

Provider Perceptions of Patient Centered Care within an Urgent Care System

A Doctor of Nursing Practice Project

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Dedication

To my wonderful, patient and amazing wife Myra John whom I thank immensely for supporting me without question in all my endeavors. To my three sons, Clevon, Jaylin and Carson, who complete my world. I could not have accomplished this without any of you. To my loving parents and family who never ever stopped praying and believing in me. I truly appreciate all the commitment and support provided to me by the East Carolina University College of Nursing.

“I can do all things through Christ who strengthens me.” Phillipians 4:13

Abstract

Institutes of Medicine (IOM) definition of providing care that is responsive and respectful of individuals and patients desires, needs, preferences and values, including these parties in the decision making process (IOM, 2001). Provision of this care is found to improve outcomes, patient adherence and patient satisfaction. Providers who possess a patient centered attitude inclusive of these elements can truly enhance the patient experience. Ascertaining the differential attitudes toward this concept between providers has not been studied producing a rich data set from which interprofessional collaborative training efforts can burgeon. The purpose of this project is to evaluate Nurse Practitioner (NP), Physician Assistant (PA), Physician (MD) attitudes toward provision of patient centered care in an urgent care environment.

The project used a nonrandomized, non-experimental quantitative design with a convenience sample of NP, PA and MD professionals practicing within a large North Carolina for-profit Urgent Care system with clinics disbursed within urban and rural settings. The providers completed a validated survey Patient-Practitioner Orientation Scale (PPOS) survey, (Krupat, Hiam, Fleming & Freeman, 1999), a measure of patient centered care attitudes. The results revealed MDs exhibited higher patient centered attitudes than their NP and PA colleagues. NPs scored higher on the caring subscale than PAs, but slightly lower on this scale compared to MDs. PAs scored higher on the sharing subscale compared to NPs and slightly lower on this scale compared to MDs. These findings suggest that MDs within this setting hold a more favorable attitude toward patient centeredness as a whole than their NP and PA colleagues. NPs scored high only on the caring subscale, suggesting that NPs continue to manifest core beliefs of caring within their advance practice roles but may not have a high affinity for patient centeredness as a whole within the urgent care environment.

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Chapter 1 Introduction

Patient centered care (PCC) is regarded as a critical element necessary for the provision of high quality, patient focused care. There is a preponderance of literature prorogating for the diffusion of this innovation into all aspects of the health care delivery system (Cronenwett, et.al, 2007; Davis, 2005; Stewart, 2000). Within the current health care system a divide exist between the wants and needs of the patient and the medical provider leading to a convoluted and fragmented delivery system (Institutes of Medicine, [IOM], 2001). In the urgent care environment, development of long term relationships may not be a salient desire of the provider or patient. However, improving patient adherence to treatment regimen, maintenance of patient and family satisfaction and facilitating reciprocal communication is a win-win situation for both parties and evidenced as a consequence of PCC infusion (Robinson, Callister, Berry & Dearing, 2008).

Patient centered approaches to practice and the development of patient centered medical homes is increasingly touted as a viable route to improved quality, enhanced patient satisfaction and potentially decreased cost (Rosenthal, 2008; Shortell, 2009). The concept of patient centered care has burgeoned as a crucial remedy to the disjointed delivery of high quality health care (Auerbach et.al, 2013). Health care providers especially advanced practice nurses who garner an understanding of this concept and its health care ramifications can guide system and organizational change. Furthermore, research reveals that patient centered care health profession education is a proven strategy to help health care providers improve their communication with patients (Dill & Gumpert, 2012; Street, Krupat, Bell, Kravitz & Haidet, 2003). Patients often experience higher levels of satisfaction, gain a better understanding of the treatment plan and adherence to instructions when they are actively engaged during medical encounters (Dill & Gumpert, 2012). Within the health promotion dynamic

adherence remains a vital factor in ongoing health care cost reduction efforts. It is estimated that billions of dollars are lost per year due to lack of adherence to treatment regimens (Chiatti, 2012; DiMatteo, 2004; vanBoven et.al, 2014).

Institution of the Affordable Care Act (ACA) is projected to increase the numbers of individuals with health coverage, the necessity of expanded clinic hours to accommodate these persons, greatly reduces the rates of Emergency Department (ED) utilization (O'Malley, 2013). Over the last 20 years the United States has experienced an exponential rise in the number of urgent care centers, now reaching to nearly 9,000 (AAUCM, 2014). These visits can range from request for refills for chronic condition medications, request to work up a chronic complaint, or treatment for a psychiatric illness. In addition, there are a subset of patients who present to the urgent care with undiagnosed highly acute life threatening illnesses, requiring an astute qualified provider to quickly discern the acuity of the presentation, most of which is based off clinical history alone.

