing to understand their patient’s perspective
(Huntington & Kuhn, 2003). In turn, poor communication leads to provider dissatisfaction
affecting the quality of working relationships, patient safety, and job satisfaction (IHC, 2011)
evident in high turnover rates and related indirect costs (Donadio, 2005; IHC, 2011; VHA, 2002;
Wieck, Dols, & Northam, 2009).

Placing patients at the center of their health care decision making entails “physicians
‘ascertaining’ the reasons for the appointment and addressing presenting concerns; the patient
and physician finding ‘common ground;’ and patients receiving information and participating in
decision making” (Sibille et al., 2010, p. 8). Despite the array of resources and time spent on
these key factors of patient-centered care, the prevalence of behavior-related diseases continues
to rise (Sibille et al., 2010).

**Behavioral Health Interventions**

Behavioral health interventions encourage patients to change existing unhealthy
behaviors by adopting healthy lifestyle behaviors (Wagner & Goldstein, 2004). The
effectiveness of these interventions is deemed as either a success or failure. Despite
surmountable empirical research into leading health behavior theories, there is no conclusion on
what models of health behavior are most accurate or influential (Weinstein, 1993).

Various behavioral health interventions have shown initial enhancement to behavioral
change; however, they do not identify tools that produce sustainable change (Donadio, 2011).
Additionally, electronic theoretical models developed to enhance engagement are introducing a
dehumanizing factor in the patient-provider relationship. Extensive literature review on the
effectiveness of strategies to improve patient-provider communication shows little is known about the degree to which positive short-term effects are demonstrated over time (Chesser, 2013).

Given the plethora of research linking ineffective provider-patient communication with increased nonadherence, poor health outcomes, and patient and provider dissatisfaction, it is imperative communication skills deficits are addressed (IHC, 2011) in the patient-provider encounter. A behavioral change model that is whole person focused and applies an integrated approach to interpersonal communication, engaging both patients and providers, is essential to facilitating emotional shifting for sustained behavior change (Donadio, 2011).

**Purpose of the Study**

The primary purpose of the research study was to examine the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships. This objective was attained utilizing a quantitative research method to obtain data on patient and provider perspectives. Results of this research will attempt to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol. Pilot data obtained from this research will be useful in conducting further research studies on application of the model in emerging technologies that impact communication such as the electronic medical record and the management of chronic illnesses such as type 2 diabetes.
Significance of the Study

The significance of the study centers on examining the effects Behavioral Engagement with Pure Presence™ on improving patient-provider communications. Improving provider communication skills is essential to transforming the patient-provider relationship, increasing the quality of service to patients and level of patient-provider satisfaction.

In today’s health care environment, providers are challenged to manage their time while adhering to increasing regulatory, technological and administrative requirements. The World Health Organization (2005) reports, as traditional provider-focused practices shift to patient-centered care, providers must develop communication skills that empower patients by seeing health from the patient’s perspective and motivating and educating patients in health-related self-management. Further, the IOM Report on Health Professions and Training has called attention to the importance of communication training for healthcare professionals recognizing communication skills can be learned and improved upon through commitment and practice (Goold & Lipkin, 1999; IHC, 2011).

A new model of education that teaches healthcare professionals to treat the whole person, rather than just the disease and to strengthen relationships with their patients is necessary to improve the patient-provider encounter and thereby patient outcomes (Donadio, 2004). As the Behavioral Engagement with Pure Presence™ Model was formulated to provide communication-skills training for providers, the knowledge gained from this research may demonstrate the significance of its application in outpatient protocol to improve the patient-provider encounter.
Key Research Questions

The purpose of this study is to explore the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships.

Research question 1: What are the psychological effects, if any; of introducing Behavioral Engagement with Pure Presence™ in patient-provider relationships on patients?

Research question 2: What effects, if any; do healthcare providers who practice Behavioral Engagement with Pure Presence™ experience in overall workplace satisfaction?

Hypotheses and Rationale

Hypothesis 1

Null hypothesis ($H_0$): Patients who participate in Behavioral Engagement with Pure Presence™ will not experience improved psychological effects, as indicated by an adapted Consultation and Relational Empathy (CARE) Measure survey instrument (e.g., patient perception of relational empathy).

Alternate hypothesis ($H_a$): Patients who participate in Behavioral Engagement with Pure Presence™ will experience improved psychological effects, as indicated by an adapted Consultation and Relational Empathy (CARE) Measure survey instrument (e.g., patient perception of relational empathy).

Hypothesis 2

Null hypothesis ($H_0$): Healthcare providers who practice Behavioral Engagement with Pure Presence™ with their patients will not experience enhanced patient-provider satisfaction and enhanced job satisfaction, as indicated by the Work Satisfaction Survey.
Alternate hypothesis (Hₐ): Healthcare providers who practice Behavioral Engagement with Pure Presence™ with their patients will experience enhanced patient-provider satisfaction and enhanced job satisfaction, as indicated by the Work Satisfaction Survey.

Rationale

The rationale for the above hypotheses pertains to evaluating if there are any significant differences between patient and provider study groups pre- and post-implementation of the intervention. The patient evaluation will pertain to psychological variables identified as components measured in the adapted CARE Measure Survey. The provider evaluation will pertain to variables identified in the Work Satisfaction Survey.

Key Variables

The dependent variables for analyzing patient perspective of relational empathy, pre-and post-intervention, were derived from the CARE Measure Survey. They are defined in Table 1.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
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<tr>
<td>Valued</td>
<td>Making the patient feel valued. Patient report on provider being friendly and warm, treating patient with respect; not cold or abrupt.</td>
</tr>
<tr>
<td>Present</td>
<td>Being fully present to the patient. Patient report on provider giving patient time to fully describe their illness in their own words without interrupting or diverting the patient.</td>
</tr>
<tr>
<td>Listen</td>
<td>Really listening to the patient. Patient report on provider paying close attention to what patient is saying; not looking at notes or computer as patient is talking.</td>
</tr>
<tr>
<td>Whole</td>
<td>Addressing the needs of the patient as a whole person. Patient report on provider asking or knowing relevant details about the patient’s life and situation; not treating the patient as “just a number”.</td>
</tr>
<tr>
<td>Understand</td>
<td>Understanding the patient’s concerns. Patient report on provider communicating that he/she accurately understands the patient’s concerns; not overlooking or dismissing anything</td>
</tr>
<tr>
<td>Behavior</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>Eye Contact</td>
<td>Making consistent, attentive eye contact with patient. Patient report on provider seeming genuinely concerned with patient on a human level; not being indifferent or detached.</td>
</tr>
<tr>
<td>Positive</td>
<td>Being positive, caring and respectful to the patient. Patient report on provider having a positive approach and attitude while being honest, not negative about the patient’s problems.</td>
</tr>
<tr>
<td>Explain</td>
<td>Explain information clearly to patient. Patient report on provider fully answering patient’s questions, explaining clearly, providing adequate information; not being vague.</td>
</tr>
<tr>
<td>Take Control</td>
<td>Facilitating patient to take control. Patient report on provider discussing with patient what he/she can do to improve their health; encouraging rather than lecturing the patient.</td>
</tr>
<tr>
<td>Develop Plan</td>
<td>Developing a plan of action with the patient. Patient report on provider discussing options with patient, involving him/her in decisions as much as patient would like to be involved; not ignoring patient’s views.</td>
</tr>
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**Assumptions**

Methodological assumptions in this study concerned adhering to study protocol. Patient recruitment, tracking and follow-up visits were followed as detailed and reported to the researcher. Provider training was conducted as agreed under of provision of academic integrity to receive the full benefit of the curriculum.

Instrument-specific assumptions were made on the validity of research instruments used. It is assumed the reliability of the patient and provider surveys measured what they were tested to measure.

Participant assumptions included patient honesty in reporting perceived empathy and recall of the patient-provider encounter at the time of post-visit. It is assumed the patient recalled the first experience they had with their provider to a degree that would permit them to see a perceived change in provider behavior and interaction if any.
Summary

The patient-provider relationship is the foundational element of patient care. Effective communication is the basis of this relationship impacting satisfaction among both patients and providers. In today’s patient-centered healthcare environment a behavior change model formulated to provide communication-skills training for providers to effectively engage and empower patients for sustained behavior change, improved patient-provider satisfaction and patient outcomes is needed. As the Behavioral Engagement with Pure Presence™ Model was formulated to provide communication-skills training for providers, the knowledge gained from this research may demonstrate the significance of its application in outpatient protocol to improve the patient-provider encounter.

The research is a pre-experimental, one-group pretest-posttest pilot study. The researcher collected quantitative pre- and post-intervention survey data of provider and patient participants measuring their perspective of communication and the patient-provider relationship. The hypotheses were formed to examine if there were any significant differences between patient and provider study groups pre- and post-implementation of the intervention, Behavioral Engagement with Pure Presence™. The researcher defined key variables derived from the CARE Measure Survey. The variables measured patient reporting on their psychological status pre- and post-intervention. The researcher named methodological, instrument-specific and participant assumptions made.

Results of this research will attempt to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol. Pilot data obtained from this research will be useful in
conducting further research studies on application of the model in emerging technologies that impact communication such as the electronic medical record and the management of chronic illnesses.
CHAPTER II
REVIEW OF LITERATURE

Introduction

The researcher conducted a comprehensive literature review. The literature review centered on communication and the patient-provider relationship to provide some context prior to examining the effects of a behavioral change model on providers of varying area of specialty and the patients they service. Literature findings are cited as appropriate throughout the dissertation prospectus.

Numerous literature and articles identified ineffective or poor patient-provider communications with patient-provider dissatisfaction, increased nonadherence and poor patient health outcomes. The converse was also evident with positive effects resulting from favorable patient-provider communications. May of the articles addressed patient and provider satisfaction. Literature findings also revealed the verbal and nonverbal aspects of communication. The literature and articles discussed what patients are seeking in the patient-provider relationship and how that leads to sustained behavior change. Evident in the conclusion of many articles and discussed in a limited number was the importance of communication skills training for healthcare professionals.

Literature findings revealed limited research to support long-term effects of behavioral health intervention models. Research findings on various health behavior models were limited as findings concluded the concept differentiation of models makes it difficult to scientifically evaluate a point-by-point comparison. With many models, each is a small variation of another. Literature referenced introduced the Behavioral Engagement with Pure Presence™ Model
discussing its formulation and the evidence-based research in support of its development and application.

**Literature Search**

The researcher utilized a variety of resources to conduct the literature review. The primary resource was peer-reviewed journal articles extracted from the expansive database of Central Michigan University’s Global Campus Library. Advanced searches were conducted utilizing the psychology databases most frequently. Main search terms were used alone or as search strings with Boolean operators. These include: patient-provider relationship, communication, encounter; patient satisfaction; provider satisfaction; patient adherence, compliance, nonadherence, lifestyle; behavioral change, modification; sustained behavior change; changing behavior; and behavioral change models.

The researcher began collecting resources two years prior to implementing the study. A plethora of journal articles, news articles and valid website sources were also obtained through a network of colleagues and industry professionals.

**Prevalence and Cost of Behavior-Related Chronic Diseases**

The Centers for Disease Control and Prevention (2014) reports as of 2012, an estimated half of all adults, or 117 million Americans, has one or more chronic health conditions. One in four adults suffers from two or more chronic conditions.

Chronic diseases are the leading causes of death and disability in the United States (CDC, 2014). Among the most prevalent, costly and preventable are heart disease, stroke, cancer,
diabetes, obesity, and arthritis. In 2012, 7 of the top 10 causes of death were chronic diseases. Of these, heart disease and cancer accounted for approximately 48% of all deaths (CDC, 2014).

The costs of chronic diseases and associated health risk behaviors account for the majority of health care and economic costs associated with medical conditions in the United States (CDC, 2014). In 2006, 84% of total health care spending was attributed to 50% of the population who have one or more chronic health condition (CDC, 2014).

Improving patient lifestyles is essential to reduce escalating behavior-related diseases and their health-related consequences (Sibille et al., 2010). Sibille, Greene and Bush (2010) report “dialogue between an individual and his or her physician can significantly affect health care outcomes” (p. 7). Health behavior models have responded to this health care dilemma placing emphasis on patient-provider communication and principles of behavior change.

**Communication in the Patient-Provider Relationship**

The patient-provider relationship is the foundation of care (Goold & Lipkin, 1999). Patients and providers value effective communication as an essential component in the patient-provider encounter (Rhoades, McFarland, Finch, & Johnson, 2001). Effective communication is reciprocated when ideas and information are both given and received in the exchange between two individuals. When this communication is one sided it can result in miscommunication or misunderstanding that can be physically and financially costly in the healthcare environment (Hicks, n.d.).

“Extensive research has shown that no matter how knowledgeable a clinician might be, if he or she is not able to open good communication with the patient, he or she may be of no help” (as cited in IHC, 2011). The connection a patient feels with their provider can impact their
health. Their perception of quality of care received is highly dependent on the quality of their interaction with their provider (DeBlasio & Walker, 2011; IHC, 2011). Patients assess the quality of care they receive on the basis of their interaction with their provider (Huntington & Kuhn, 2003). As most patients believe their provider is properly trained to provide their medical care, providers who exhibit highly valued skills such as compassion and caring concern are considered better providers (Huntington & Kuhn, 2003).

Effective communication skills are critical to providers establishing an optimal relationship with their patients (Huntington & Kuhn, 2003). Research indicates there is a significant positive relationship between a provider’s communication skills and a patient’s ability to adhere to medical recommendations, self-manage a chronic illness, improve pain management, resolve concerns, and incorporate preventive health behaviors into their lifestyle (Ciechanowski et al., 2004; Huntington & Kuhn, 2003; IHC, 2011; Rouf, Whittle, Lu, & Schwartz, 2007). Studies reveal a provider’s ability to listen, explain and empathize with their patients can profoundly affect patient satisfaction, patients’ perceptions of quality of care and overall health outcomes (Huntington & Kuhn, 2003; IHC, 2011; Rouf et al., 2007). Further, communication among providers has been shown to improve the quality of working relationships and workplace satisfaction, as well as a reduction in medical errors (IHC, 2011; Rouf et al., 2007). Poor patient-provider communication leading to miscommunication of information and failure to understand the patient’s perspective can result in litigious outcomes (Huntington & Kuhn, 2003; Rouf et al., 2007).

Consumer consciousness is changing bringing a new awareness to patients in today’s health environment. With patient access to more health-related information on the internet,
technological and scientific advances, and government regulations the medical community is continuously changing (Rhoades et al., 2001). Since the advent of new technologies in communications and information exchange and physicians partnering with patients in patient-centered care, the rules of patient-provider engagement are changing (Donadio, 2011).

With this change communications rises to the forefront of enhancing patient participation and responsibility (Rhoades et al., 2001). Providers will need to strengthen their communication skills to navigate these changes in providing optimal quality of care services. The IOM has called upon strengthening training requirements in patient-centered care which rests on core communication skills (e.g., open-ended inquiry, reflective listening and empathy) to respond to the values, preferences and needs of each patient (IHC, 2011).

Providers need communication skills that enable them to engage with their patients, share power and involve their patients in all aspects of health care decision-making for improved health outcomes (WHO, 2005). Providers should possess communication skills that permit interviewing and communicating effectively to elicit information from the patient’s perspective by delving into the patient’s concerns, emotional status, social situations and behaviors. Providers must be skilled in communicating effectively to identify potential problems and listen to what their patients express without judgment. Developing effective communication skills also allows providers to support their patients throughout changes in their health-related behaviors.

Research has identified seven essential tasks in patient-provider communication which include: building the patient-provider relationship, opening the discussion, gathering information, understanding the patient’s perspective, sharing information, reaching an agreement
We all have a good idea of how we want things to go when we visit a physician. We expect—count on—being able to talk to the physician about why we are there. This means telling him or her what feels wrong, explaining why we think prior treatment recommendations are not working, and even suggesting what we think the problem could be or recommending something new to try. We hope that the physician will listen, possibly ask questions that will help us clarify our thoughts, and provide new information that could be useful. Most of us hope for some expression of empathy for whatever the problem is that led us to see attention. We then expect the physician to combine our information with more information collected through tests or an examination and tell us what he or she thinks is wrong. We hope that the explanation is relatively clear and nontechnical, so that we can remember it and respond to the inevitable questions from family members, friends, and coworkers. Finally, we expect that the physician will explain our options and elicit our input about what to do next. . . . Certainly we would appreciate it if the physician asked us about our ability to follow the recommendations, given the other demands in our lives, and gave us some sense of what it will all cost. (p. 1)

Health care that is relationship-centered entails providers partnering with their patients in their care (WHO, 2005). “Patients differ in their values, preferences, and expectations for care” and their “psychosocial, emotional, and lifestyle issues are integral to medical care” (Beach et al., 2006, p. S5). They want to be valued, seen, and heard (Donadio, 2011). “The quality of communication between patients and clinicians is…an interactive process that is dependent on
the efforts of both participants” (Beach et al., 2006, p. S6). Placing patients at the center of their health care decision making entails “physicians ‘ascertaining’ the reasons for the appointment and addressing presenting concerns; the patient and physician finding ‘common ground;’ and patients receiving information and participating in decision making” (Sibille et al., 2010, p. 8).