Needs assessment

Due to the complexity and diverse patient population seen in the urgent care clinic setting, fostering a stronger episodic care relationship with the interprofessional team may assist in reducing the burden of illness in this population by providing appropriate care transitions (Shamji, Baier, Gravenstein & Gardner, 2014). Strengthening of the communication dyad takes an understanding of the foundational elements from which medical providers communication arises. Under the provider centered rubric, the provider focuses on their respective agenda, maintaining power and control during the patient encounter. Conversely, the patient-centered style lends itself to inclusion of the patient in the communication process, fostering open communication and mutual discussion (Cooper, et.al, 2012; Roter & Hall, 1992). Extensive literature exists on the physician-patient communication interaction, the majority of which reveal patient affinity for patient centered communication styles.

Fostering a bidirectional, patient inclusive communication style among all provider disciplines yields positive patient satisfaction and improves patient physiologic markers (Cooper, et.al, 2012; Kaplan, Greenfield & Ware, 1989; Manary, Boulding, Staelin, Glickman, 2013; Roter & Hall, 1992).

Although this type of physician-patient communication has been extensively studied, the variations in attitudes toward patient-centered styles of communication between NPs and their PA/Physician counterparts are few to absent and in need of illumination. Recognizing true PCC means providers do not just give the patient what they request. Nor making attempts to meet every patient demand, but balancing evidence based clinical practice, patient expectations, time management and cost effectiveness.

There is an ongoing physician shortage with a predicted shortfall of 159,000 physicians by the year 2025 (AAMC, 2012). Another study projects that by 2020 or 2025 the physician deficit may be as high as 200,000 (Cooper, 2004). Auerbach et. al (2013); Chen, Mehrotra, Auerbach (2014) suggests that simply educating more physicians may not be a timely cost effective solution due to the length of time and expense incurred. Additionally, these authors proposes building a NPs work force to fill this void, has proven to be a very viable, cost effective strategy to meet this pressing need. Ryan and Rahman (2012) found that the provision of NP services within rural urgent care centers yielded high patient satisfaction especially among uninsured patients. Furthermore, NP led urgent care clinics have been shown to provide competent cost effective care, while decreasing ED utilization and enhancing patient satisfaction (Ruegg, 2013).

Background and significance of the problem

Technological advances, like other disciplines, are moving forward at lightening pace, creating a new and fascinating healthcare landscape in which NPs will practice. Willingness to become a completely engaged participant in this change process is essential in order to provide the active and responsive care patients' desire. Changes are indeed necessary in order to meet the diverse needs of patients who desire new and variable perspectives of receiving their care. Provision of PCC includes providing care irrespective of distance limitations. Evidence suggest NPs are amenable to integration of new and novel technological advances to improve the care of their patients (Henderson, Davis, Smith, & King, 2014; Jacob, Duran, Stinson, Lewis, & Zeltzer, 2013). Moreover, exchange of medical information, remote patient monitoring and mobile health communication has become omnipresent in this new future of health care and many NPs are accepting this new shifting dynamic (Henderson et al., 2014). Research reveals this aspect of PCC provision is cost effective, provides enhanced care coordination and improves patient satisfaction (Bynum, Irwin, Cranford & Denny, 2003; Yuji & Masatsugu, 2012). Understanding the process present for sustainable high quality patient outcomes, treatment adherence and satisfaction is paramount within the investigation of the NP care delivery. Work by Fenton and Brykctynski 1993, highlight several domains in which NP expertise exist and specifically the management of the patient and illness status. Within this particular domain the NP meshes the cognitive awareness of wholeness, caring and advocacy with the medical model knowledge and clinical expertise to diagnose, treat and manage urgent or emergent simple to complex medical presentations.

The line by which these two distinct, yet commonly connected concepts intersect is the concern of this type of research. As NPs increasingly expand their roles in detecting and treating acute, chronic and episodic illness within Urgent Care settings, assessing the degree to which NPs maintain consistency and effectiveness with dual role operation is research worthy. As the American

Association of Colleges of Nursing (AACN) discuss in their 2004 position statement on nursing research, the cultural environment, scientific basis for health and the health care workforce need to be understood separately and in interaction to impact the research mission of the discipline and profession. Furthermore, Chism 2012, notes the requisite Doctor of Nursing Practice (DNP) exemplifies the synergy between research and practice to meet and exceed the complex demands of a shifting healthcare landscape. Garnering a practical understanding of the Urgent Care functioning NP attitudes toward patient centeredness compared to their colleagues in the same practice demographic provides the logical progression of research into sharing and caring concepts within clinical urgent care practice.