**Communication Barriers in Health Information Technologies**

Efforts to contain costs and increase productivity have placed even greater time constraints on face-to-face patient-provider communications as providers attempt to care for increasingly chronically ill patients. Health Information Technology (HIT) offer opportunities to enhance patient-provider partnerships by empowering patients to self-manage more effectively and facilitate and reinforce health behavior changes (Ahmed et al., 2011). Provider usage of Electronic Health Records (EHRs) may assist in completing information intensive tasks (McGrath, Arar, & Pugh, 2007); however, research reveals they are less likely to explore psychosocial/emotional issues such as how health status affects a patient’s life (McGrath, Arar, & Pugh, 2007). While HIT are geared toward enhancing patient-provider encounters (Wakefield et al., 2010), research indicates the EHR may detract from interpersonal connection hindering communication in the patient-provider relationship (Alsos, Das, & Svanes, 2012; Bonner et al., 2010; Frankel et al., 2005).

The interference with face-to-face patient care is among the principal sources of provider dissatisfaction (Craviotto, 2014) with the concern of compromising patient care for adhering to the mandates of EHR documentation (Cox, 2013). The patient-provider relationship is impacted as “patients have begun complaining that their doctors are not listening to them anymore, because they are spending more time staring on their screens and keyboards, and checking boxes,
typing and filling in spaces” (Aldasouqi, 2013, para. 4). Limited research has been published on the direct impact of EHRs on provider-patient relationships or how EHRs improve or hinder communication (Boucher, 2010; Rouf et al., 2007).

**Verbal and Nonverbal Communication**

A key influential factor in perceived quality of care is the verbal and non-verbal communication between the patient and provider (DeBlasio & Walker, 2011). Verbal communication extends beyond the spoken word to verbal inflection such as pauses in speech and tone of voice. Nonverbal communication or visual cues can be demonstrated through body positioning, posture, and gaze. These nonverbal cues comprise 80% of interpersonal communication.

The neurology of the human brain and facial structure reveal nonverbal communications (Donadio, 2011). An individual’s conscious and unconscious thoughts correlate with facial nerves and muscles expressing a wide range of communication. The human body does not mask what the mind is thinking.

Verbal and nonverbal behaviors affect patient outcomes. Patient satisfaction and adherence relate to such behaviors as empathy, tone of voice, posture, and gesture (Frankel et al., 2005). Nonverbal behaviors, associated with emotional aspects of care, also influence the patient-provider relationship (Rouf et al., 2007).

**Skilled Listening**

Skilled listening, or intentional listening, is the practice of being mindfully present to comprehend on intellectual, emotional and spiritual levels what another individual is
communicating (Donadio, 2011). There are many ways listening is practiced. One can act as if they are listening, listen with distraction, listen with filters or prejudice, or one can practice skilled listening; hearing the whole person and understanding what they are communicating with one’s whole self. It is evident to another when someone is truly listening or when they are simply physically hearing what is being said, thinking about what they will say next.

These types of listening are demonstrated in patient-provider communications. Research shows patients are interrupted an average of 12 seconds after they begin speaking with their provider (Rhoades et al., 2001). An interruption can also be a mental or visual shift or distraction of attention from the patient. This can cause an interruption in the physical, neurological, emotional and hormonal rapport between the provider and their patient (Donadio, 2011).

**Patient-Provider Satisfaction**

**Patient Satisfaction**

Many of the core elements comprising patient satisfaction are reflected in the patient-provider encounter scenario previously cited from Chesser (2013). The importance of these elements is evident in the literature. The IHC (2011) describes how these elements increase patient satisfaction in the following manner:

- *Expectations*: patients were provided an opportunity to tell their story
- *Communication*: providers seriously evaluated patient concerns, explained information clearly, tried understanding the patient’s perspective, and provided viable options
- *Control*: providers encouraged patients to express their ideas, concerns and expectations
- **Decision-making**: providers acknowledged their patients’ social and mental functioning as much as their physical functioning

- **Time spent**: patient satisfaction improved as the length of time provider spent with patient increased

- **Dignity**: patients experienced greater satisfaction when they were treated with respect and invited to partner in their healthcare decisions

**Provider Satisfaction**

“Patients and providers alike have the same need for relationships and for being valued” (Donadio, 2005, para. 5). Providers with limited time to build essential relationship-centered interactions necessary for work satisfaction and self-esteem are expressed through escalating turnover rates (Donadio, 2005). An average turnover rate of 20% ultimately costs a health care facility $5.5 million a year in replacement costs (VHA, 2002). Indirect turnover costs such as eroding staff productivity and morale may increase the cost of turnover four to five times even greater (Wieck et al., 2009). Turnover rates of 20% or higher result in increased costs by 36%, decrease in profitability of approximately 17% and higher length-of-stays by 1.2 days (VHA, 2002).

Effective communication encourages satisfaction among providers. The core elements of provider satisfaction encompass feeling supported both administratively and interpersonally; being respected, valued, and heard; clearly understanding their role and to be understood; work equity; and reasonable compensation (IHC, 2011). Provider team satisfaction is central to the quality of working relationships, job satisfaction and patient safety. Research reveals effective communication leads to a significant reduction in nurse turnover and improved workplace
satisfaction. A direct relationship was reported between the provider’s satisfaction level and their ability to build a rapport and express empathy with their patients (IHC, 2011).

**Changing Behavior**

Human behavior has been defined as an individual’s “responses to stimulation or our response to the environment” (Donadio, 2011, p. 94). Many variables affect whether one can change behavior and how long these changes can be sustained before a primal trigger occurs (Donadio, 2011). Behaviors are deeply rooted in the subconscious brain to avoid pain and seek pleasure. As a coping mechanism, self-medicating behavior leads to unhealthy lifestyle practices giving rise to behavior-related chronic illnesses. Survival drives overcome intellectual thinking, rational judgment and pragmatic thinking.

The quality of a patient’s life depends on how well he or she can integrate new circumstances into their life (Brody, 2010). Patients cannot achieve sustained behavior without new information from an internal self directed place (Donadio, 2011). Providers addressing the physical aspects of a condition or illness often fail to ask probing questions on the impact of the patient’s quality of life. Learning this information from their patients is essential to identifying the proper treatments and encouraging self-management techniques that enable patients to reclaim their lives to their greatest potential (Brody, 2010).

The Behavioral Engagement with Pure Presence™ Model indicates for long-term, sustained change emotional shifting must occur (Donadio, 2011). Patients have a conditioned response to their belief system as emotions are anchored in one’s beliefs and behaviors. Individuals are conditioned to respond to their environment in a way that is safe, holding to their belief system and world views. For sustained change the individual must feel the information
they receive is part of their belief system for a world view shift to occur. A key factor of the model’s whole person focus is to embrace the individual’s need to be valued, seen, and heard. This is achieved by applying an integrated approach to interpersonal communication, engaging both patients and providers.

**Behavioral Health Models**

One of the most noted behavioral change models is the Transtheoretical Model which centers on the stages of change and indicates cognitive restructuring is a result of an individual applying the appropriate processes of change throughout each appropriate stage of change (Bensley et al., 2004; Prochaska & DiClemente, 1982; Redding, Rossi, J. S., Rossi, Velicer, & Prochaska, 2000). Over time emerging theories have begun drawing upon previous models such as variables in the Transtheoretical Model to integrate into their own framework (Redding et al., 2000).

The use of the internet to convey health-related information to consumers has grown over the past decade (Bensley et al., 2004). Internet-based behavior management models permit a large number of individuals to be reached at fairly low costs. These approaches assess individual need based on traditional theory by pairing the individual’s stage of change to resources on the internet (Bensley et al., 2004). Research shows the effectiveness of internet-based interventions is enhanced by the use of additional methods of communicating with individuals (Webb, Joseph, Yardley, & Michie, 2010).
Critique of Previous Research

Many behavioral interventions have been inconsistently defined and have shown mixed results (Wolever et al., 2013). Further, the degree of behavioral change and communication-skills training reported is lacking. A systematic review of 143 articles evaluating content training for health professionals and coaches in behavior change methods based on numerous behavioral theories (i.e., Health Beliefs Model, Social Cognitive Theory, Theory of Planned Behavior, Transtheoretical Model, Self-Determination Theory, Self-Perception Theory and Motivational Enhancement) revealed only 61% included behavior change training and 67% communication skills training for rapport building, providing emotional support, and expressing empathy (Wolever et al., 2013).

Behavioral Engagement with Pure Presence™

Behavioral Engagement with Pure Presence™ originated from 34 years of development and research by the National Institute of Whole Health (NIWH). The behavior change model teaches health care professionals to treat the whole patient as opposed to their disease and to form relationships with their patients for sustained behavior modification and improved patient outcomes (Donadio, 2004).

In 1980, NIWH began conducting the first pilot studies on the model which incorporated disease prevention through demystified health information, respectful peer presence, shared decision making and whole health advocacy for patient wellness and self-directed care (National Institute of Whole Health [NIWH], 2014). Dr. Ted Kapchuck expressed the application of the model was shown to consistently “re-moralize and spark renewed interest in health and well-being” (as cited in NIWH, n.d., para. 1) in their difficult patient populations studied.
In a Harvard affiliate hospital pilot study on recalcitrant patients with varying cardiovascular disease, researchers learned from study participants that it is one thing to be told what to do and it is another to understand why (NIWH, 2002). This is very empowering for the patient. One of the most significant findings was the response of 94% of patients who stated, “Never before in my life have I been listened to like this” (as cited in NIWH, 2002). The hospital’s Medical Director, Dr. Harvey Zarren, stated, “The relationship of educator (provider) with patient gave people a behavior model that, with the content of the education, allowed for persistent lifestyle changes” (as cited in NIWH, 2002). He concluded this method of education could help transform medical care for patients and providers.

The goal of this research was to demonstrate how this behavioral change model created better communication outcomes in healthcare benefiting both patients and providers. It also created an evidence-based way to bring the model into a variety of healthcare delivery environments. The model has shown consistent, effective communication skills results in enhanced patient-provider relationships, ability to overcome communication behaviors in the healthcare environment, sustained patient behavior change, improved patient adherence to treatment regimens and therefore patient outcomes, increased patient-provider satisfaction, and increased efficiency and cost management of healthcare organizations (Donadio, 2011).

**Summary**

This chapter summarizes the key aspects that encompass communication in the patient-provider encounter. The researcher’s comprehensive review of the literature cited the effects poor communication has on patients and providers, individually and collectively. The literature and articles discussed what patients are seeking from their providers and how this may lead to
behavior modification. Literature findings discussed the importance of communication-skills training for healthcare professionals to effectively engage with their patients for sustained behavior change; however, training content in this area was lacking. Finally, there was limited research on various health behavior models as the concept differentiation of these models makes it difficult to scientifically evaluate a point-by-point comparison.

The researcher introduced the behavior change model, Behavioral Engagement with Pure Presence™ discussing its origination and the evidence-based research in support of its development and application. The model was formulated to provide communication-skills training for providers to effectively engage in a manner other models have not demonstrated in the literature findings.

The literature review provided the researcher with context prior to examining the effects of a behavioral change model to be used as the intervention in this research study. This assisted the researcher in developing a methodology that would contribute to advancing research in patient-provider relationships. The methodology of the research study is described in Chapter III.
CHAPTER III
METHODOLOGY

Study Design Overview

The researcher conducted a pre-experimental pilot study to examine the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships. The purposive sample of participants was recruited from outpatient medical centers in the state of Michigan. The researcher aimed to secure a minimum of five practice sites to explore effects of the model in patient-provider relationships across various providers (i.e., physicians, physician assistants, nurse practitioners, and nurses) and areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.) and their patients. Initially each provider was to recruit a minimum of 10 patients. The researcher aimed for a study population comprising a minimum of 10 trained providers and 100 patients.

The researcher secured two practice sites with specialties in endocrinology and orthopedics. A signed research pilot study agreement detailing the collaborative agreement between practice site, researcher, and originator of the intervention; provider training; authorizations; and proprietary information (Appendix A) was obtained from each participating site. Of these two participating sites, the endocrinology practice aimed to recruit a total of 75 patients from three participating providers. The orthopedic practice aimed to recruit 25 patients from one participating provider.

The researcher met with each practice manager to review study protocol and implementation in daily operations. The research team of participating site, Alzohaili Medical Consultants, advised the researcher on patient participation criteria. A. Y. Solaiman and M.
Kattan (personal communication, February 17, 2014) recommended the patient inclusion criteria include new patients only to eliminate potential bias from patients with established relationships with their providers. The researcher modified the patient participation criteria to exclude established patients.

M. Kattan (personal communication, August 1, 2014) recommended the researcher compose a patient recruitment statement (Appendix B). A member of the practice research team used the script to initially introduce the study to each potential patient participant during the recruitment process.

The researcher discussed assigning participant personal identification numbers and tracking patients for completion of pre- and post-surveys. M. Kattan (personal communication, August 1, 2014) recommended he maintain a separate database of study participants to include the patient’s name, location of practice site, pre-intervention visit and post-intervention visit. The researcher conducted periodic chart audits to monitor completion of patient enrollment forms, demographic information and surveys.

Potential provider participants were instructed on time commitment, training, confidentiality and participation in the study by the researcher. Upon acceptance to participate, each provider submitted a copy of their credentials; a signed confidentiality and disclosure form (Appendix C); and a participant information and consent form (Appendix D) provided by the researcher. Prior to study implementation, the researcher met with each participating provider and designated staff study coordinator to review study protocol and educate on patient recruitment including patient inclusion and exclusion criteria, informing potential patient participants of their time commitment, protection of their confidentiality and patient
participation, privately consenting and enrolling interested subjects meeting eligibility criteria, and completing patient forms.

Identification of the patient study population was made through provider recommendation based on the study’s defined patient eligibility criteria. Providers made the initial contact with potential patient participants instructing them on time commitment, confidentiality and participation in the study. During enrollment patients were required to sign an informed consent form (Appendix E) with instruction on their participation and an authorization for disclosure of health information form (Appendix F) of specified health information. Patients providing consent were asked to complete a survey at the end of their clinic visit.

The provider received training on use of the intervention, Behavioral Engagement with Pure Presence™. All study participants completed surveys pre- and post-implementation of the intervention.

Quantitative Approach

The research design comprised a quantitative analysis utilizing a self-administered, pre- and post-intervention survey to participants measuring their perspective on the patient-provider relationship. In this pre-experimental research, the one-group pretest-posttest design did not include a control group.

A pre-intervention, adapted CARE Measure Survey (Appendix G) was provided to patients meeting eligibility criteria at the time of their scheduled visit upon recruitment. Providers were then trained in application of the intervention. A post-intervention, adapted CARE Measure Survey was provided on the patient’s return or follow-up visit. This study did
not require additional visits outside the standard of care in frequency for regularly scheduled visits.

Patient demographic and medical information, extraneous variables indicated as covariates in the study, were derived from the patients’ medical records and recorded on a data collection form (Appendix H) by the provider. Information obtained included: age, gender, race, ethnicity, number of visits to their provider during the study, length of scheduled visits, current health status, and patient complaint or reason for visit.

The participating healthcare provider completed a pre-intervention, Work Satisfaction Survey (Appendix I) at the onset of the study. A post-intervention, Work Satisfaction Survey was initially to be completed within a 90-day interval upon completion of the study. The 90-day interval would permit the provider to apply the model in practice over a period of time to best evaluate its effectiveness on provider satisfaction. With one participating provider the researcher was not able to test the second hypothesis. The provider completed the post-intervention survey after the patient participant post-visits were completed.

Provider demographic and practice information was derived from a provider participation form (Appendix J) completed by the provider. Information obtained included: age, gender, race, ethnicity, licensure, area(s) of specialty, practice type, length of time as a practicing healthcare professional, and degree and source of communication skills training. In testing the second hypothesis this data would have been analyzed as extraneous variables and indicated as covariates in the study.
Data Management and Participant Confidentiality

All hard copy data obtained throughout the duration of the study (e.g., surveys, forms) were retained in a separate file in a secure storage cabinet at each practice location. Records were accessed only by clinic personnel with current privileges to health protected information. The management and transfer of data for analysis were conducted adhering to organizational policy in compliance with privacy laws. The researcher was responsible for the transfer of data; extracting and entering data into a secured database.

To retain confidentiality, patients and providers were assigned a unique identification number. Identifying information will not be stored with data contained in the research database. Research data will be retained in a secure, password protected database created for the purpose of this study. All noninvestigators were required to sign a Research Assistance Confidentiality Agreement (Appendix K). Noninvestigators are defined as individuals who may assist in conducting specific research tasks such as collecting or entering data.

Study Population and Sample Size

The study population aimed to reflect representation of various providers (i.e., physicians, physician assistants, nurse practitioners, and nurses) in areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.) and respective patients of the communities serviced. A limited purposive sample was obtained as detailed below and explained in Chapter IV.

Patient eligibility criteria included men and women at least 18 years of age that were new patients of the provider, were able to complete pre- and post-survey instruments, and speak and read English. Participant exclusion criteria included established patients and new patients with
severe comorbidities, limited life expectancy, and cognitive dysfunction or severe mental illness that are under active psychiatric treatment with intensive psychotropic medications (i.e., schizophrenia or severe bipolar disorder). Patients must be willing to sign an informed consent and authorization for release of medical information form if they meet eligibility criteria for participation.

Provider participation criteria included licensed health practitioners with staff privileges at each of the participating practice locations. Providers may include physicians, physician assistants, nurse practitioners, registered nurses, and allied health professionals. Providers must be willing to sign an informed consent and confidentiality and disclosure form at time of recruitment.

A purposive sample included an arbitrary selection of two practice locations. The unit of analysis consists of the patient and the provider. The endocrinology practice aimed to recruit a total of 75 patients from three participating providers. The orthopedic practice aimed to recruit 25 patients from one participating provider. Of the two practice sites that initially agreed to participate, only one site participated. The reduction in participating practice sites resulted in a sample size of one provider and 40 patients. The one provider pre- and post-intervention survey results are reported while the patient sample size is sufficient for analysis in a pilot study.

**Participating Practice Site**

The participating practice, Alzohaili Medical Consultants, is a private endocrinology practice and research department with two locations in southeastern Michigan. The study’s participating provider, Opada Alzohaili, M.D., FACE, established Alzohaili Medical Consultants in 2003. Dr. Alzohaili is a renowned endocrinologist practicing over 20 years. His area of
specialty includes: diabetes, insulin resistance, Poly Cystic Ovary Syndrome (PCOS), thyroid disease and obesity. Dr. Alzohaili is also an Assistant Professor at Wayne State University in Detroit, Michigan. He has participated in numerous clinical trials for diabetes, osteoporosis, heart disease, growth hormone disorders and hypercalcemia.

**Data Collection and Statistical Analysis**

Patient recruitment commenced on August 20, 2014 and concluded on October 7, 2014. Following pre-intervention visits, provider preparation for training began in November and training was completed in December. Patient post-intervention visits occurred in January 2015.

Patient data was obtained from medical records and patient self reporting using the adapted CARE Measure Survey for pre-intervention observation and follow-up visit, or post-intervention. Dependent variables for patient reporting on their psychological status are listed in Table 1 and included Valued, Present, Listen, Whole, Understand, Eye Contact, Positive, Explain, Take Control, and Develop Plan. The researcher’s definition of each variable was extracted from the explanation of each measure provided to participants in the CARE Measure Survey.

The patient participant was asked to rank each variable on a 5-point Likert scale with an opt-out response “Does Not Apply”. The Likert scale is a variation of the summated rating scale which asks respondents to agree or disagree with statements that express a favorable or unfavorable attitude toward the object of study (Cooper & Schindler, 2008). A numerical score is assigned to each response to reflect the degree of favorableness. The following descriptors were assigned to the CARE Measure Survey instrument: 0 = Does Not Apply, 1 = Poor, 2 = Fair,
3 = Good, 4 = Very Good, 5 = Excellent. The Likert Scale Summated Rating used produces interval data (Cooper & Schindler, 2008).

Provider data was obtained from provider self-reporting demographic and professional practice information and the Work Satisfaction Survey at pre- and post-intervention. As the total provider participant population resulted in one provider, analysis for the dependent variables on provider reporting on workplace satisfaction named to include measures in patient-provider satisfaction and job satisfaction will not be conducted. The pre- and post-intervention survey results are reported. Response for each item on the 5-point Likert scale of the Work Satisfaction Survey instrument is scaled as follows: Never, Almost Never, Sometimes, Fairly Often, Very Often. Provider demographic and practice information is reported.

Exposure to Behavioral Engagement and Pure Presence™ was analyzed as the independent variable in this study against patient data. Patient demographic and medical information were indicated as covariates and tested as independent variables. Nominal, ordinal, and ratio level of data was obtained.

**Quantitative Analysis**

The statistical analysis was conducted using IBM Statistical Package for Social Sciences (SPSS) software version 22. SPSS is statistical analysis software designed to perform a comprehensive range of statistical procedures to analyze quantitative data (IBM, n.d.).

The researcher first developed a codebook to complete a data set in SPSS for analysis. A codebook contains a complete list of all research data, designating the name of each variable and the assigned value (Appendix K).
Descriptive statistics were tabulated for dependent variables and independent variables. Data was screened for accuracy and missing values were coded as necessary. The analyses adjusted for covariates pertaining to patient participant demographic and medical information.

The researcher analyzed the one-group, pretest-posttest research design using the paired-samples t test. The test is applicable to repeated-measures designs where participants are assessed on two occasions on one measure (Green & Salkind, 2011). As applied to this research study, participants were assessed before and after an intervention. The paired-samples t test evaluates whether the mean difference between variables of the two occasions are significantly different from zero (Green & Salkind, 2011).

There are two underlying assumptions for the paired-samples t test (Field, 2009; Green & Salkind, 2011). Assumption 1: The sampling distribution of the differences between scores is normally distributed. A sample size of 30 pairs of scores is an acceptable value to obtain reasonably accurate p values even when the difference scores are not normally distributed.

Although this research study resulted in 40 pairs of scores, variables were tested to determine if data met the assumption for normality. The researcher computed a new variable collapsing pretest and posttest data into a different score and adjusted mean differences to test normality assumption in paired samples. Two tests of normality, the Kolmogorov-Smirnov Test and the Shapiro-Wilk Test, were performed using adjusted variables. Histograms of dependent variables using adjusted means were inspected. Skewness and kurtosis showed adjusted variables were within acceptable ranges for normality.
Assumption 2: The difference scores between pairs are independent of each other. If this assumption is violated the paired-samples \( t \) test would yield and inaccurate \( p \) value. The data met this assumption.

The paired-samples \( t \) test is a parametric test which assumes both normal distribution and interval level data. The Likert Scale Summated Rating used in the study produces interval data (Cooper & Schindler, 2008); however, such data is often classified as categorical data and analyzed as an ordinal level of measurement. For interval data, equal intervals on the scale must represent equal differences in the property being measured (Field, 2009). Given the variable results in testing for normality and subjective variation in determining the level of measurement in Likert scale data (Field, 2009; Grace-Martin, n.d.), the researcher conducted a related samples Wilcoxon signed-rank test to determine if significant results would be obtained as in the paired-samples \( t \) test.

The Wilcoxon signed-rank test is a nonparametric test used to analyze data from a repeated-measure with an intervention (Green & Salkind, 2011). Nonparametric tests are used on ordinal data without assumption of normal distribution (Field, 2009). The Wilcoxon signed-rank test was conducted to evaluate whether population means of patient participant ranks differed in their perspective of the patient-provider relationship before and after the intervention.

In controlling for extraneous variables, covariates were assessed using one-way, repeated-measures multivariate analysis of covariance (MANCOVA). The MANCOVA evaluates the influence of one or more independent variables on one dependent variable while removing the effect of covariate factors (Statistics Solutions, 2014). In repeated-measures MANCOVA, two or more dependent variables are measured over a series of within-group time
points (Multivariate Analysis, n.d.). In the event of a significant interaction or main effect using MANCOVA, analysis of covariances (ANCOVA) on the dependent variables would be conducted. Significant ANCOVA findings would lead to post hoc analyses to conduct pairwise comparisons for difference in means (Green & Salkind, 2011).

The assumptions for MANCOVA are as follows (Field, 2009; Green & Salkind, 2011; Multivariate Analysis, n.d.; Statistics Solutions, 2014):

- Assumption 1: The score on a variable for participants are independent of one another. If this assumption is violated, MANCOVA should not be conducted.
- Assumption 2: Participants are randomly sampled and measured at an interval level.
- Assumption 3: The population variances and covariances for each dependent variable are roughly equal. Homogeneity of variances is examined if there are between-group independent variables.
- Assumption 4: Dependent variables collectively have multivariate normality within groups.
- Assumption 5: A statistical relationship exists between the covariate(s) and the dependent variables.

The pretest-posttest research design examined within-subject effects. Assumption 3 was not met as the analysis did not test for homogeneity because there were no between-subject factors.

Assumption 4 states, for multivariate normality, each variable is normally distributed and normally distributed at every combination of values of other variables (Green & Salkind, 2011).
In evaluating normality, an explanation for normal distribution of variables is previously detailed under the assumptions for the paired-samples \( t \) test.

**Provider Training and Participation**

Provider training was conducted through the National Institute of Whole Health (NIWH). Training comprised an orientation and webinar series comprising four workshops, three videos, assignments, required readings to supplement the training sessions and a 10 minute recorded interview demonstrating the provider’s application of the model at the completion of the training. Participating providers were required to submit a copy of their credentials and a signed confidentiality and disclosure form provided by the researcher. In preparation for the training, providers were required to read the book, *Changing Behavior: Immediately Transform Your Relationships with Easy-to-Learn, Proven Communication Skills* by Georgianna Donadio, MSc, DC, PhD. Future training or dissemination of the model outside the scope of the Behavioral Engagement with Pure Presence\(^\text{TM}\) research will require a signed licensing agreement with the originator of the model.

The NIWH will issue an individual Communication Facilitator Certificate for the successful completion of the Behavioral Engagement with Pure Presence\(^\text{TM}\) program. Providers eligible to receive continuing education credit must complete an evaluation form plus conduct at least one interview demonstrating their use of the Behavioral Engagement and Pure Presence\(^\text{TM}\) Model to receive credit. The interview may be conducted with a friend, patient, etc. while working with a provided interview form. Providers must submit to NIWH a recording of their interview on a computer compatible memory stick.
All participating providers agreed to share their practice experience and comments with NIWH. Participants were asked to complete written program evaluations after the NIWH training. Additionally, the participants agreed to be available for one-on-one and/or group telephone conferences to discuss the NIWH program efficacy, as well as their personal experiences in applying the information learned from the program to their own clinical practice.

**Model Description**

The intervention consists of incorporating Behavioral Engagement with Pure Presence™ in patient-provider relationships. Behavioral Engagement with Pure Presence™ is a behavioral change model that has been researched and developed by the NIWH in hospitals and medical centers around the United States for over 30 years (Donadio, 2011). What NIWH’s pilot studies have identified is the impact that this holistic model of health education and behavioral interaction is a tool for health practitioners affording the momentum of care to be redirected toward in-the-moment, relationship-centered whole person care (Donadio, 2005; NIWH, 2014). The outcomes evidenced have included enhanced patient satisfaction, provider work satisfaction, increased self-directed patient-provider compliance, reduced stress induced errors, and a reduction in workplace attrition among providers (NIWH, 2014).

The model applies an integrated approach to inter-person communication while engaging both patients and providers (Donadio, 2011). Designed to enhance and transform patient-provider relationships, it serves as a best practice model of relationship-centered, patient education training for providers. Centered on “a state of being fully and wholly present to another person” (Donadio, 2011, p. 41), it comprises 20 core relational dynamics that are “multi-dimensional and Whole Person focused” (Donadio, 2011, p. 41) and 12 steps of Pure Presence.
These transformational components work with the physiological brain state to facilitate emotional shifting that is essential to sustained behavior change (Donadio, 2011).

The NIWH’s Whole Health Education® curriculum, an accredited, post-professional training program for credentialed health professionals, has at its base the Behavioral Engagement with Pure Presence™ Model of relationship communication. Whole Health Education with Behavioral Engagement and Pure Presence™ is a Harvard hospital identified Best Practice Model of Relationship-Centered Care, nominated for the Fetzer Institute’s Norman Cousins Award, for excellence in relationship-centered, whole person care.

Research Validity, Reliability, and Limitations

Data Validity and Reliability

The Consultation and Relational Empathy (CARE) Measure is a tool for measuring a patient’s perception of empathy in the clinical setting (Mercer, Maxwell, Heaney, & Watt, 2004). The instrument was modestly adapted for application and use in the NIWH’s pilot studies. Modification was made to reword a nominal number of statements to reflect proper evaluation of the Behavioral Engagement and Pure Presence™ Model. Research supports the validity and reliability of this instrument as an empathy-based consultation process measure in its original form (Mercer, Maxwell, Heaney, & Watt, 2004). The NIWH reports its reliability and validity in its adapted form.

The Work Satisfaction Survey was developed by the NIWH to include evidence-based research in support of Whole Health Education that measures patient-provider satisfaction and job satisfaction. This instrument was tested for validity and reliability by the NIWH.
Internal Validity

The casual relationship of this experimental study examines whether the intervention caused an improved psychological effect in patients and workplace satisfaction in providers. Internal validity of the study would demonstrate whether an observed change was in fact attributed to the intervention as opposed to other potential causes.

Threats to internal validity using a one-group pretest-posttest research design, as it applies to this study, include potentially confounding extraneous variables such as history, maturation, and testing (Cooper & Schindler, 2008). In regard to history, extraneous events could occur to confound the effects of the intervention in study participants such as provider time constraints that impede how much they engage with their patient or the level of attention given by the provider to learn the curriculum as required during training. In maturation, the provider or patient may experience a change throughout the study’s duration within themselves that effects their complete participation such as inattention due to life events. Testing can result in a learning effect that influences the responses of study participants when they take the survey a second time.

External validity

A threat to external validity is the ability to generalize the research findings. The pre-experimental design did not include a control group. Further, the population sample size (n = 40) was sufficient for a pilot study; however, the sample size was not large enough to demonstrate generalizability across the patient population. The reduced sample size of provider participants (n = 1) was not large enough to conduct a statistical analysis where results may be generalizeable across provider types or areas of specialty as a whole or within the practice of endocrinology.
Limitations

A primary limitation to purposive sampling is the generalizability of study results. The small sample size of patient participants drawn from the endocrinology practice is not representative of the general population. Further, the reduced sample size of provider participants (n = 1) was not large enough to conduct a statistical analysis where results may be generalizeable across provider types or areas of specialty as a whole or within the practice of endocrinology.

A second limitation is the potential for bias in the selection process as the study participants were not drawn from a random sample of the general population. A purposive sample of potential participating practice sites were selected based on practice specialty to satisfying the duration and design of the study. Patients who frequent their provider more regularly due to management of a chronic health condition or emergent acute condition, as opposed to an annual health check-up with a general practitioner, would permit a reasonable time frame to conduct the pretest-posttest study. Patient participants were selected randomly within the participating practice.

Summary

This chapter summarized the methodology utilized in a pre-experimental, one-group pretest-posttest research design. The researcher utilized a quantitative approach to examine the effects of the intervention, Behavioral Engagement with Pure Presence™, in patient-provider relationships. A description of the intervention expounds on its application.

The researcher secured a single practice site to conduct the research study. Self-administered, pre-and post-intervention quantitative surveys were provided to 40 patients and
one provider. The one provider pre- and post-intervention survey results are reported while the patient sample size is sufficient for analysis in a pilot study. The researcher conducted a variety of statistical analyses and tests. Results will be discussed in Chapter IV.

Data validity and reliability were strengthened by the researcher’s utilization of survey instruments that have been tested for validity and reliability. The researcher discusses threats to internal validity using a one-group pretest-posttest research design. The researcher acknowledged the study’s limitations including the generalizability of study results.
CHAPTER IV

PRESENTATION OF DATA

Introduction

The researcher initially aimed for a more expansive scope of research and study design reflecting representation of various providers (i.e., physicians, physician assistants, nurse practitioners, and nurses) in areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.) and respective patients of the communities serviced. Lack of grant funding and a significant delay in Institutional Review Board (IRB) approval resulted in a modified research design and reduction in the number of practice sites and study participants.

Two years prior to study implementation the researcher, in conjunction with Central Michigan University (CMU) and Michigan State University (MSU), applied for grant funding to the following: American Diabetes Association, Office of Behavioral and Social Sciences Research, Agency for Healthcare Research and Quality, American Association of University Women and Blue Cross Blue Shield of Michigan Foundation. Of these, the researcher was awarded a $3,000.00 grant from the Blue Cross Blue Shield of Michigan Foundation’s Student Award Program.

The initial proposed research project was an experimental research design to be conducted through MSU clinical centers. The proposal was submitted to MSU’s IRB and approved September 9, 2013. Lack of substantial grant funding lead the researcher to seek other potential research sites and modify the study design.

A pre-experimental research design proposing multiple practices and provider types was first submitted to CMU’s IRB January 19, 2014 and approved July 8, 2014. The researcher
received final approval to begin dissertation research study on July 16, 2014. The IRB informed the researcher the delay was due primarily to lack of resources. This delay resulted in an unanticipated reduction in practice participation resulting in a reduction of participating providers and patients previously secured. The researcher reported this change to CMU’s IRB.

The aforementioned collectively lead the researcher to modify the original research study to comprise a one-group pretest-posttest design that does not include a control group. A single group of patient participants were tested before and after an intervention. The presentation of the data will first examine descriptive statistics and results of the quantitative, pre- and post-intervention surveys.

**Data Screening**

The data was screened for accuracy. The value “99” was designated as a missing value and excluded. Missing value for the variable measuring the length of patient pre-intervention visit was 7.5% and 52.5% for the post-intervention visit. The researcher excluded these variables as more than half of the post-intervention visit scores were not reported.