Theoretical framework

Although there are a host of ways to define PCC, this author utilizes the Institutes of Medicine (IOM) definition of providing care that is responsive and respectful of individuals and patients desires, needs, preferences and values, including these parties in the decision making process (IOM, 2001). A preponderance of studies reveal the intention to perform a particular behavior is heavily influenced by attitude toward that behavior, which is the tenet proposed in Ajzen and Fishbein's (1977) Theory of Reasoned Action (TRA). The TRA focuses primarily on individual motivating factors implicated in performance of a specific behavior (Ajzen, 2002; Fishbein, 2007).

This extensively studied construct assumes the predictor of one's behavior is behavioral intention, which is a combination of attitude toward the said behavior and social normative perceptions regarding the behavior (Ajzen and Fishbein, 1977). The TRA has been used in a number of studies to predict and explain a host of health beliefs and behavioral intentions such as health care utilization, smoking, alcohol use and sexually transmitted disease prevention (Albarracin, Fishbein & Goldestein de Muchnik, 1997; Bosompra, 2001; Trafimow, 1996). Additionally, TRA asserts that in

order for the individual's attitude and subjective norm to predict a particular behavior one must have a high degree of volitional control over the behavior (Madden, Ellen & Ajzen, 1992). For situations where there is perceived diminished volitional control the construct developers added the perceived control component to the framework entitling it The Theory of Planned Behavior (TBP) (Madden, Ellen & Ajzen, 1992). The expansion of the construct focuses on attitude, subjective norm and perceived control and has been utilized in numerous studies to predict behavioral intentions and engagement (Madden, Ellen & Ajzen, 1992). The addition of the perceived control elements takes into account factors outside of the individual's control. TBP asserts that when attitude and subjective norms are held constant, an individual's perception of the how easy or difficult it is to engage in a particular behavior will ultimately affect their intention to engage in that behavior. A summative description of this framework therefore predicts that attitudes (positive/negative feelings about a behavior), perceived social pressure from others (subjective norms) and perceived control (the ease of performing a behavior), strongly predict intention and behavior. This framework is arguably considered the one of the most dominant models of attitude-behavior predictors (Armitage & Christian, 2003). TRA/TBP is displayed in Figure 1:

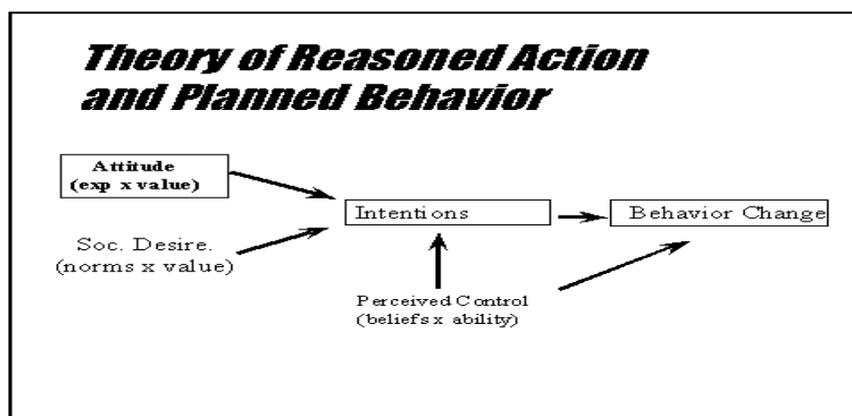


Figure 1: Theory of reasoned action and planned behavior, Madden, Ellen and Ajzen, 1992.

For example if one has a favorable attitude toward adoption of a new Electronic Health Record (EHR), their colleagues harbor similar attitudes and the adoption and implementation of this product perceived as relatively easy to adopt, the TPB framework predicts this individuals would more likely engage in the adoption of this innovation. Conversely, if the individual has a favorable attitude toward the innovation adoption, but is surrounded by individuals or an environment inhospitable to the innovation and/or the innovation is perceived to be difficult to adopt, this individual is not likely engage in adoption. Secondly, if most providers have a positive attitude toward PCC, are with individuals who share this attitude, are in an environment conducive to this attitude and the behavior is easy to perform, the construct predicts these individuals will likely engage in PCC behaviors. TPB cannot however predict and explain all intentions and behaviors, as contextual factors may influence those behaviors even in situations where all positive adoption factors are present.

Researchers utilizing this construct find some behaviors are exclusively under attitudinal control, normative control or perceived control (Albarracin, Johnson, Fishbein & Muellerleile, 2001; Albarracin, Kumkale and Johnson, 2004; Fishbein & Cappella, 2006). For example, a provider may harbor favorable attitudes toward PCC, have a favorable normative environment and positive perceive control, but has an extremely ill patient who desires paternalistic behavior from the provider. Although, not inclusive of every extenuating circumstance, the TPB has been found beneficial in empirically identifying factors from which behavior change interventions could focus. Understanding the antecedent components implicated in behavioral intentions can help in development of individual and organizational interventions geared toward these model components. Based off this framework, this study seeks to measure, quantify and describe provider attitudes toward PCC in the Urgent Care practice setting. Secondly, this study seeks to determine if attitudes toward PCC differ among providers by discipline, gender, age and years since completing formal training. Garnering a better

understanding and consistent utilization of PCC in patient interactions ultimately improve patient health status. Measuring the practice orientations of providers yields promise in prediction of provider behavior in the patient-provider interaction (Krupat, Putnam & Yeager, 1996).