Two tests of normality, the Kolmogorov-Smirnov Test and the Shapiro-Wilk Test, were performed using adjusted means of dependent variables to increase accuracy of assessment in a repeated-measures research design. The tests yielded significant p values indicating the difference scores were not normally distributed. A visual inspection of histograms using the adjusted means showed a slightly negative skewed distribution to the left for pre-intervention measures and slight positive skewed distribution for post-intervention measures. Research has indicated an acceptable range of skewness and kurtosis for normal distribution of data is below +1.5 and above -1.5 (www.researchgate.net). Skewness and kurtosis showed adjusted variables
were within acceptable ranges for normality. There were minimal differences observed between mean, median and mode in both measures. The researcher used parametric and nonparametric tests in the analysis.

Normality of independent variables was assessed using histograms, skewness and kurtosis. Visual inspection of histograms showed an approximate normal distribution for patient age and gender. Skewness and kurtosis showed each variable was within acceptable ranges for normality. Variables measuring ethnicity, race and health status were not normally distributed.

Descriptive Statistics

Descriptive statistics were tabulated for dependent variables and independent variables using IBM® SPSS® 22.0. Participants were 15 male and 25 female aged 19 to 69 years. The average age of participants was 42.7 years (SD = 14.89). The variable for age with a ratio level of measurement was re-coded into a new variable categorizing age ranges into an ordinal level of measurement. Table 2 shows the frequency and percentage of participant age.

<table>
<thead>
<tr>
<th>Age Range</th>
<th># of Participants</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 to 34</td>
<td>14</td>
<td>35.0</td>
</tr>
<tr>
<td>35 to 44</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>45 to 54</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>55 to 64</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>65+</td>
<td>3</td>
<td>7.5</td>
</tr>
</tbody>
</table>
Table 3 shows the age range of participants by gender is as follows:

### Table 3. Participant Age by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>18 to 34</th>
<th>35 to 44</th>
<th>45 to 54</th>
<th>55 to 64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>46.7%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>25.7%</td>
<td>6.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Participant Age Range</td>
<td>50.0%</td>
<td>0.0%</td>
<td>27.3%</td>
<td>66.7%</td>
<td>33.3%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>28.0%</td>
<td>24.0%</td>
<td>32.0%</td>
<td>8.0%</td>
<td>8.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Participant Age Range</td>
<td>50.0%</td>
<td>100.0%</td>
<td>72.7%</td>
<td>33.3%</td>
<td>66.7%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

Participants were predominately Caucasian (n = 37, 92.5%). African Americans comprised the remaining participant population (n = 3, 7.5%). Participant ethnic origin was predominately non-Hispanic or Latino (n = 39, 97.5%).

Current health status was obtained from the patient’s medical history. Participant health status by diagnosis indicated 31, or 77.5%, of participants had a thyroid condition. Six, or 15%, were being treated for diabetes. Figure 1 illustrates participant health status by diagnosis.
Figure 1. Patient Health Status
Bar chart showing frequency and percentage of patient health status by diagnosis

The length of time for pre-intervention visits ranged from 60 to 105 minutes. Post-intervention visits ranged from 60 to 80 minutes. It is unknown how much of that time was spent with the participating provider. As previously reported, greater than half the post-intervention variable had missing values. These variables were excluded from further analysis.
Quantitative Survey Results

A quantitative survey was administered to 40 patient participants at a single participating practice site specializing in endocrinology. The patients were asked to rate the importance of key variables using a Likert rating scale (0 = Does Not Apply, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent) on their perception of provider empathy in patient-provider communications. The mean or average Likert scale rating pre- and post-intervention are detailed in Figures 2 and 3, respectively.

Figure 2. Mean Likert Rating Pre-Intervention
Mean response score of patient perception of provider relational empathy before the intervention
Dependent variables for patient reporting on their psychological status, as defined in Table 1 of Chapter I, are illustrated in Figures 2 and 3. The mean value of each dependent variable increased Signifying a higher rating on average for each measure. As observed in Figures 2 and 3, the greatest difference in patient reporting was provider listening improved on their post-intervention visit (mean difference = .42). The least degree of change reported was a
slight improvement in provider having a positive approach and attitude (mean difference = .17).

Patient response to pre-intervention and post-intervention survey scores on key dependent variables are detailed in the tables that follow.

In Table 4 it is observed the pre-intervention patient Likert rating response on the variable Valued ranged from Good to Excellent with 29 participants, or 72.5%, reporting Excellent. The post-intervention response indicates 100% of the patients report they felt valued. This variable measured the patient’s perspective on their provider being friendly and warm, treating him/her with respect and not being cold or abrupt.

<table>
<thead>
<tr>
<th>Variable: Valued</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making you feel valued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(pre-intervention) Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Far</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Very Good</td>
<td>10</td>
<td>25.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>29</td>
<td>72.5%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

In Table 5 it is observed the pre-intervention patient Likert rating response on the variable Present ranged from Good to Excellent with 32 participants, or 80%, reporting
Excellent. The post-intervention response indicates 100% of the patients report their provider was fully present. This variable measured the patient’s perspective on their provider giving him/her time to fully describe their illness in their own words without interruption or diversion from their provider.

Table 5. Participant Pre-Intervention and Post-Intervention Survey Response to Present

<table>
<thead>
<tr>
<th>Variable: Present (pre-intervention)</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Very Good</td>
<td>7</td>
<td>17.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>32</td>
<td>80.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable: Present (post-intervention)</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>40</td>
<td>100.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

In Table 6 it is observed the pre-intervention patient Likert rating response on the variable Listen ranged from Good to Excellent with 26 participants, or 65%, reporting Excellent. The post-intervention response indicates 100% of the patients report their provider really listened to them. This variable measured the patient’s perspective on their provider paying close attention to what he/she is saying. The provider is not looking at their notes or the computer as the patient is talking.
In Table 7 it is observed the pre-intervention patient Likert rating response on the variable Whole ranged from Good to Excellent with 28 participants, or 70%, reporting Excellent. The post-intervention response indicates 100% of the patients report their provider addressed their needs as a whole person. This variable measured the patient’s perspective on their provider asking or knowing relevant details about his/her life and situation; not treating them as “just a number”.

<table>
<thead>
<tr>
<th>Variable (pre-intervention)</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Really listening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
<td>7.5%</td>
</tr>
<tr>
<td>Very Good</td>
<td>11</td>
<td>27.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>26</td>
<td>65.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable (post-intervention)</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Really listening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>40</td>
<td>100.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
In Table 8 it is observed the pre-intervention patient Likert rating response on the variable Understand ranged from Good to Excellent with 32 participants, or 80%, reporting Excellent. The post-intervention responses ranged from Very Good (n = 1) to Excellent (n = 39). This indicates 97.5% of patients report their provider was Excellent in understanding his/her concerns. This variable measured the patient’s perspective on their provider communicating that he/she accurately understands their patient’s concerns and is not overlooking or dismissing anything.
Table 8. Participant Pre-Intervention and Post-Intervention Survey Response to Understand

<table>
<thead>
<tr>
<th>Variable: Understand (pre-intervention)</th>
<th>#Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>6</td>
<td>15.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>32</td>
<td>80.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable: Understand (post-intervention)</th>
<th>#Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>39</td>
<td>97.5%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100%</td>
</tr>
</tbody>
</table>

In Table 9 it is observed the pre-intervention patient Likert rating response on the variable Eye Contact ranged from Good to Excellent with 28 participants, or 70%, reporting Excellent. The post-intervention responses ranged from Very Good (n = 2) to Excellent (n = 38). This indicates 95% of patients report their provider was Excellent in making consistent, attentive eye contact with them. This variable measured the patient’s perspective on their provider seeming genuinely concerned with him/her on a human level and not being indifferent or detached.
Table 9. *Participant Pre-Intervention and Post-Intervention Survey Response to Eye Contact*

<table>
<thead>
<tr>
<th>Variable: Eye Contact</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making consistent, attentive eye contact (pre-intervention)</td>
<td>Poor</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Does Not Apply</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>40</td>
</tr>
<tr>
<td>Making consistent, attentive eye contact (post-intervention)</td>
<td>Poor</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Does Not Apply</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

In Table 10 it is observed the pre-intervention patient Likert rating response on the variable Positive ranged from Good to Excellent with 32 participants, or 80%, reporting Excellent. The post-intervention responses ranged from Very Good (n = 2) to Excellent (n = 38). This indicates 95% of patients report their provider was Excellent in being positive, caring and respectful. This variable measured the patient’s perspective on their provider having a positive approach and attitude while being honest and not negative about his/her problems.
In Table 11 it is observed the pre-intervention patient Likert rating response on the variable Explain ranged from Good to Excellent with 30 participants, or 75%, reporting Excellent. The post-intervention responses ranged from Very Good (n = 1) to Excellent (n = 39). This indicates 97.5% of patients report their provider was Excellent in explaining information clearly to them. This variable measured the patient’s perspective on their provider fully answering his/her questions, explaining clearly, providing adequate information and not being vague.
In Table 12 it is observed the pre-intervention patient Likert rating response on the variable Take Control ranged from Good to Excellent with 29 participants, or 72.5%, reporting Excellent. The post-intervention responses ranged from Very Good (n = 1) to Excellent (n = 39). This indicates 97.5% of patients report their provider was Excellent in facilitating him/her to take control. This variable measured the patient’s perspective on their provider discussing what he/she can do to improve their health while providing encouragement rather than lecturing them.
In Table 13 it is observed the pre-intervention patient Likert rating response on the variable Develop Plan ranged from Good to Excellent with 30 participants, or 75%, reporting Excellent. One participant reported Does Not Apply. The post-intervention responses ranged from Very Good (n = 1) to Excellent (n = 39). This indicates 97.5% of patients report their provider was Excellent in developing a plan of action with them. This variable measured the patient’s perspective on their provider discussing options, involving him/her in decisions as much as they would like to be involved; not ignoring his/her views.

Table 12. Participant Pre-Intervention and Post-Intervention Survey Response to Take Control

<table>
<thead>
<tr>
<th>Variable: Take Control (pre-intervention)</th>
<th>#Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating you taking control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>5</td>
<td>12.5%</td>
</tr>
<tr>
<td>Very Good</td>
<td>6</td>
<td>15.0%</td>
</tr>
<tr>
<td>Excellent</td>
<td>29</td>
<td>72.5%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable: Take Control (post-intervention)</th>
<th>#Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating you taking control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>39</td>
<td>97.5%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Hypothesis 1: Patient Psychological Effects

The quantitative analysis examined what are the psychological effects, if any; of introducing Behavioral Engagement with Pure Presence™ in patient-provider relationships on patients? The researcher conducted a paired-samples t test and related samples Wilcoxon signed-rank test to test the null hypothesis (H₀): Patients who participate in Behavioral Engagement with Pure Presence™ will not experience improved psychological effects, as indicated by an adapted CARE Measure survey instrument.

Paired-Samples t Test

A paired-samples t test was conducted to compare patient perception of relational empathy in the patient-provider relationship before and after applying the intervention. For each

Table 13. Participant Pre-Intervention and Post-Intervention Survey Response to Develop Plan

<table>
<thead>
<tr>
<th>Variable: Develop Plan</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a plan of action with you (pre-intervention)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>7</td>
<td>17.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>30</td>
<td>75.0%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing a plan of action with you (post-intervention)</th>
<th># Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Good</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>39</td>
<td>97.5%</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
of the paired samples, results indicated that the mean for post-intervention scores were significantly greater than pre-intervention scores. For example, results indicated that the mean patient post-intervention score for developing a plan of action \((M = 4.98, SD = .16)\) was significantly greater than the mean patient pre-intervention score \((M = 4.60, SD = .93)\), \(t(39) = 2.94, p < .01\). The paired-samples \(t\) test results for each pair are detailed in Table 14.

<table>
<thead>
<tr>
<th>Variable Pairs</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>(t)</th>
<th>(df)</th>
<th>(p)</th>
<th>Cohen’s (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valued</td>
<td>4.70 (.52)</td>
<td>5.00 (.00)</td>
<td>-3.67*</td>
<td>39</td>
<td>.001</td>
<td>.58</td>
</tr>
<tr>
<td>Present</td>
<td>4.78 (.48)</td>
<td>5.00 (.00)</td>
<td>-2.97*</td>
<td>39</td>
<td>.005</td>
<td>.47</td>
</tr>
<tr>
<td>Listen</td>
<td>4.58 (.64)</td>
<td>5.00 (.00)</td>
<td>-4.23*</td>
<td>39</td>
<td>.000</td>
<td>.67</td>
</tr>
<tr>
<td>Whole</td>
<td>4.65 (.58)</td>
<td>5.00 (.00)</td>
<td>-3.82*</td>
<td>39</td>
<td>.000</td>
<td>.60</td>
</tr>
<tr>
<td>Understand</td>
<td>4.75 (.54)</td>
<td>4.98 (.16)</td>
<td>-2.68*</td>
<td>39</td>
<td>.011</td>
<td>.42</td>
</tr>
<tr>
<td>Eye Contact</td>
<td>4.63 (.63)</td>
<td>4.95 (.22)</td>
<td>-3.34*</td>
<td>39</td>
<td>.002</td>
<td>.53</td>
</tr>
<tr>
<td>Positive</td>
<td>4.78 (.48)</td>
<td>4.95 (.22)</td>
<td>-2.21*</td>
<td>39</td>
<td>.033</td>
<td>.35</td>
</tr>
<tr>
<td>Explain</td>
<td>4.68 (.62)</td>
<td>4.98 (.16)</td>
<td>-3.37*</td>
<td>39</td>
<td>.002</td>
<td>.53</td>
</tr>
<tr>
<td>Variable Pairs</td>
<td>Pre-Intervention</td>
<td>Post-Intervention</td>
<td>t</td>
<td>df</td>
<td>p</td>
<td>Cohen’s d</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>-----</td>
<td>-----</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>Take Control</td>
<td>4.60 (.71)</td>
<td>4.98 (.16)</td>
<td>-3.55*</td>
<td>39</td>
<td>.001</td>
<td>.56</td>
</tr>
<tr>
<td>Develop Plan</td>
<td>4.60 (.93)</td>
<td>4.98 (.16)</td>
<td>-2.94*</td>
<td>39</td>
<td>.005</td>
<td>.46</td>
</tr>
</tbody>
</table>

Note. * = p ≤ .05. Standard deviations appear in parenthesis below means.

A level of significance or alpha level of .05 was utilized by the researcher to test the hypothesis. As the p values are less than .05, the researcher rejected the null hypothesis that the population mean difference is equal to 0.

After rejecting the null hypothesis the researcher calculated the effect size using Cohen’s d to measure the magnitude or strength of mean differences (Lakens, 2013; University of Minnesota, 2014). Cohen's d is defined as the difference between two means divided by a standard deviation (Green & Salkind, 2011). It evaluates the degree that the mean of the difference scores diverge from 0 in standard deviation units. The greater d diverges from 0, the effect size becomes larger. The effect size values of d are small (d = .2), medium (d = .5) and large (d = .8). Calculated values for paired samples are shown in Table 14.

Cohen’s d values show a medium effect size of .5 or greater for 8 of the 10 paired samples. The largest effect size was observed in paired samples variable Listen (d = .7). The larger effect size indicates the means are likely very different. The larger effect size observed for Listen is consistent with the mean difference reported in reference to Figures 2 and 3. The paired samples variables Understand and Positive each had the smallest effect size (d = .4).
These results indicate the intervention has a psychological effect on the patient’s perception of the patient-provider encounter. Specifically, results suggest when providers are trained and apply the intervention, Behavioral Engagement with Pure Presence™, patient perception of relational empathy in the patient-provider relationship increases.

**Wilcoxon Signed-Rank Test**

In a paired-samples $t$ test, a sample size of 30 pairs of scores is an acceptable value to obtain reasonably accurate $p$ values even when the difference scores are not normally distributed (Green & Salkind, 2011). As previously discussed in Chapter III, although the study sample size consisted of 40 pairs of scores the researcher conducted tests for normality. Given the variable results in testing for normality and subjective variation in determining the level of measurement in Likert scale data (Field, 2009; Grace-Martin, n.d.), the researcher conducted a related samples Wilcoxon signed-rank test to determine if significant results would be obtained as in the paired-samples $t$ test. This nonparametric test is used on ordinal data without assumption of normal distribution (Field, 2009) to analyze data from a repeated-measure with an intervention (Green & Salkind, 2011).

A Wilcoxon signed-rank test was conducted to determine whether there was a difference in the ranking of patient perception of relational empathy as reported pre-intervention and post-intervention. Results of that analysis indicated that there was a significant difference in pre-intervention and post-intervention ranks. The results indicate patient perception of relational empathy following the intervention was more favorable and received significantly more favorable rankings. The tests statistics are reported in Table 15.
Table 15. Wilcoxon Signed-Rank Test Statistics for Repeated Measures

<table>
<thead>
<tr>
<th>Related Samples</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>$z$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valued</td>
<td>6.00</td>
<td>0.00</td>
<td>-3.21*</td>
<td>.001</td>
</tr>
<tr>
<td>Present</td>
<td>4.50</td>
<td>0.00</td>
<td>-2.71*</td>
<td>.007</td>
</tr>
<tr>
<td>Listen</td>
<td>7.50</td>
<td>0.00</td>
<td>-3.49*</td>
<td>.000</td>
</tr>
<tr>
<td>Whole</td>
<td>6.50</td>
<td>0.00</td>
<td>-3.28*</td>
<td>.001</td>
</tr>
<tr>
<td>Understand</td>
<td>4.00</td>
<td>0.00</td>
<td>-2.46*</td>
<td>.014</td>
</tr>
<tr>
<td>Eye Contact</td>
<td>5.50</td>
<td>0.00</td>
<td>-2.92*</td>
<td>.004</td>
</tr>
<tr>
<td>Positive</td>
<td>4.57</td>
<td>4.00</td>
<td>-2.11*</td>
<td>.035</td>
</tr>
<tr>
<td>Explain</td>
<td>5.50</td>
<td>0.00</td>
<td>-2.97*</td>
<td>.003</td>
</tr>
<tr>
<td>Take Control</td>
<td>6.00</td>
<td>0.00</td>
<td>-3.04*</td>
<td>.002</td>
</tr>
<tr>
<td>Develop Plan</td>
<td>5.50</td>
<td>0.00</td>
<td>-2.91*</td>
<td>.004</td>
</tr>
</tbody>
</table>

*Note. $* = p \leq .05.$

A level of significance of .05 was utilized by the researcher to test the hypothesis. The researcher rejected the null hypothesis that the population mean difference is equal to 0. These findings were consistent with the paired-samples $t$ test.

**Confounding Variable Analysis**

In controlling for extraneous variables, covariates were assessed using one-way, repeated-measures MANCOVA. The MANCOVA evaluated the influence of the independent variables (i.e., Age, Gender, Ethnicity, Race, Health Status) on the dependent variable, pre- and post-intervention measures, while removing the effect of covariate factors (Statistics Solutions,
In repeated-measures MANCOVA, two or more dependent variables are measured over a series of within-group time points (Multivariate Analysis, n.d.).

The predicted main effect of Age pre-intervention was not significant, $F(1, 34) = .37, p = .55, \eta^2 = .01$, nor was the predicted main effect of Age post-intervention, $F(1, 34) = .05, p = .83, \eta^2 = .00$.

The predicted main effect of Gender pre-intervention was not significant, $F(1, 34) = .25, p = .62, \eta^2 = .01$, nor was the predicted main effect of Gender post-intervention, $F(1, 34) = 1.94, p = .17, \eta^2 = .05$.

The predicted main effect of Ethnicity pre-intervention was not significant, $F(1, 34) = .79, p = .38, \eta^2 = .02$, nor was the predicted main effect of Ethnicity post-intervention, $F(1, 34) = .11, p = .74, \eta^2 = .00$.

The predicted main effect of Race pre-intervention was not significant, $F(1, 34) = 1.45, p = .24, \eta^2 = .04$, nor was the predicted main effect of Race post-intervention, $F(1, 34) = .75, p = .39, \eta^2 = .02$.

The predicted main effect of Health Status pre-intervention was not significant, $F(1, 34) = .00, p = .95, \eta^2 = .00$, nor was the predicted main effect of Health Status post-intervention, $F(1, 34) = 2.81, p = .10, \eta^2 = .08$.

**Hypothesis 2: Provider Satisfaction**

The researcher aimed to examine what effects, if any; do healthcare providers who practice Behavioral Engagement with Pure Presence™ experience in overall workplace satisfaction? The null hypothesis ($H_0$) to be tested: Healthcare providers who practice Behavioral Engagement with Pure Presence™ with their patients will not experience enhanced satisfaction.
patient-provider satisfaction and enhanced job satisfaction, as indicated by the Work Satisfaction Survey.

As the total participant population resulted in one participating provider, analysis for the dependent variables on provider reporting on workplace satisfaction named to include measures in patient-provider satisfaction and job satisfaction was not conducted. Provider demographic and practice information was derived from a provider participation form completed by the provider. The provider was a 48 year old male, Caucasian, non-Hispanic or Latino. He was a board-certified, medical doctor in private practice specializing in endocrinology. The provider has been a practicing healthcare professional for 24 years. He reported his highest level of patient-provider communications skills training completed was basic, core curriculum. His source of training in communications skills training was in medical school and residency training.

A quantitative survey was administered to the provider at pre- and post-intervention. The provider was asked to rate his work satisfaction level using a Likert rating scale. The Work Satisfaction Survey instrument is scaled as follows: Never, Almost Never, Sometimes, Fairly Often, Very Often. The pre- and post-intervention survey responses are reported in Table 16.

| Question |
|-----------------|-----------------|-----------------|
| 1. In the last month, how often have you been concerned or upset because of something that happened at work? | Fairly Often | Sometimes |
| 2. In the last month, how often have you felt that you were not able to perform your job tasks to the best of your ability, due to work related issues or events? | Sometimes | Sometimes |
| 3. In the last month, how often have you felt "stressed" at work? | Very Often | Fairly Often |

*(table continues)*
<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. In the last month, how often have you dealt <em>successfully</em> with day-to-day problems and annoyances at work?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>5. In the last month, how often have you dealt <em>unsuccesfully</em> with day-to-day problems and annoyances at work?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>6. In the last month, how often have you felt confident about your ability to handle unexpected changes or stress at work?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>7. In the last month, how often have you thought about leaving your job?</td>
<td>Almost Never</td>
<td>Almost Never</td>
</tr>
<tr>
<td>8. In the last month, how often have you found that you left work feeling tired?</td>
<td>Fairly Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>9. In the last month, how often have you found that you left work feeling satisfied?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>10. In the last month, how often have you felt that you were on top of tasks and paper work with your patient care?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>11. In the last month, how often have events that happened at work caused you to provide <em>hurried</em> patient care?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>12. In the last month, how often have you found yourself thinking about things that you have to accomplish at work but don’t have enough time to complete?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>13. In the last month, how often have you felt valued at work?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>14. In the last month, how often have you felt fulfilled and appreciated in your work?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>15. In the last month, how often have you felt pleased working and feel a valued member of a team?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>16. In the last month, how often have you felt heard by and received recognition from colleagues and supervisors?</td>
<td>Fairly Often</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>17. In the last month, how often have you felt that your work environment expresses your values and allows you to work with integrity?</td>
<td>Fairly Often</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>18. In the last month, how often have you felt that you are able to provide your patients with the best care possible?</td>
<td>Fairly Often</td>
<td>Fairly Often</td>
</tr>
<tr>
<td>19. In the last month, how often have you felt that you had enough time to provide the kind of care and information you wanted to give your patient?</td>
<td>Sometimes</td>
<td>Fairly Often</td>
</tr>
</tbody>
</table>

*(table continues)*
20. In the last month, how often have you felt your job allows you to provide your patients with the type of care and information you envisioned you would when you began your career?

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. In the last month, how often have you felt your job allows you to provide your patients with the type of care and information you envisioned you would when you began your career?</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>21. In the last month, how often have you made a mistake with a patient’s care?</td>
<td>Almost Never</td>
<td>Almost Never</td>
</tr>
</tbody>
</table>

The provider completed the pre-intervention survey prior to training. The post-intervention survey was completed after training and applying the model on study participants. On 9 measures (n = 21) the provider reported a favorable change in workplace satisfaction. Positive responses were indicated in Questions 1, 3, 4, 8, 10, 13, 14, 15 and 19. These measures pertained to concern of occurrences at work, feeling stressed, dealing successfully with problems, feeling tired, feeling productive in providing care, feeling valued, feeling fulfilled and appreciated, feeling pleased and being a valued member in the workforce, and having enough time with patients. The provider indicated no change on the remaining measures. A negative response was not reported on any measure.

**Summary of Quantitative Results**

The researcher accounted for the modified pre-experimental, one-group pretest-posttest study design. A quantitative analysis was conducted on a sample size of 40 patients. Provider pre- and post-intervention survey results were reported. Descriptive statistics were tabulated for dependent variables and independent variables. Data was screened for accuracy and missing values. The researcher excluded variables measuring the length of patient pre- and post-intervention visits due to a large number of missing values.
Two tests of normality, the Kolmogorov-Smirnov Test and the Shapiro-Wilk Test, were performed using adjusted means of dependent variables to increase accuracy of assessment in a repeated-measures research design. The tests yielded significant $p$ values indicating the difference scores were not normally distributed. Skewness and kurtosis showed adjusted variables were within acceptable ranges for normality. There were minimal differences observed between mean, median and mode in both measures. To satisfy the assumptions for normality and level of measurement, the researcher used parametric and nonparametric tests in the analysis.

A paired-samples $t$ test was conducted to compare patient perception of relational empathy in the patient-provider relationship before and after applying the intervention. For each of the paired samples, results indicated that the mean for post-intervention scores were significantly greater than pre-intervention scores. The researcher rejected the null hypothesis that the population mean difference is equal to 0 ($p < .05$). After rejecting the null hypothesis the researcher calculated the effect size using Cohen’s $d$. Cohen’s $d$ values showed a medium effect size of .5 or greater for 8 of the 10 paired samples.

A Wilcoxon signed-rank test for repeated measures was conducted to determine whether there was a difference in the ranking of patient perception of relational empathy as reported pre- and post-intervention. Results of that analysis indicated that there was a significant difference in pre-intervention and post-intervention ranks. The results indicate patient perception of relational empathy following the intervention was more favorable and received significantly more favorable rankings. The researcher rejected the null hypothesis that the population mean difference is equal to 0 ($p < .05$). These findings were consistent with the paired-samples $t$ test.
In controlling for extraneous variables, covariates were assessed using one-way, repeated-measures MANCOVA. The predicted main effect of independent variables pertaining to patient participant demographic and medical information (i.e., Age, Gender, Ethnicity, Race, Health Status), pre- and post-intervention, were not significant.

Demographic and practice information was presented on the single participating provider. Provider rating on a 5-point Likert scale, quantitative survey measuring workplace satisfaction was reported. On 9 measures (n = 21) the provider reported a favorable change in workplace satisfaction. Positive responses indicated pertained to concern of occurrences at work, feeling stressed, dealing successfully with problems, feeling tired, feeling productive in providing care, feeling valued, feeling fulfilled and appreciated, feeling pleased and being a valued member in the workforce, and having enough time with patients. The provider indicated no change on the remaining measures. A negative response was not reported on any measure.
 CHAPTER V
DISCUSSION

Summary and Interpretation of Findings

The research study examined the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships. The pre-experimental, one-group pretest-posttest study comprised a quantitative approach to examining the psychological effects in patient participants. As the total provider participant population resulted in one provider, analysis for the dependent variables on provider reporting on workplace satisfaction named to include measures in patient-provider satisfaction and job satisfaction was not conducted. The pre- and post-intervention survey results were reported.

The quality of the communication between a patient and their provider can have a significant effect on a patient’s self-management of a chronic condition and success in adopting sustainable healthy lifestyle behaviors. Improving patient outcomes through healthier lifestyles will require a deeper understanding of how to effectively engage patients through the patient-provider relationship. With the focus today on patient-centered care, providers must develop communication skills that empower patients by seeing health from the patient’s perspective and motivating and educating patients in health-related self-management (WHO, 2005).

Many behavioral interventions have been inconsistently defined and have shown mixed results (Wolever et al., 2013). The degree of behavioral change and communication-skills training reported is lacking. Further, little is known about the degree to which positive short-term effects are demonstrated over time (Chesser, 2013).
Behavioral Engagement with Pure Presence™ is a whole-person focused behavioral change model, applying effective communication skills while engaging both patients and providers. The model facilitates emotional shifting altering subconscious brain state which is essential to sustained behavior change. G. Donadio (personal communication, September, 24, 2014) explains the provider learns a skill set that creates the “ah-ha” moments of cognitive insight which allows the patient to integrate new information derived from conscious and unconscious, mindful communication that then shifts the patient’s beliefs, worldviews or values and allows for sustainable change in relational behaviors. This research may enhance communication-skills training of providers to improve the patient-provider relationship for implementation of the model in mainstream medicine.

A comprehensive literature review centered on communication and the patient-provider relationship to provide some context prior to examining the effects of a behavioral change model on the study participants. The population for the research study was limited to a private endocrinology practice with two locations in southeastern Michigan. Patient data was obtained from medical records and patient self reporting using the quantitative, adapted CARE Measure Survey at pre- and post-intervention. Provider data was obtained from provider self-reporting demographic and professional practice information and the Work Satisfaction Survey at pre- and post-intervention. The provider received training in application of the intervention.

Patient Psychological Effects

The study tested the null hypothesis (Ho): Patients who participate in Behavioral Engagement with Pure Presence™ will not experience improved psychological effects, as indicated by an adapted CARE Measure survey instrument. The CARE Measure is a tool for
measuring a patient’s perception of empathy in the clinical setting (Mercer, Maxwell, Heaney, & Watt, 2004). The instrument was modestly adapted for application and use in the NIWH’s pilot studies.

Dependent variables for patient reporting on their psychological status were extracted from the CARE Measure Survey and are defined in Table 1 and included Valued, Present, Listen, Whole, Understand, Eye Contact, Positive, Explain, Take Control, and Develop Plan. The patients were asked to rate the importance of key variables using a Likert rating scale (0 = Does Not Apply, 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent) on their perception of provider empathy in patient-provider communications.

Exposure to Behavioral Engagement and Pure Presence™ was analyzed as the independent variable in this study against patient data. Patient demographic and medical information were indicated as covariates and tested as independent variables.

Of the 40 patient participants, 15 were male and 25 were female aged 19 to 69 years (M = 42.7, SD = 14.89). Participants were predominately Caucasian (n = 37, 92.5%) and non-Hispanic or Latino (n = 39, 97.5%). Participant health status by diagnosis indicated the majority (n = 31, 77.5%) had a thyroid condition or diabetes (n = 6, 15%).

The quantitative analysis examined what are the psychological effects, if any; of introducing Behavioral Engagement with Pure Presence™ in patient-provider relationships on patients? To satisfy the assumptions for normality and level of measurement, the researcher used parametric and nonparametric tests in the analysis. A paired-samples t test and related samples Wilcoxon signed-rank test to test the null hypothesis
A paired-samples $t$ test was conducted to compare patient perception of relational empathy in the patient-provider relationship before and after applying the intervention. As a result of the analysis, there was statistical significance to reject the null hypothesis in favor of the alternate hypothesis ($H_a$): Patients who participate in Behavioral Engagement with Pure Presence™ will experience improved psychological effects, as indicated by an adapted CARE Measure survey instrument.

A Wilcoxon signed-rank test for repeated measures was conducted to determine whether there was a difference in the ranking of patient perception of relational empathy as reported pre-intervention and post-intervention. Findings were conclusive with the paired-samples $t$ test. There was statistical significance to reject the null hypothesis in favor of the alternate hypothesis.

In controlling for extraneous variables, covariates were assessed using one-way, repeated-measures MANCOVA. The predicted main effect of independent variables pertaining to patient participant demographic and medical information (i.e., Age, Gender, Ethnicity, Race, Health Status), pre- and post-intervention, were not significant.

To conclude, the quantitative finding indicates there is sufficient statistical evidence to conclude when providers are trained to improve communication-skills through the application of Behavioral Engagement with Pure Presence™, patient psychological effects in perceived relational empathy in the patient-provider relationship improves.

Patient-centered communication or patient-centered care has become the new standard of practice. This relationship-centered focus is “based on the concept that the patient’s viewpoint needs to be incorporated into all aspects of the healthcare experience” (Sibille et al., 2010, p. 8). Studies have shown when primary care physicians are relationship-centered patients are likely to
experience sustained behavior change (Sibille et al., 2010). Haidet and colleagues express ‘patient-centered care is one aspect of the doctor-patient relationship that takes into account patients’ preferences, concerns, and emotions; it has been proposed as a mechanism through which favorable patient outcomes are achieved’ (as cited in Sibille et al., 2010). In doing so, the “patients’ needs, values and preferences, patients’ participation and autonomy in decision making increases” (Ciechanowski, et al, 2004, p. 720). This is consistent in previously cited literature findings and the results of this study as it pertains to patient perception of relational empathy as defined in each measure. The potential for sustainable behavior change is outside the scope of this study and will be tested in future research.

The participating provider of this study was a seasoned health practitioner who was communicative, personable and mindful while engaging with his patients. The patient inclusion criteria therefore included new patients only to eliminate potential bias from patients with established relationships with the provider. After training in the Behavioral Engagement with Pure Presence™ Model the provider was able to further develop and improve his communication skills resulting in the statistical significant results of pre- and post-intervention scores of new patients.