Project statement and questions

Given the diverse definitional characteristics and wide ranging attributes of PCC, this author seeks to understand the antecedent attribute of attitude implicated in provider willingness to emulate PCC behavior.

1. How do providers score on the Patient Practitioner Orientation Scale?
2. Do providers differ in their attitudes toward provision of PCC?
3. Do provider attitudes differ based off of demographic factors (gender, age and years since completing formal training)?
4. Which variables are best predictors that a provider would likely have a more favorable attitude toward PCC?

Chapter 2 Research Based Evidence

Review of Literature

To measure the PCC concept in practice, it is important to discover the existing literature defining the term. Electronic searches were carried out to identify studies from 2004-2014 that define the patient centered care (PCC concept). This consisted of a general search in electronic databases including the World Wide Web, Cumulative Index for Nursing and Allied Health (CINAHL), PubMed, MEDLINE and Psychinfo. The exact term patient-centered care was instituted to highlight

the specific definitions in literature. Reference list of related articles were scrutinized and utilize in supplementation to computer based searches. This was further narrowed to English only and included “healthcare” as an additional connective term. This yielded interchangeable terms finding patient centered, person centered common in the review of this concept. The review sought to find clear cut definitions of PCC used by NPs, PAs) and MDs. Numerous studies were noted that specifically studied this concept in relation to staff nursing care and excluded as focus on defining this characteristic among NPs was the goal. A plethora of studies defining the use of this concept among physicians permeates the literature. However, few studies exist examining the relationship between this concept and PAs or NPs.

Additionally, this author sought to review measurement tools utilized in study of this concept among the various provider groups. To find a viable measurement tool for use within this study, the author used the literature review conducted by deSilva (2014). The researchers reviewed PCC themes from twenty three thousand studies and included specific examples from nine hundred and twenty one. The researchers found five hundred and three studies focusing on person-centered care as a broad holistic concept focusing on shared decision making, communication and patient focused (deSilva, 2014).

Although, the use of the term patient centered care (PCC) is pervasive in the literature, with diffuse defining attributes, it lacks a one true definition. Researchers use a host of methods for measurement of this framework. The most typical are non-experimental designed physician, patient questionnaires, audio or video taped observational studies or before/after surveys of patients or medical providers (Mead & Bower, 2000; Mead & Bower, 2002). Currently there is no gold standard for measurement of this concept. However, review of its use across a broad swatch of clinical settings and patient populations reveal consistent improved patient satisfaction and improved outcomes (Mead & Bower, 2002; Stewart, 2001). Jeppson and Thomas (1994), define patient centered care as an

approach to the planning, delivery and evaluation of health care grounded in partnerships among health care providers, patients and families. Laine and Davidoff (1996), describe the concept as one which is congruent with, and responsive to patients' wants, needs and preferences. Additionally, McComack and McCance (2006), promote several essentials necessary for patient centered care. These include: (a) working with the patient's beliefs and values, (b) engagement, (c) having sympathetic presence, (d) sharing decision-making, and (e) providing for physical needs. However, the authors acknowledge significant competing factors in successful implementation of these strategies, including commitment of the organization and culture of the workplace.

Globally the International Alliance of Patients' Organizations (IAPO) proposes five global principles developed and agreed upon thru research with global patient groups (Groves, 2010). These five principles define patient-centered healthcare as (a) respect, (b) choice and empowerment, (c) patient involvement in health policy (d) access and support, and (c) information. Kitson, Marshall, Bassett and Zeitz (2012), present three core themes to define this concept: (a) patient participation and involvement, (b) relationship between the patient and the healthcare professional, and (c) the context where care is delivered. Stewart et al. (1995a), propose six defining components; (a) exploring both the disease and the illness experience, (b) understanding the whole person, (c) finding common ground regarding management, (d) incorporating prevention and health promotion, (e) enhancing the doctor-patient relationship, and (f) being realistic about personal limitations and issues such as the availability of time and resources.

Mead and Bower's, (2000, 2002) seminal work on PCC, conducted a review of conceptual and empirical patient centered care literature to develop a model for patient centered care. The authors identified five defining attributes within the literature used in attempts to clearly define the patient center care concept. These include: (a) biopsychosocial perspective, (b) patient as person, (c) sharing power and responsibility, (d) therapeutic alliance and (e) doctor as person.

The biopsychosocial perspective combines the biological, psychological and social aspects of a patients' illness (Mead & Bower, 2000). It proposes health care providers view patients' within the broader context of their illness. It suggest incorporating the psychosocial elements of the patient encounter and include them when managing the acute or chronic physical disorders. Viewing patient as person is the second defining attribute necessary for patient centered care. This includes avoidance of viewing the patient as a diagnostic label, but considering the patients' own individual view of their illness. This attribute proposes the provider attempt to develop a better understanding of the patient as a whole individual by being inclusive of their social and cultural view of their illness (Mead & Bower, 2000). Furthermore, within this aspect of patient centered care the provider or entity providing the medical care should create an open access environment, wherein the patient has accessibility to their provider, continuity of care and receive biased free care.

Although, no single operational definition exist, it has been demonstrated thru multiple studies that patients desire the core attributes of PCC and these core conceptual components positively influence outcomes (Stewart, 1995; Stewart, 2001; Williams, Freedman, & Deci, 1998). Although patients uniformly prefer and value all aspects of PCC, they may not prefer every component all the time and that these elements are contextual changing with each patient encounter. Thus, having a provider who is flexible, willing to participate in PCC behaviors will readily adjust to the context in which the interaction takes place.

Understanding PCC behaviors and attributes inherit to this type of communication is complex, as it is influenced by a host of contextual factors. PCC can be viewed as a trait, or style of practice (McWhinney, 1995), or it can be viewed as a state, encompassing a set of behaviors during a particular interaction (Roter, 1997).

Caring is elementally foundational to the core of nursing provision and as literature suggest does not diminish as nurse progress toward NP roles. Brunton and Beagman (2000), utilized the Caring Behaviors Inventory (CBI) to measure caring NPs. The authors did not note any statistically significant difference in NP perceptions of caring, who differed by a host of sociodemographic factors (i.e. age, sex, race), practice locations and specialties. These NPs projected common themes present in perceptions of their care including being respectful to the patient, talking to the patient, being honest and listening closely to the patient. Conversely, the only measure found statistically significant was length of time as an NP. Furthermore, their respondents scored highest in the talking to patients dimension compared to staff nurses under query. This would be consistent with work by Benner (2004), who utilized the Dreyfus skill acquisition model to explore domains of novice to expert nursing. Finding those who functioned successfully within the expert domain typically were more experienced, practiced for longer periods of time and honed specific relational skills gained through experience in repeated clinical scenarios. Skilled NPs are found to be essential to the provision of high quality low cost care to minor non emergent patients in the emergency room setting, while continuing to maintain high levels of patient satisfaction (Sakr, et.al., 1999).

Chapter 3 Methods and Design

Setting and Participants

This author has obtained an exemption from the East Carolina University (ECU) institutional review board (IRB) prior to initiation of this study. The study used a nonrandomized, non-experimental quantitative design with a convenience sample of NP, PA and MD practicing within a large North Carolina for profit Urgent Care system (N= 80). All study providers were in active practice within the system, with no differentiation made between full time or part-time status. The urgent care system consists of fifty-one centers dispersed across a range of urban and rural counties

across all of North Carolina. Per the organization administration at the time of study permission, there were 16 NPs, twelve MDs, one-hundred and twenty PAs. However, given the ongoing organizational change (new urgent care organization acquisition, new provider credentialing and provider attrition) the exact numbers of provider type by the time of survey response collection is unknown. These providers are diverse in age, gender and years of practice. A survey instrument (Krupat, Putnam & Yeager, 1999) was distributed via the urgent care system provider email listserv, open to all employed providers, encouraging participation, explaining the purpose of the study, assuring anonymity and voluntary participation. No IP addresses were stored, no personally identifiable data was obtained and the data was collected and stored in an online, password protected web folder. The participants had the option of completing the survey, opting out prior to taking the survey or stopping and closing the survey prior to completion without consequence.

Outcome Variables

To ascertain the provider attitudes toward patient centered care communication, the Patient-Practitioner Orientation Scale (PPOS) (Krupat, Putnam & Yeager, 1999) was utilized and distributed in survey format. (See Appendix for the instrument). The PPOS was originally developed to determine the distinction between patient centered versus physician centered attitudes toward PCC. It has yet to be utilized in the study of NP or PA groups singularly or together. All applicable permissions to utilize the instrument were received from the instrument developer. This scale has 18 items in a Likert format, using a six point scale labeled strongly disagree to strongly agree.