In comparing the results of this study to literature findings, the literature substantiates the increase in patient reported relational empathy as measured by key dependent variables. The association between what research has shown and the statistically significant results of the variables tested are summarized in the proceeding paragraphs. Table 17 replicates the definition of key variables defined in Chapter I for ease of reference in comparing literature findings.
Table 17. *Key Variables and Definitions*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valued</td>
<td>Making the patient feel valued. Patient report on provider being friendly and warm, treating patient with respect; not cold or abrupt.</td>
</tr>
<tr>
<td>Present</td>
<td>Being fully present to the patient. Patient report on provider giving patient time to fully describe their illness in their own words without interrupting or diverting the patient.</td>
</tr>
<tr>
<td>Listen</td>
<td>Really listening to the patient. Patient report on provider paying close attention to what patient is saying; not looking at notes or computer as patient is talking.</td>
</tr>
<tr>
<td>Whole</td>
<td>Addressing the needs of the patient as a whole person. Patient report on provider asking or knowing relevant details about the patient’s life and situation; not treating the patient as “just a number”.</td>
</tr>
<tr>
<td>Understand</td>
<td>Understanding the patient’s concerns. Patient report on provider communicating that he/she accurately understands the patient’s concerns; not overlooking or dismissing anything.</td>
</tr>
<tr>
<td>Eye Contact</td>
<td>Making consistent, attentive eye contact with patient. Patient report on provider seeming genuinely concerned with patient on a human level; not being indifferent or detached.</td>
</tr>
<tr>
<td>Positive</td>
<td>Being positive, caring and respectful to the patient. Patient report on provider having a positive approach and attitude while being honest, not negative about the patient’s problems.</td>
</tr>
<tr>
<td>Explain</td>
<td>Explain information clearly to patient. Patient report on provider fully answering patient’s questions, explaining clearly, providing adequate information; not being vague.</td>
</tr>
<tr>
<td>Take Control</td>
<td>Facilitating patient to take control. Patient report on provider discussing with patient what he/she can do to improve their health; encouraging rather than lecturing the patient.</td>
</tr>
<tr>
<td>Develop Plan</td>
<td>Developing a plan of action with the patient. Patient report on provider discussing options with patient, involving him/her in decisions as much as patient would like to be involved; not ignoring patient’s views.</td>
</tr>
</tbody>
</table>

Patients want to know how they can take control of their own condition or concern.

Patients are more likely to make lifestyle changes when they have been authentically engaged by their provider and their self knowledge has been valued (Donadio, 2011). These literature findings support the significant findings in variables Value, Present and Take Control.

Placing patients at the center of their health care decision making entails “physicians ‘ascertaining’ the reasons for the appointment and addressing presenting concerns; the patient
and physician finding ‘common ground;’ and patients receiving information and participating in decision making” (Sibille et al., 2010, p. 8). These literature findings support the significant findings in variables Understand, Explain and Develop Plan.

Studies reveal a provider’s ability to listen, explain and empathize with their patients can profoundly affect patient satisfaction, patients’ perceptions of quality of care and overall health outcomes (Huntington & Kuhn, 2003; IHC, 2011; Rouf et al., 2007). These literature findings support the significant findings in variables Listen and Explain.

Providers should possess communication skills that permit interviewing and communicating effectively to elicit information from the patient’s perspective by delving into the patient’s concerns, emotional status, social situations and behaviors (WHO, 2005). Providers must be skilled in communicating effectively to identifying potential problems and listen to what their patients express without judgment. These literature findings support the significant findings in variables Listen, Whole, and Understand.

“Patients differ in their values, preferences, and expectations for care” and their “psychosocial, emotional, and lifestyle issues are integral to medical care” (Beach et al., 2006, p. S5). They want to be valued, seen, and heard (Donadio, 2011). These literature findings support the significant findings in variables Valued, Listen and Eye Contact.

Research has identified essential tasks in patient-provider communication which include: gathering information, understanding the patient’s perspective, sharing information, and reaching an agreement on concerns and treatment options (Chesser, 2013). These literature findings support the significant findings in variables Present, Understand, Explain and Develop Plan.
Skilled listening, or intentional listening, is the practice of being mindfully present to comprehend on intellectual, emotional and spiritual levels what another individual is communicating (Donadio, 2011). One of the many ways listening is practiced is to hear the whole person and understand what they are communicating with one’s whole self. These types of listening are demonstrated in patient-provider communications. These literature findings support the significant findings in variables Present, Listen, Whole and Understand.

A key influential factor in perceived quality of care is the verbal and non-verbal communication between the patient and provider (DeBlasio & Walker, 2011). Nonverbal communication such as a gaze comprises 80% of interpersonal communication. This literature finding supports the significance in the variable Eye Contact.

Many of the core elements comprising patient satisfaction are reflected in the patient-provider encounter scenario previously cited from Chesser (2013) in the literature review. The importance of these elements is evident in the literature. The IHC (2011) describes how these elements increase patient satisfaction in the following manner:

- **Expectations**: patients were provided an opportunity to tell their story
- **Communication**: providers seriously evaluated patient concerns, explained information clearly, tried understanding the patient’s perspective, and provided viable options
- **Control**: providers encouraged patients to express their ideas, concerns and expectations
- **Decision-making**: providers acknowledged their patients’ social and mental functioning as much as their physical functioning
- **Time spent**: patient satisfaction improved as the length of time provider spent with patient increased
- **Dignity**: patients experienced greater satisfaction when they were treated with respect and invited to partner in their healthcare decisions.

These literature findings support the significant findings in variables Present, Understand, Positive, Explain, Take Control and Develop Plan.

In a Harvard affiliate hospital pilot study with the National Institute of Whole Health, providers were trained in application of Behavioral Engagement with Pure Presence™ on recalcitrant patients with varying cardiovascular disease. One of the most significant findings was the response of 94% of patients who stated, “Never before in my life have I been listened to like this” (as cited in NIWH, 2002). Listening, as previously explained, allows the provider to be mindfully present to hear the whole person and truly comprehend what the patient is communicating. The qualitative findings in the hospital pilot study explain what the patient experience to be listened to means to them. The quantitative findings of this study compliments that research in the statistically significant findings for the patients improved perception of relational empathy in variables Present, Listen, Whole and Understand.

**Report on Provider Satisfaction**

Demographic and practice information was presented on the single participating provider. The provider was a 48 year old male, Caucasian, non-Hispanic or Latino. He was a board-certified, medical doctor in private practice specializing in endocrinology. The provider has been a practicing healthcare professional for 24 years. He reported his highest level of patient-provider communications skills training completed was basic, core curriculum. His source of training in communications skills training was in medical school and residency training.
Provider rating on a 5-point Likert scale, quantitative survey measuring workplace satisfaction was reported. Response for each item is scaled as follows: Never, Almost Never, Sometimes, Fairly Often, Very Often. On 9 measures (n = 21) the provider reported a favorable change in workplace satisfaction. Positive responses indicated pertained to concern of occurrences at work, feeling stressed, dealing successfully with problems, feeling tired, feeling productive in providing care, feeling valued, feeling fulfilled and appreciated, feeling pleased at work and being a valued member in the workforce, and having enough time with patients to provide the kind of care and information as a provider you want to give your patient.

These findings are consistent with the literature review. “Patients and providers alike have the same need for relationships and for being valued” (Donadio, 2005, para. 5). As reported by the Institute for Healthcare Communication (2011), among the core elements of provider satisfaction are feeling supported both administratively and interpersonally, being respected and valued, clearly understanding their role and to be understood and work equity. Having enough time with patients is essential to building relationship-centered interactions necessary for work satisfaction (Donadio, 2005).

A direct relationship was reported between the provider’s satisfaction level and their ability to build a rapport and express empathy with their patients (IHC, 2011). Literature findings reveal a direct correlation between provider satisfaction and patient satisfaction (Donadio, 2004; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). The measures signifying positive response changes in the provider experience are reflective of the positive change in patient relational empathy experienced.
Limitations

The primary limitations of the research study are the use of purposive sampling and potential for bias in the selection process to obtain a small sample size of study participants that may not be representative of a larger population. A total of 40 Patient participants were surveyed from an endocrinology practice. Within that sample size, demographic characteristics and health status were primarily of a specific subgroup of the general population. Reduction in the number of provider participants (n = 1) was not large enough to conduct a statistical analysis where results may be generalizeable across provider types or areas of specialty as a whole or within the practice of endocrinology.

A purposive sample of potential participating practice sites were selected based on practice specialty. This selection criterion was used to obtain a patient sample to suffice conducting a pretest-posttest study design during an approximated 90-day period.

These limitations can be addressed in future research with a larger sample size of patient and provider participants (i.e., physicians, physician assistants, nurse practitioners, and nurses) of various areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.). The researcher may improve representativeness by using more than one control dimension for sampling of trained providers as this study originally aimed to obtain a diverse population of provider types and areas of specialty to acquire a range of points of view in the health care environment. Patient population controls include defined inclusion criteria resulting in subsets under each provider type and practice area. This would permit gathering data in the extremes in the patient population. Inclusion of a control group would also minimize the concerns of the study’s internal validity.
Implications of the Study

Results of this research will attempt to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in clinical practice across diverse health delivery systems. Implications include increased patient-provider satisfaction, improved self-directed patient-provider compliance, sustained patient behavior change, improved patient outcomes and an increase in provider job satisfaction; all of which may contribute to a decrease in healthcare costs. In today’s healthcare environment this would complement the growing initiatives and mandates arising from the Affordable Care Act, Accountable Care Organizations, Patient-Centered Medical Homes and the convergence of Electronic Medical Records to achieve these common goals.

Publications resulting from this research will be shared locally in Michigan with state organizations such as the Michigan Department of Community Health, to formulate partnerships with providers and associations that would benefit from continued research and the model’s dissemination. These efforts will be expanded to a national level. In addition to national efforts in continued research and application, publications will be shared with the Chronic Diseases and Prevention Management Office of the World Health Organization for post-doctoral research and potential for global applications.

Examining the impact of this sustainable behavior change model on health-related quality of life, patient outcomes, and cost-effectiveness can provide information to guide healthcare management and public policy initiatives as the rise in chronic illnesses and behavior-related diseases could be significantly addressed by these findings through continued research and
dissemination of the model on a national level. Pilot data obtained will provide data necessary to conduct future studies to further these efforts.

**Recommendations**

Communication is a science that embodies the interaction of all human relationships. The Behavioral Engagement with Pure Presence™ is designed to enhance and transform patient-provider relationships. The model was formulated to enhance communication outcomes in healthcare benefiting both patients and providers. It also created an evidence-based way to bring the model into a variety of healthcare delivery environments. It is applicable to any healthcare setting in transforming its cultural environment.

NIWH’s Whole Health Education with Behavioral Engagement and Pure Presence™ is a Harvard hospital identified *Best Practice Model of Relationship-Centered Care*. It is the first known patient education and health behavior change model developed, tested and applied in a health care setting. It is recommended the model be brought to the forefront as a standard in how to engage patients and enhance communications in the patient-provider relationship.

In today’s health care environment dissemination of the model in mainstream medicine is timely. As traditional, provider-focused practices shift to patient-centered care, providers must develop communication skills that empower patients by seeing health from the patient’s perspective and motivating and educating patients in health-related self-management (WHO, 2005; IHC, 2011). The Joint Commission on Accreditation of Health Care Organizations and the Institute of Medicine identify key guidelines in the practice of medicine which encompass placing patients at the center of their health care decision making, treating the patient as a whole.
person, and evidence-based health education for prevention and disease management (Donadio, 2011).

It is recommended the model be utilized to improve patient-provider communications for improved patient-provider relationships, more effective health management and disease prevention through sustainable patient behavior change, and evidence-based research to improve outpatient protocol and provider communication-skills training. At the completion of a NIWH pilot study, Dr. Harvey Zarren, Medical Director of a Harvard affiliate hospital in 2002, recognized “The relationship of educator (provider) with patient gave people a behavior model that, with the content of the education, allowed for persistent lifestyle changes” (as cited in NIWH, 2002). He concluded this method of education could help transform medical care for patients and providers.

Through research and education change can be cultivated in health delivery systems and public policy. The results of projected future studies will set the foundation for educating providers, healthcare organizations, medical associations and public health organizations on the model’s effectiveness, benefits and implementation in clinical protocol. The research will also be instrumental in shaping new health policy and supporting current government and industry initiatives in health management and disease prevention. Strategic relationships forged and interest in research resulting from the model’s application with the World Health Organization, Centers for Disease Control and Prevention, Washington, D.C., Medicare and Blue Cross Blue Shield will also aid in its dissemination.

Effective September 1, 2014, the training curriculum for Behavioral Engagement and Pure Presence™ used in the study was approved by the American Academy of Family
Physicians (AAFP) for 20 continuing education units. AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA Physician's Recognition Award (PRA) Category 1 Credit™ toward the AMA PRA. Providers and health care organizations will now derive another benefit in implementing the model.

It is recommended the model be implemented in policy at the regulatory level or established as a gold standard in patient engagement and patient-provider communications by accrediting bodies of various health delivery systems such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO), Commission on Accreditation of Rehabilitation Facilities (CARF) and Community Health Accreditation Program (CHAP).

It is recommended the model be established as a standard in communication-skills training by accrediting bodies for medical education programs such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA).

**Future Research**

The pre-experimental, one group pretest-posttest study data will provide pilot data necessary to conduct future studies. There are several applications to apply and test Behavioral Engagement with Pure Presence™ and means by which the study design and scope can be expanded in experimental research.

The scope of future research could encompass a larger sample size of patient and provider participants (i.e., physicians, physician assistants, nurse practitioners, and nurses) of
various areas of specialty (i.e., endocrinology, orthopedics, primary care, cardiology, etc.). Additionally, the inclusion of various types of health organizations could examine patient-provider communications in diverse clinical settings such as hospitals, physician practices and rehabilitation centers.

There are numerous applications in future studies on the physiological and psychological effects of the model. Experimental clinical trials using a control group could test the effects of the model in patient-provider relationships in patient with a specific chronic disease or multiple chronic conditions. Comparing new and established patient response to trained providers may provide additional insight into the strength of the model’s effectiveness at various stages of the patient-provider relationship.

Provider communication-skills training and practice experience varies in the degree and source of training and application across patient populations in a multitude of clinical settings. Evaluating the effectiveness of the model on seasoned versus less experienced providers may provide further insight into the patient-provider encounter, receptiveness of provider to undergo training and the level of provider satisfaction in the workplace. Research is lacking on communication-skills training.

Various future research designs could be utilized. Observational studies could be conducted to observe the application of the model and its effect on participants in the patient-provider encounter. A qualitative approach could be utilized to explore the experiences, opinions and knowledge derived from patient and provider participants to enhance quantitative findings. Longitudinal studies could evaluate the effectiveness of the model in sustained patient behavior change. Research is lacking on long-term effects of behavior change.
A growing focal point of interest in research is the usage of Health Information Technologies. Efforts to contain costs and increase productivity with the implementation of Electronic Health Records (EHRs) have placed even greater time constraints on face-to-face patient-provider communications as providers attempt to care for patients. While HIT are geared toward enhancing patient-provider encounters (Wakefield et al., 2010), research indicates the EHR may detract from interpersonal connection hindering communication in the patient-provider relationship (Alsos, Das, & Svanøes, 2012; Bonner et al., 2010; Frankel et al., 2005). Limited research has been published on the direct impact of EHRs on provider-patient relationships or how EHRs improve or hinder communication (Boucher, 2010; Rouf et al., 2007). This research study and a current research collaborative with Michigan State University will provide the pilot data necessary to conduct a mixed methods randomized controlled clinical trial examining the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships on patients with chronic illnesses while utilizing the model in EHR communications.

Publications resulting from the dissertation research study will be shared as requested by Dr Gojka Roglic, Medical Officer of the Department of Management of Noncommunicable Diseases at the World Health Organization. A significant finding prompts the interest for future research on the effectiveness of the model. Dr. Roglic proposed a randomized controlled trial examining harder outcomes such as comorbidity complications in chronic illness and mortality.

**Conclusion**

The research has demonstrated Behavioral Engagement with Pure Presence™ has a psychological effect on the patient’s perception of the patient-provider encounter. Patient
perception of relational empathy in the patient-provider relationship increases through improved provider communication skills in applying the model.

Empowering patients to have a greater understanding and control over health management and disease prevention will require placing patients at the center of their health care decision making. Sustained behavior change cannot occur without new information that impacts a patient’s belief system. This emotional shifting can be achieved through effective communication in the patient-provider relationship.

Utilization of findings is applicable to how the patient-provider relationship may be supported to increase health behavior change in patients for reduction in the prevalence of behavior-related diseases. This can be useful in enhancing education programs or specialized training to improve patient-provider communication. Consideration for the reciprocal nature of the patient-provider relationship amidst a co-dependent healthcare system is needed for a deeper understanding and appreciation of this relationship’s ability to positively influence change.

Further research will provide greater insight into the effects of behavior modification and disease management models for sustainability in lifestyle changes. Examining the impact of sustainable self-management intervention programs on health-related quality of life, patient outcomes, and cost-effectiveness can provide information to guide healthcare management and public policy initiatives as the rise in chronic illnesses and population health needs converge in an ever dynamic healthcare industry.
APPENDIX A

RESEARCH PILOT STUDY AGREEMENT

Behavioral Engagement with Pure Presence™:

RESEARCH PILOT STUDY

Agreement

This document serves as a letter of agreement on pilot study collaboration between Christie Clipper, researcher; the National Institute of Whole Health (NIWH) and ________________ (herein referred to as “PARTICIPATING SITE”) located at ____________________________.

COLLABORATIVE RELATIONSHIP

The collaboration between the above named parties is to conduct a Pilot Study in Behavioral Engagement with Pure Presence™ with Primary Investigator Christie Clipper. The research will be conducted through select medical practice locations to include the above named PARTICIPATING SITE.

The purpose of this research study is to examine the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships across various providers (i.e., physicians, physician assistants, nurse practitioners, and nurses) and areas of specialty and their patients. This objective will be attained utilizing a quantitative, experimental research method to obtain pre- and post-intervention survey data on a purposive sample of participants over a 90-day period.