The total scores to determine patient centered versus provider centered orientation can be calculated. The instrument contains two subscales dimensions measuring sharing and caring. The sharing nine item subscale assesses the extent to which providers believe they should share power, control, information with patients and the belief that patients should be part of the decision making

process (Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000). Providers who score high in the sharing dimension are considered those who want their patients to have as much information as possible and desire for their patients to engage in the shared decision making (Krupat, Hiam, Fleming & Freeman, 1999). The caring nine item subscale evaluates providers' interest in the patient's feelings, preferences, expectations and life circumstances as crucial factors in the treatment process along with the provision of warmth and support to patients (Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000). These providers consider the patient from a psycho-social perspective rather than just projection of a biomedical perspective (Krupat, Hiam, Fleming & Freeman, 1999).

The reliability and validity of the instrument and has been demonstrated in several studies assessing self-perceived patient centeredness and the subscale items were found to be highly correlated (Krupat, Hiam, Fleming & Freeman, 1999; Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000). The sharing subscale demonstrates an internal validity of .85, while the caring subscale demonstrated an internal validity of .84 (Krupat, Hiam, Fleming & Freeman, 1999). Combined subscale items demonstrate an internal validity of .89 (Krupat, Hiam, Fleming & Freeman, 1999). All of the instruments wording and content integrity was maintained with only the word doctor (in the original instrument), changed to provider for appropriate use within this study.

The scale was converted to an online Qualtrics ® (Qualtrics, 2015) survey format and included the following demographic data: Gender (Male, Female, Transgender), professional designation (NP, PA, MD/DO), years since completing formal training stratified into five categories (0 – over 15 years) and age span stratification (21 – over 60 years). Data was collected and calculations of a summative total of the instrument and subscales occurred. The urgent care system has granted full permission to survey their providers, granted that no personal identifying data was collected. Respondents were dropped from the study for failing to complete the entire survey in an effort to maintain the integrity and richness of the data collected.

Data Analysis

Analysis consist of a one way analysis of variance (ANOVA) to classify providers according to their orientation preferences using PPOS total scores, sharing and caring as the dependent variables. For example, this statistical analysis can help determine if female physicians were oriented toward PCC or if providers with longer years of service harbor less PCC attitudes. Furthermore, to investigate the independent relationships of age, gender, years of practice and professional role and PPOS total scores a multiple linear regression analysis was conducted. The benefit of the regression analysis is that it allows for analysis of more than independent variables (demographics) and the effect of interactions with the dependent variable (attitudes). This deeper exploration of the interrelationships between the variables allows for evaluation of the relative contribution of each of the independent variable in predicting the PPOS scoring outcome.

Once the survey data was obtained from the Qualtrics® survey website, it was imported into version 22.0 SPSS (SPSS, 2013) and reviewed for outliers or missing items. Descriptive statistics were used to describe the study participants. These included analysis of the means and frequencies. Statistician consultation was utilized to appropriately utilize proper statistical methods of analysis. Several items were recoded for appropriate statistical analysis to take place. The independent variables (profession, age, years since completion of profession training/school, gender), were examined in their relationship to the dependent variable (PPOS tool). The dependent and independent variables relationships were addressed with a combination of one way analysis of variance, Tukey HSD post hoc analysis and multiple regression testing. Statistical significance for data analysis was set at $p \leq .05$ level.

Validity Analysis

As mentioned previously the original PPOS creator noted total PPOS scale ($\alpha = .89$, sharing sub scale ($\alpha = .85$ and caring subscale ($\alpha = .84$). The initial internal validity scoring obtained for the 18 total items with this survey cohort revealed a ($\alpha = .595$). Due to the lower level of internal reliability present, additional evaluation of each individual subscale alpha's were obtained. This revealed a nine item sharing subscale ($\alpha = .555$) and nine item caring subscale ($\alpha = .592$). Within the sharing subscale further evaluation to determine which question item reduced the alpha substantially finds that with removal of the question nine, "patients should be treated as if they were partners with the provider, equal in power and status," a significant improvement is realized ($\alpha = .715$).

Additionally, within the caring subscale analysis removal of question 13, "the treatment plan cannot succeed if it is in conflict with a patient's lifestyle or value" improvement is also noted ($\alpha = .651$) and removal of question 17, "humor is a major ingredient in the provider's treatment of the patient" subsequent improvement is further noted ($\alpha = .644$). This study's analysis was conducted utilizing the entire scale and subscale items without manipulation or removal of the study items and with original Cronbach alpha scores obtained. A secondary analysis however was performed to discern if retention of question nine and recoding of questions 13 and 17 would reveal any statistically significant change in the original results. Upon reversal and recoding of the likert scale format for questions 13, 17 respectively within the caring subscale a new alpha ($\alpha = .649$). Repeat analysis of the entire 18 question scale including retention of question nine and the recoded questions presented a significant increase ($\alpha = .738$). Within this new analysis it is found that removal of question nine would again increase the total scale alpha ($\alpha = .792$). These findings suggest question nine performs poorly and lacks internal reliability within this project's population. Reverse coding of question nine revealed a new sharing subscale ($\alpha = .745$) and total scale ($\alpha = .804$). The rise in total scale alpha after reverse ordering of question nine, 13, 17 respectfully achieved the greatest alpha

results. Thus, reverse ordering of these questions should be considered within any future use of this survey tool. Reevaluation of the use of this question in further study with this population should be considered.

Sample Characteristics

There were 85 respondents to the survey, five were removed due to several missing data inputs thus deeming these responses unusable for statistical analysis. Therefore, 80 respondent participants were retained. The provider scores on the PPOS were calculated for the 80 useable surveys and each was expressed as the total mean of all items answered. Additionally, the PPOS subscale items were obtained, statistically measured and reviewed in relation to the total scale means. Robust statistical analysis was performed on data obtained from these respondents and can be view in the following corresponding tables. The demographic characteristics of the respondents are contained within Table 1-2. Most of the respondents were female (54.1%) and PA (41.3%), followed by male PAs (30%), female NPs (10%), male NPs (7.5%). While male ($N=5$) and female ($N=5$) MDs were split evenly at (6.25%) respectively. Respondents were presented with age range choices beginning at 21-25 to > 60. The majority of respondents documented their age range at 26-30, (20%) of this value the majority were PAs (20%). The majority of MDs (40%) fell within the 51-55 age range. The majority of MDs practiced >15years, (40%), followed by PAs (26%), while the majority of NPs, (42%) and PAs (30%) practiced two to five years.

Table 1

<i>Demographics and Characteristics of the Survey Sample (N=80)</i>			
Demographics and Characteristics		<i>N</i>	<i>P (%)</i>
Gender	Male	35	41.2
	Female	45	54.1
Years since completing formal training	0-1	9	10.6
	2-5	25	29.4
	6-10	15	17.6
	11-15	11	12.9
	>15	21	24.7
Age	21-25	3	3.5
	26-30	17	20
	31-35	12	14.1
	36-40	14	16.5
	41-45	11	12.9
	46-50	9	10.6
	51-55	7	8.2
	55-60	4	4.7
	>60	4	4.7
NP	Male	6	7.5
PA	Male	24	30
MD	Male	5	6.25
NP	Female	8	10
PA	Female	32	41.3
MD	Female	5	6.25
Nurse Practitioner (NP)		14	16.5
Physician Assistants (PA)		56	67.1
Physicians (MD/DO*)		10	11.8
Cases in working data file		85	100
Cases missing values		5	5.8
Total valid files (N)		80	94.1

Table 2
Years since completing formal training/school (N=80)

Years	NP N (%)	PA N (%)	MD N (%)	Total
0-1	0 (0.00)	9 (16.1)	0 (0.0)	9
2-5	6 (42.9)	16 (28.6)	2 (20.0)	24
6-10	3 (21.4)	9 (16.1)	3 (30.0)	15
11-15	3 (21.4)	7 (12.5)	1 (10.0)	11
>15	2 (14.3)	15 (26.8)	4 (40.0)	21
Total	14	56	10	80

Chapter 4 Results

Descriptive analysis of survey results and corresponding subscales were recorded. These results were obtained after achieving a total PPOS scale ($\alpha = .559$). The mean and standard deviation of these scores were tabulated to discern which profession had higher favorable attitudes toward the provision of PCC. Statistical analysis of total provider scores reveals MDs ($M=3.23$), scoring higher on total score elements followed by PAs ($M=2.65$) and NPs ($M=2.54$), suggesting physicians in this survey were most patient centered than their counterparts, thus yielding more favorable attitudes this concept (Table 3). Table 4 depicts the descriptive analysis of provider subscale scores along with total scores. Similarly, within the sharing subscale measure, MDs ($M=3.13$) scored highest, followed by PAs ($M=2.88$) then NPs ($M=2.40$). Conversely, within the caring subscale MDs ($M=3.13$) maintained consistent high scores, however NPs ($M=2.67$) fared better than their PA ($M=2.42$) colleagues. The MD variability noted in this project could be associated with the low N for MDs.