Behavioral Engagement with Pure Presence™ is a NIWH patented model of health behavior change communication skills and competencies that has been clinically proven to enhance and transform all types of relationships through this unique, communication skills model.

NIWH will provide online training to health professionals in the use of the model for purposes within the scope of the pilot study. The NIWH’s Whole Health Education® curriculum, an accredited, post-professional training program for credentialed health professionals, has at its base the Behavioral Engagement with Pure Presence™ model of relationship communication. Whole Health Education with Behavioral Engagement and Pure Presence™ is a Harvard hospital identified Best Practice Model of Relationship-Centered Care, nominated for the Fetzer Institute’s Norman Cousins Award, for excellence in relationship-centered, whole person care.

PROVIDER TRAINING

NIWH’s online training will include a brief orientation introducing the Behavioral Engagement with Pure Presence™ Model, a webinar series comprising four workshops (approximately 40 minutes each) and three informational videos (approximately one hour each). The curriculum is formulated to provide health practitioners with the skill-set necessary to transform the patient-provider relationship increasing the quality of service to their patients and level of patient-provider satisfaction.
NIWH requires pre-requisites for health professionals who are being trained to provide the model to their patients. Participating health professionals must:

1) Sign a confidentiality, commitment, and disclosure form
2) Submit a copy of their credentials
3) Obtain and read the course book, Changing Behavior: Immediately Transform Your Relationships with Easy-to-Learn, Proven Communication Skills by Georgianna Donadio, MSc, DC, PhD.

Trained health professionals will be eligible to receive continuing education contact hours for their respective discipline. To obtain continuing education credit, providers will fill out an evaluation form and conduct at least one interview demonstrating their application of the Behavioral Engagement and Pure Presence™ Model. Health professionals will submit to NIWH a recording of their interview on a computer compatible memory stick. The participants shall permit their submitted memory stick video assignment to be used for future training purposes.

The NIWH will issue an individual Communication Facilitator Certificate for the successful completion of the Behavioral Engagement with Pure Presence™ program.

Collaborating parties shall provide feedback to NIWH regarding data and the efficacy of the NIWH training in enhancing the practitioner’s ability to effectively communicate with patients and clients through this Whole Health - Whole Person perspective and Pure Presence behavior.

All participants agree to share their practice experience and comments with NIWH. Participants will complete written program evaluations after the NIWH training. Additionally, the study participants will be available for one-on-one and/or group telephone conferences to discuss the NIWH program efficacy, as well as their personal experiences in applying the information learned from the program to their own clinical practice.

AUTHORIZATIONS

PARTICIPATING SITE shall grant permission to NIWH to write and publish a press release about its collaboration between NIWH, Christie Clipper and Collaborators. This Press Release will be provided to PARTICIPATING SITE for approval prior to publication.

NIWH reserves the right to identify the pilot study including referring to, collecting and publishing data.

PARTICIPATING SITE will permit NIWH to interview at least one its representative regarding the pilot study. The designated professional shall provide NIWH with a statement on the organizations participation in the pilot study, to be shared publicly at NIWH’s discretion.

PARTICIPATING SITE may be identified on the NIWH website as a Collaborator with NIWH in support and acknowledgement of the pilot study.
PROPRIETARY INFORMATION

All proprietary materials, including but not limited to the following; written copy, logos, confidential links, information, course content, both written and media based, trademarks/servicemarks, copy written materials, as well as the model concept and components shall remain the sole ownership of NIWH, the originating program, and shall not be shared, copied, adapted or similarly utilized in any form or manner by the collaborating affiliate organization which would constitute an illegal use of the material/model components. Future training or dissemination of the model outside the scope of the Behavioral Engagement with Pure Presence™ Pilot Study will require a signed licensing agreement.

The undersigned agrees to the aforementioned and attests to PARTICIPATING SITE’s commitment to support completion of this pilot study.

Agreed:

__________________________________________
Signature

__________________________________________
Date

__________________________________________
Print Name

__________________________________________
Title
Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships:
Communication and the Effect on Patients and Providers

Patient Recruitment Statement

Alzohaili Medical Consultants is participating in a research study conducted through Central Michigan University in partnership with the National Institute of Whole Health. Our participation signifies our support and recognition of the importance of the patient-provider relationship in patient care. What we learn will be of great value in better understanding how patients and providers communicate and how this relationship affects patient care.

We would like to invite you to participate in a brief survey at the end of your clinic visit today. Your responses will remain confidential. You will complete the survey once again at the time of a follow-up visit scheduled with your provider within the next 90-days. This will conclude your participation in the study. Would you be willing to join us in participating?
APPENDIX C

PROVIDER NONDISCLOSURE OF CONFIDENTIAL INFORMATION AND COMMITMENT FORM

Behavioral Engagement with Pure Presence™:
RESEARCH PILOT STUDY

Provider Agreement Regarding
Nondisclosure of Confidential Information and Commitment

This confidential disclosure agreement is entered into by and between ____________________________ (herein referred to as “Provider”) a health professional on staff at a participating practice location for this study and National Institute of Whole Health (herein referred to as “Discloser”) of the Behavioral Engagement with Pure Presence™ Model.

WHEREAS, the Discloser has special confidential information concerning Behavioral Engagement with Pure Presence™

WHEREAS, the Discloser will train health professionals in the use of the model for purposes within the scope of this research pilot study.

WHEREAS, for purposes of conducting the research pilot study, it is considered necessary and desirable that Discloser disclose to Provider confidential information (Proprietary Information) concerning Behavioral Engagement with Pure Presence™ and its applications.

NOW THEREFORE, the parties agree as follows:

1. Provider shall not communicate Proprietary Information to any third party and shall use its best efforts to prevent inadvertent disclosure of Proprietary Information to any third party.

2. Provider shall neither use Proprietary Information nor circulate it within its own organization except to the extent necessary for completion of this research study:
   a. for completion of this research study with personnel or authorized representatives of Discloser; and
   b. any purpose Discloser may hereinafter authorize in writing.

3. Provider agrees that it will not without the written permission of Discloser use the Proprietary Information supplied hereunder for any purpose other than for which it was intended.

4. Provider agrees not to disclose or circulate any webinar training access information, including identification numbers or program content, without written permission from Discloser.
5. All proprietary materials, including but not limited to the following: trademarks/servicemarks, copy written materials, written copy, logos, confidential links, information, course content, both written and media based, as well as the model concept and components shall remain the sole ownership of Discloser, the originating program, and shall not be shared, copied, adapted or similarly utilized in any form or manner by the collaborating affiliate organization which would constitute an illegal use of the material/model components.

6. Communications from Provider to personnel or authorized representative of Discloser shall not be in violation of the proprietary rights of any third party and shall be made without any obligation of confidence.

7. Future training or dissemination of the model outside the scope of the Behavioral Engagement with Pure Presence™ Research Pilot Study will require a signed licensing agreement between Provider and Discloser.

8. This agreement shall govern all communications between Discloser and Provider that are made for the period beginning from the date this agreement is signed by Provider to the date on which the Provider receives from Discloser written notice that subsequent communications shall not be so governed.

9. Nothing contained in this agreement shall be construed as granting or conferring any patent rights, by license, expressly, impliedly, or otherwise by Discloser.

NOW THEREFORE, the Provider will attest to commitment in participation as follows:

1. Provider will complete the webinar training series by:
   
   a. obtaining and reading the course book, *Changing Behavior: Immediately Transform Your Relationships with Easy-to-Learn, Proven Communication Skills* by Georgianna Donadio, MSc, DC, PhD in preparation for the first workshop;

   b. complete all workshops, videos, assignments and a ten (10) minute recorded interview demonstrating his/her application of the model at the completion of the training; and

   c. providing for full participation during training. As the model addresses distraction and disconnect that exits in the provider-patient relationship it is required full attention without distraction or multi-tasking be provided 1) to receive the full training benefit of a highly concentrated curriculum delivered in an abbreviated format, 2) for the viability of the research, and 3) patients will not be the recipients of the kind of interaction that is now becoming critical for providers to deliver in the new whole person care
medical environment that is emerging. Provider understands it is in good faith they he/she participates with complete engagement.

2. Provider will submit to Discloser a recording of their ten (10) minute interview on a computer compatible memory stick. Provider shall permit their submitted memory stick video assignment to be used for future training purposes.

3. Provider will receive a confidential identification number for access to training curriculum that identifies his/her participation. Provider must register on the training website with this identification number. Provider understands this identification number may be used to register only one time through one computer selected for training.

4. Provider shall provide feedback to Discloser regarding the efficacy of the training in enhancing his/her ability to effectively communicate with patients through this Whole Health - Whole Person perspective and Pure Presence behavior through completion of a written program evaluation.

5. Provider will be available for one-on-one and/or group telephone conferences to discuss the Discloser’s program efficacy, as well as his/her personal experiences in applying the information learned from the program to their own clinical practice.

NOW THEREFORE, the Discloser agrees as follows:

Discloser will issue continuing education contact hours to eligible Providers for their respective discipline. To obtain continuing education credit, Provider must apply by submitting an evaluation form in addition to the recorded interview demonstrating their application of the Behavioral Engagement and Pure Presence™ Model.

Discloser will issue an individual Communication Facilitator Certificate to Provider for the successful completion of the Behavioral Engagement with Pure Presence™ webinar series training program.

Discloser and Provider have caused this agreement to be executed, in duplicate, by their respective duly authorized officers on the dates indicated below.

By: ___________________________  By: ___________________________
      Signature                        Signature

      ___________________________  ___________________________
      Print Name                        Print Name

Title: ___________________________  Title: ___________________________

Date: ___________________________  Date: ___________________________
Provider Participant Information and Consent Form

You are being asked to participate in a research study. Researchers are required to provide a consent form to inform you about the research study, to convey that participation is voluntary, to explain risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Study Title: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships: Communication and the Effect on Patients and Providers

Researchers: Christie Clipper, Principal Investigator
Steven D. Berkshire, EdD, MHA, SPHR, FACHE, Co-Investigator (Advisor)

Department and Institution: Central Michigan University
Doctor of Health Administration Program

Address and Contact Information: 208H Rowe Hall, Mt. Pleasant, Michigan, 48859
Office: 989-774-1640

WHAT IS THE PURPOSE OF THIS STUDY?
You are being asked to participate in a research study involving the effects of a behavioral change model on patient-provider relationships. The purpose of the study is to examine the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships across various providers and areas of specialty and their patients. Behavioral Engagement with Pure Presence™ is a whole-person focused behavioral change model, applying effective communication skills while engaging both patients and providers, which is essential to patients achieving lasting behavior change for improved patient outcomes. The model is formulated to afford providers the skill-set necessary to transform the patient-provider relationship increasing the quality of service to their patients and level of patient-provider satisfaction.

You have been selected as a possible participant in this study because you are a provider (i.e., physician, physician assistant, nurse practitioner, registered nurse, or allied health professional) that works for a practice participating in this study. In the entire study, 100 patients and 10 providers are being asked to participate.

From this study, the researchers hope to learn how Behavioral Engagement with Pure Presence™ can improve provider communication skills and increase patient-provider satisfaction, improving the patient-provider relationship. The results will be used to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol.

Please initial that you have read and understood this page.
WHAT WILL I DO IN THIS STUDY AND HOW MUCH OF MY TIME WILL BE REQUIRED?

Providers will submit a copy of their credentials and a signed confidentiality, commitment, and disclosure form provided by the Principal Investigator.

Your participation in this study will entail seeing patients during their regularly scheduled visits over a 90-day period. In addition to the time you spend with a patient during their visit, you will spend an additional 10 minutes to complete a provider demographic and professional practice information sheet and 30 minutes (approximately) to complete a Work Satisfaction Survey at the onset of the study and at 90-days upon completion of the study.

Time commitment for provider training:

The National Institute of Whole Health (NIWH) will provide on-line access to training for qualified participants. In preparation for the training, you are required to obtain and read the book, Changing Behavior: Immediately Transform Your Relationships with Easy-to-Learn, Proven Communication Skills by Georgianna Donadlo, MSc, DC, PhD (approximately four hours).

Provider training will comprise an orientation (approximately 40 minutes) and webinar series comprising four workshops (approximately 40 minutes each), three videos (approximately one hour each), assignments (approximately two hours), required readings to supplement the training sessions (approximately one hour), and completion of a 10 minute videotaped interview demonstrating application of the model. The recorded interview may be conducted with a patient while working with an interview form provided by NIWH. You will receive instruction on how to submit your recorded interview to NIWH at the completion of your training. You will receive feedback on your performance. The NIWH may or may not use your video for future training purposes.

Trained providers agree to share their practice experience and comments with NIWH. Participants will complete written program evaluations after the NIWH training. Additionally, the participants will be available for one-on-one and/or group telephone conferences to discuss the NIWH program efficacy, as well as their personal experiences in applying the information learned from the program to their own clinical practice. The time commitment for this effort will be approximately one hour.

Total estimated time commitment: 15 hours (not including one hour post-survey evaluation feedback on training)

ARE THERE ANY RISKS OF PARTICIPATING IN THE STUDY?

There are no foreseeable risks associated with participation in this study.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THE STUDY?

You will acquire knowledge and skills through your training to apply a behavioral change model that serves as a best practice model of relationship-centered, patient education training for providers. The NIWH’s Whole Health Education® curriculum, an accredited, post-professional training program for credentialed health professionals, has at its base the Behavioral Engagement with Pure Presence™ model of relationship communication. Whole Health

Please initial that you have read and understood this page

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Education with Behavioral Engagement and Pure Presence™ is a Harvard hospital identified Best Practice Model of Relationship-Centered Care, nominated for the Fetzer Institute’s Norman Cousins Award, for excellent in relationship-centered, whole person care.

The NIWH will issue to you an individual Communication Facilitator Certificate for the successful completion of the Behavioral Engagement with Pure Presence™ program. If you are eligible and wish to receive continuing education credit you must complete an evaluation form in addition to the submission of your 10 minute videotaped interview demonstrating your use of the Behavioral Engagement and Pure Presence™ Model to receive credit.

Your participation in this study may contribute to the understanding of how this model can improve provider communication skills and increase patient-provider satisfaction, improving the patient-provider relationship. The results will be used to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol.

**WILL ANYONE KNOW WHAT I DO OR SAY IN THIS STUDY (CONFIDENTIALITY)?**

The data for this project will be kept confidential. The management and transfer of data for analysis will be conducted adhering to organizational policy in compliance with privacy laws. The Principal Investigator will be responsible for the transfer of data into a secured database. The data will be extracted and entered into a secured database by designated data collection and data entry professionals.

To retain your confidentiality, you will be assigned a unique identification (ID) number. Your ID number will be assigned to you by the Principal Investigator. A master list containing all provider names with assigned ID numbers will be kept separately and securely in a password protected data file. Identifying information will not be stored with data contained in the research database. Your Work Satisfaction Survey will include your ID number only. The completed surveys will be retained at your practice site in a confidential file for collection and data entry as designated by the Principal Investigator.

Research data will be stored for a period of three (3) years after the completion of the study. The data will be retained in a secured, password protected database with fire wall created for the purpose of this study. The study’s Principal Investigator and collaborating researchers will have access to the research data. Data collection and entry personnel will be authorized to access the data system to input data only during data collection. Central Michigan University’s Institutional Review Board (IRB) and grant award organizations may require access to the research data.

**WILL I RECEIVE ANY COMPENSATION FOR PARTICIPATION?**

You will not be compensated for your participation in this study. Providers trained in the model may receive continuing education credit as explained under benefits of participation.

Please initial that you have read and understood this page_____
WHO CAN I CONTACT FOR INFORMATION ABOUT THIS STUDY?

If you have any concerns or questions about this research study, such as scientific issues, how to do any part of it, or to report an injury, please contact me, Christie Clipper, the researcher, at dipp1cl@cmich.edu or (734) 751-7618 or my dissertation chair and sponsor:

Steven D. Berkshire, EdD, MHA, SPHR, FACHE
Professor and Director
Doctor of Health Administration Program
Central Michigan University
208H Rowe Hall
Mount Pleasant, Michigan, 48859
Office: 989-774-1640
Fax: 989-774-2888
Email: berks1sd@cmich.edu

YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

You are free to refuse to participate in this research project or to withdraw your consent and discontinue participation in the project at any time without penalty or loss of benefits to which you are otherwise entitled. Your participation will not affect your relationship with the institution(s) involved in this research project.

DOCUMENTATION OF INFORMED CONSENT

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall, Central Michigan University, Mt. Pleasant, MI 48859.

My signature below indicates that all my questions have been answered. I agree to participate in the project as described above.

_________________________  ______________________
Signature of Subject       Date Signed

A copy of this form has been given to me.________ Subject’s Initials

_________________________  ______________________
Signature of Responsible Investigator       Date Signed

Please initial that you have read and understood this page_______
APPENDIX E

PATIENT PARTICIPANT INFORMATION AND CONSENT FORM

Patient Participant Information and Consent Form

You are being asked to participate in a research study. Researchers are required to provide a consent form to inform you about the research study, to convey that participation is voluntary, to explain risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Study Title: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships: Communication and the Effect on Patients and Providers

Researchers: Christie Clipper, Principal Investigator
                       Steven D. Berkshire, EdD, MHA, SPHR, FACHE, Co-Investigator (Advisor)

Department and Institution: Central Michigan University
                                      Doctor of Health Administration Program

Address and Contact Information: 208H Rowe Hall, Mt. Pleasant, Michigan, 48859
                                      Office: 989-774-1640

WHAT IS THE PURPOSE OF THIS STUDY?

You are being asked to participate in a research study involving the effects of a behavioral change model on patient-provider relationships. The purpose of the study is to examine the effects of Behavioral Engagement with Pure Presence™ in patient-provider relationships across various providers and areas of specialty and their patients. Behavioral Engagement with Pure Presence™ is a whole-person focused behavioral change model, applying effective communication skills while engaging both patients and providers, which is essential to patients achieving lasting behavior change for improved patient outcomes. The model is formulated to afford providers the skill-set necessary to transform the patient-provider relationship increasing the quality of service to their patients and level of patient-provider satisfaction.

You have been selected as a possible participant in this study because you meet the eligibility criteria for participation. This means you have been identified as an adult, man or woman 18 years of age or older who speak(s) and read(s) English. In the entire study, 100 patients and 10 providers are being asked to participate.

From this study, the researchers hope to learn how Behavioral Engagement with Pure Presence™ can improve provider communication skills and increase patient-provider satisfaction, improving the patient-provider relationship. The results will be used to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol.

Please initial that you have read and understood this page
WHAT WILL I DO IN THIS STUDY AND HOW LONG WILL IT TAKE ME TO DO THIS?
As a participant in this study you will see your provider for your regularly scheduled visits. This study will not require additional visits outside the standard of care in frequency for regularly scheduled visits.

Your participation in this study will entail at least two regularly scheduled visits to your provider over a 90-day period. In addition to the time you spend with your provider during your visit you will spend an additional 30 minutes (approximately) to complete a patient CARE Measure Survey, after seeing your provider on your first visit at time of enrollment in the study. The survey will ask about your visit with your provider. You will complete the survey once again at the time of a subsequent visit scheduled with your provider within the 90-day period. This will conclude your participation in the study.

You may or may not be asked by your provider to participate in a 10 minute interview at the completion of this study to demonstrate how Behavioral Engagement with Pure Presence™ is applied in the patient-provider encounter. The video will be submitted by your provider to the National Institute of Whole Health (NIWH). The NIWH offers accredited, post-professional training programs for credentialed health professionals; providing the training your provider received for purposes of this study. The NIWH may or may not use the video for future training purposes. You are free to participate or refuse to participate in the demonstrational video. Your refusal to participate will have no impact on your relationship with your provider.

ARE THERE ANY RISKS OF PARTICIPATING IN THE STUDY?
There are no foreseeable risks associated with participation in this study. However, there is a risk associated with the potential for unforeseen release of health information. The protection of your privacy and confidentiality are explained in this document.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THE STUDY?
The potential benefits to you for taking part in this study will be better communication and improved relationship between you and your provider, improved outcomes in your care, and sustainable changes in lifestyle behavior to better manage your health.

Your participation in this study may contribute to the understanding of how Behavioral Engagement with Pure Presence™ can improve provider communication skills and increase patient-provider satisfaction, improving the patient-provider relationship. The results will be used to determine the effects of the model for communication-skills training of providers to improve the patient-provider encounter for implementation in outpatient protocol.

WILL ANYONE KNOW WHAT I DO OR SAY IN THIS STUDY (CONFIDENTIALITY)?
The data for this project will be kept confidential. Information about you will be kept confidential to the maximum extent allowable by law. Your patient information will be accessed only by clinic personnel with current privileges to health protected information. You will be provided a Patient Authorization for Disclosure of Health Information for Research form which provides a description of the health record information to be disclosed.

The management and transfer of data for analysis will be conducted adhering to organizational policy in compliance with privacy laws. The Principal Investigator will be responsible for the
transfer of data into a secured database. The data will be extracted and entered into a secured
database by designated data collection and data entry professionals. To retain your
confidentiality, you will be assigned a unique identification (ID) number. Your ID number will be
assigned to you by the Principal investigator. Identifying information will not be stored with data
contained in the research database.

Research data will be stored for a period of three (3) years after the completion of the study.
The data will be retained in a secured, password protected database with fire wall created for
the purpose of this study. The study’s Principal Investigator and collaborating researchers will
have access to the research data. Data collection and entry personnel will be authorized to
access the data system to input data only during data collection. Central Michigan University’s
Institutional Review Board (IRB) and grant award organizations may require access to the
research data.

WILL I RECEIVE ANY COMPENSATION FOR PARTICIPATION?
You will not be compensated for your participation in this study.

WHO CAN I CONTACT FOR INFORMATION ABOUT THIS STUDY?
If you have any concerns or questions about this research study, such as scientific issues, how
to do any part of it, or to report an injury, please contact me, Christie Clipper, the researcher, at
dipp1cl@cmich.edu or (734) 751-7618 or my dissertation chair and sponsor:

Steven D. Berkshire, EdD, MHA, SPHR, FACHE
Professor and Director
Doctor of Health Administration Program
Central Michigan University
208H Rowe Hall
Mount Pleasant, Michigan, 48859
Office: 989-774-1640
Fax: 989-774-2888
Email: barks1sd@cmich.edu

YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW
You are free to refuse to participate in this research project or to withdraw your consent and
discontinue participation in the project at any time without penalty or loss of benefits to which
you are otherwise entitled. Your participation will not affect your relationship with the
institution(s) involved in this research project.

DOCUMENTATION OF INFORMED CONSENT
If you are not satisfied with the manner in which this study is being conducted, you may report
(anonymously if you so choose) any complaints to the Institutional Review Board by calling
989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall, Central
Michigan University, Mt. Pleasant, MI 48859.

Please initial that you have read and understood this page______
CONFIRMATION OF INFORMED CONSENT & VOLUNTARY PARTICIPATION

My signature below indicates that all my questions have been answered. I agree to participate in the project as described above.

Signature of Subject ____________________________ Date Signed __________

VIDEO AUTHORIZATION

My signature below indicates I understand I may or may not be asked by my provider to participate in a 10 minute interview at the study’s completion to be submitted by my provider to the National Institute of Whole Health (NIWH). I further understand the NIWH may or may not use the video for future training purposes. I indicate to express consent or withhold consent by checking one of following boxes:

☐ I am providing consent to use the video for future training purposes.

☐ I am withholding consent to use the video for future training purposes. I understand my refusal to authorize the use of the video will have no impact on my relationship with my provider.

Signature of Subject ____________________________ Date Signed __________

A copy of this form has been given to me. _________ Subject’s Initials

Signature of Responsible Investigator ____________________________ Date Signed __________

Please initial that you have read and understood this page_______
APPENDIX F

AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FOR RESEARCH

Patient Name: ____________________________________________________________
Address: __________________________________________________________________
Date of Birth: ____________________________

AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

FROM: Alzohali Medical Consultants
      1331 Monroe Street, #100
      Dearborn, MI 48124
      Office: (313) 914-5591
      Fax: (313) 914-5580

TO: Steven D. Berkshire, EdD, MHA, SPHR, FACHE
    Professor and Director
    Doctor of Health Administration Program
    Central Michigan University
    2081 Rowe Hall
    Mount Pleasant, Michigan, 48859
    Office: 989-774-1640
    Fax: 989-774-2888

DESCRIPTION OF INFORMATION TO BE DISCLOSED:
Information contained in my medical record will be limited to my: age, gender, race, ethnicity, number of visits I have had with
my provider during the study, length of my scheduled visits, my current health status, and my complaint or reason for my visits.

RESEARCH STUDY FOR THIS DISCLOSURE:
Title of Study: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships:
Communication and the Effect on Patients and Providers

Name of Research Leader: Christie Clipper
Affiliation of Researcher: Central Michigan University (designated research site: Alzohali Medical Consultants)
IRB#: 509992-3
Name of IRB: Central Michigan University

EXPIRATION: Your Authorization to disclose the above information expires at the end of the research study

REVOCATION, REFUSAL, REDISCLOSURE:
You may revoke this Authorization in writing at any time by contacting Alzohali Medical Consultants
but it will not affect any information already released to the researcher(s).

You may refuse to sign this authorization and your refusal will not affect your ability to obtain treatment, however, it may affect
your ability to participate in this research study.

Your information that is disclosed to the researcher(s) may no longer be protected by Federal privacy regulations if the
researcher(s) is not a health care provider covered by the regulations, however the researcher(s) agrees to protect your
information as required by law.

__________________________________________  ____________________________
Signature of Patient or Personal Representative  Date

__________________________________________
Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient)

MSU Research Privacy Board Template – Authorization for Disclosure of Protected Health Information for Research – 2/16/06

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APPENDIX G

CONSULTATION AND RELATIONAL EMPATHY (CARE) MEASURE SURVEY

CARE Measure Survey
(adapted for NIWH Pilot from 2004 CARE Measure © Stewart W. Mercer)

1. Please rate the following statements about today’s consultation. Please tick one box for each statement and indicate an answer for each statement.

<table>
<thead>
<tr>
<th>How was the doctor or nurse at …</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Does Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making you feel valued……. (being friendly and warm towards you, treating you with respect; not cold or abrupt)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Being fully present to you (giving you time to fully describe your illness in your own words; not interrupting or diverting you)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Really listening……. (paying close attention to what you were saying; not looking at the notes or computer as you were talking)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Addressing your needs as a whole person … (asking/knowing relevant details about your life, your situation; not treating you as “just a number”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Understanding your concerns……. (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Making consistent, attentive eye contact (seeming genuinely concerned, connecting with you on a human level; not being indifferent or “detached”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Being positive, caring and respectful…. (having a positive approach and a positive attitude; being honest but not negative about your problems)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Explaining information clearly……. (fully answering your questions, explaining clearly, giving you adequate information; not being vague)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Facilitating you taking control……. (exploring with you what you can do to improve your health yourself; encouraging rather than “lecturing” you)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Developing a plan of action with you … (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX H

PATIENT INFORMATION SHEET

Participant ID # _______________________

PATIENT INFORMATION SHEET

Study Title: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships: Communication and the Effect on Patients and Providers

Age: ______

Gender: ☐ Male ☐ Female ☐ Other

Race/Ethnicity:

☐ Hispanic or Latino: ☐ Yes ☐ No

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other

FOR OFFICE USE ONLY

Current health status: _____________________________________________________________

Length of scheduled visit (time spent with provider):

Pre-intervention visit: _________

Post-intervention visit: _________

Patient complaint or reason for visit:

Pre-intervention visit: ___________________________________________________________

Post-intervention visit: _________________________________________________________

Number of visits to provider during the study: ____
APPENDIX I

WORK SATISFACTION SURVEY

NIWH Pilot Study

This evaluation form is designed to explore your work satisfaction level, as well as establish a base-line of responses that will be re--evaluated after the Behavioral Engagement with Pure Presence™ model is implemented. Thank you for providing your response to this evaluation.

For each question, mark the answer that best describes your experience.

1. In the last month, how often have you been concerned or upset because of something that happened at work?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often

2. In the last month, how often have you felt that you were not able to perform your job tasks to the best of your ability, due to work related issues or events?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often

3. In the last month, how often have you felt "stressed" at work?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often

4. In the last month, how often have you dealt successfully with day-to-day problems and annoyances at work?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often

5. In the last month, how often have you dealt unsuccessfully with day-to-day problems and annoyances at work?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often

6. In the last month, how often have you felt confident about your ability to handle unexpected changes or stress at work?
   - Never  ○  Almost Never  ○  Sometimes  ○  Fairly Often  ○  Very Often
7. In the last month, how often have you thought about leaving your job?
   - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

8. In the last month, how often have you found that you left work feeling tired?
   - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

9. In the last month, how often have you found that you left work feeling satisfied?
   - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

10. In the last month, how often have you felt that you were on top of tasks and paper work with your patient care?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

11. In the last month, how often have events that happened at work caused you to provide hurried patient care?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

12. In the last month, how often have you found yourself thinking about things that you have to accomplish at work but don’t have enough time to complete?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

13. In the last month, how often have you felt valued at work?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

14. In the last month, how often have you felt fulfilled and appreciated in your work?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □

15. In the last month, how often have you felt pleased to be working where you are and feel a valued member of a team?
    - Never  □  Almost Never  □  Sometimes  □  Fairly Often  □  Very Often  □
16. In the last month, how often have you felt heard by and received recognition from colleagues and supervisors?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often

17. In the last month, how often have you felt that your work environment expresses your values and allows you to work with integrity?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often

18. In the last month, how often have you felt that you are able to provide your patients with the best care possible?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often

19. In the last month, how often have you felt that you had enough time to provide the kind of care and information you wanted to give your patient?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often

20. In the last month, how often have you felt your job allows you to provide your patients with the type of care and information you envisioned you would when you began your career?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often

21. In the last month, how often have you made a mistake with a patient’s care?

☐ Never  ☐ Almost Never  ☐ Sometimes  ☐ Fairly Often  ☐ Very Often
APPENDIX J

PROVIDER DEMOGRAPHIC AND PROFESSIONAL PRACTICE INFORMATION FORM

Participant ID # __________________________

PROVIDER DEMOGRAPHIC AND PROFESSIONAL PRACTICE INFORMATION

As a participant in this research study, you are being asked to complete the following form to assist the researcher in obtaining demographic and professional practice information on its provider study population. A unique identification (ID) number or participant ID has been assigned to you to ensure your confidentiality.

Study Title: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships: Communication and the Effect on Patients and Providers

Demographic Information

Age: _______ Gender: □ Male □ Female □ Other

Race/Ethnicity:
□ Hispanic or Latino: □ Yes □ No
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Other

Professional Practice Information

Organization: □ Physician Group Practice □ Private Practice □ Clinic
□ Independent Practice Association □ Medical Center □ Other

Licensure: □ MD □ DO □ PA □ NP □ RN □ MA

Area(s) of specialty: _______________________________________________________

Length of time as a practicing healthcare professional: _____ Month(s) _____ Year(s)

Highest level of patient-provider communication skills training completed:
□ No Training □ Basic/Core Curriculum □ Elective/Advanced Training

Source of patient-provider communication skills training (check all that apply):
□ Medical School □ Residency Training □ Post-graduate training course □ N/A
APPENDIX K

RESEARCH ASSISTANCE CONFIDENTIALITY AGREEMENT

Central Michigan University Institutional Review Board

Research Assistance Confidentiality Agreement

This form is for individuals who conduct specific research tasks such as: transcribing, interpreting, translating, collecting, entering data, and shredding data.

Project Title: Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships: Communication and the Effect on Patients and Providers

I, (Name) __________________________ agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form of format (e.g., including but not limited to disks, tapes, transcripts) with anyone other than the Researcher(s). This Study has been reviewed and approved by the CMU IRB. For questions regarding participant rights and ethical conduct of research, contact the Director of the IRB.

2. Return all research information in any form or format (e.g., including but not limited to disks, tapes, transcripts) to the Researcher(s) when I have completed the research tasks.

3. After consulting with the Researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g., including but not limited to information stored on computer hard drive).

(Print Name) __________________________ (Signature) __________________________ (Date) __________________________
Research Assistant

(Print Name) __________________________ (Signature) __________________________ (Date) __________________________
Researcher
APPENDIX L

CODEBOOK

Behavioral Engagement with Pure Presence™ in Patient-Provider Relationships:
Communication and the Effect on Patients and Providers

CODEBOOK: Variable Names and Codes

ID_Number: ____________

Age: _____

AgeCAT:

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Ethnicity

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Race

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<td>Native or Other Pacific Islander</td>
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<td>Native Hawaiian or Other</td>
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<td>White</td>
<td>5</td>
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<td>Other</td>
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Health_Status: __________________________

LengthVisit_Pre: _________

LengthVisit_Post: _________
LengthVisitCAT_Pre:

Under 30 minutes  1  
30 – 60 minutes   2  
Greater than 60 minutes  3  

LengthVisitCAT_Post:

Under 30 minutes  1  
30 – 60 minutes   2  
Greater than 60 minutes  3  

Reason_Pre: __________________________________________

Reason_Post: __________________________________________

Number_Visits: _____

CARE Measure Survey

Scoring:

Poor          1  
Fair          2  
Good          3  
Very Good     4  
Excellent     5  
Does Not Apply 0

Item# and Variable Names:

1. Valued_Pre  
   Valued_Post

2. Present_Pre  
   Present_Post

3. Listen_Pre  
   Listen_Post
4. Whole_Pre
   Whole_Post

5. Understanding_Pre
   Understanding_Post

6. EyeContact_Pre
   EyeContact_Post

7. Positive_Pre
   Positive_Post

8. Explain_Pre
   Explain_Post

9. TakeControl_Pre
   TakeControl_Post

10. DevelopPlan_Pre
    DevelopPlan_Post
REFERENCES


Cox, C. (2013, October 22). Electronic medical records: Not the system I was hoping for. Message posted to http://cf01.diabeteseducator.org/source/blog/index.cfm?article_id=226