Table 3
Descriptive analysis of total PPOS scores (N=80)

Profession	<i>N</i> (%)	<i>M</i>	<i>SD</i>
NP	14 (17.5)	2.54	.57
PA	56 (70)	2.65	.43
MD	10 (12.5)	3.23	1.00
Total	80	2.70	.58

Table 4

Descriptive analysis of subscale vs. total PPOS scores by profession (N=80)

Sharing subscale	<i>N</i> (%)	<i>M</i>	<i>SD</i>
NP	14(17.5)	2.40	.66
PA	56 (70)	2.88	.62
MD	10 (12.5)	3.32	1.17
Caring subscale			
NP	14 (17.5)	2.67	.64
PA	56 (70)	2.42	.41
MD	10 (12.5)	3.13	.95
Total			
NP	14 (17.5)	2.54	.57
PA	56 (70)	2.65	.43
MD	10 (12.5)	3.23	1.00

A one-way between groups ANOVA was conducted to explore the sharing, caring and total PPOS scores (Table 5). There was a statistically significant difference found at the $p \leq .05$ level. Sharing analysis revealed $F(2,77) = 5.10, p \leq .05$, caring $F(2,77) = 7.84, p \leq .05$ and total $F(2,77) = 5.44, p \leq .05$. Post hoc comparisons using the Tukey *HSD* test was performed to determine the nature of the differences between the providers, indicated the MDs ($M = 3.32, SD = 1.17$), were significantly different from NPs ($M = 2.40, SD = .66$) but neither were significantly different than PAs ($M = 2.88, SD = .62$). Whereas the caring post hoc analysis reveals a statistically significant difference between MDs ($M = 3.13, SD = .95$), and PAs ($M = 2.42, SD = .41$), with no significant difference between these groups and NPs ($M = 2.67, SD = .64$) (Table 5, 6). On the PPOS score as a whole MDs ($M = 3.23, SD = 1.00$) were statistically different than both NPs ($M = 2.54, SD = .57$) and PAs ($M = 2.65, SD = .43$).

Table 5
ANOVA for total scale and subscales (N=80)

		SS	df	MS	F	Sig.
Sharing Mean	Between Groups	5.15	2	2.57	5.10*	.008
	Within Groups	38.91	77	.51		
	Total	44.1	79			
Caring Mean	Between Groups	4.61	2	2.31	7.84*	.001
	Within Groups	22.66	77	.29		
	Total	27.27	79			
Total Mean	Between Groups	3.32	2	1.67	5.44*	.006
	Within Groups	23.50	77	.305		
	Total	26.82	79			

* $p \leq .05$

Table 6
HSD post-hoc analysis for total and subscales (N=80)

Dependent Variable	Current Profession(I)	Current Profession(J)	Mean Difference (I-J)	SE	Sig.
Sharing Mean	NP	PA	-.480	.212	.068
		MD	-.925*	.294	.007
	PA	NP	.480	.212	-.03
		MD	-.445	.244	-1.03
	MD	NP	.925*	.294	.007
		PA	.445	.244	.168
Caring Mean	NP	PA	.258	.162	.255
		MD	-.459	.225	.109
	PA	NP	-.258	.162	.255
		MD	-.717*	.186	.001
	MD	NP	.459	.225	.109
		PA	.717*	.186	.001
Total	NP	PA	-.111	.165	.780
		MD	-.692*	.229	.009
	PA	NP	.111	.165	.780
		MD	-.581*	.190	.008
	MD	NP	.692*	.229	.009
		PA	.581*	.190	.008

* $p \leq 0.05$

Considering prior evidence suggesting female physicians exhibited more patient centric attitudes compared to their male colleagues, (Krupat, Hiam, Fleming and Freeman, 1999), yet no evidence at present measures this among NPs and PAs in this study emerged. ANOVA measures were performed assessing gender between these groups to assess for a difference. An ANOVA was performed in evaluation of the total female ($N=45$) versus male ($N=35$) providers, inclusive PPOS total, the sharing, caring and total mean scores revealed no significant difference on the sharing subscale $F(1,78) = 2.57, p > .05$, caring subscale $F(1,78) = .01, p > .05$ and total scale $F(1,78) = .32, p > .05$ scores. (see Table 7).

Table 7
ANOVA analysis for gender ($N=80$)

Gender		SS	df	MS	F	Sig.
Sharing mean	Between Groups	1.40	1	1.40	2.57	.113
	Within Groups	42.65	78	.547		
	Total	44.05	79			
Caring mean	Between Groups	.003	1	.003	.01	.922
	Within Groups	27.27	78	.350		
	Total	27.27	79			
Total	Between Groups	.317	1	.32	.934	.337
	Within Groups	26.50	78	.34		
	Total	26.82	79			

* $p \leq .05$

This suggest that gender within this project is not a statistically significant factor in accounting for the differences in provider attitudes toward PCC. Statistician consultation suggested repeat analysis with a reduced randomly selected number of PAs to better equalized the three provider groups. As noted previously, the low N for MDs could account for the greater variability in MD scores compared to other group measures. Under statistician assistance a completely random selection of PAs was chosen ($N=15$). Repeat testing of homogeneity after random PA ($N=15$) selection did not produce any violations in variance assumption. The reduction in PA sample size produced increased equality in sample size. However, there remained statistically significant difference in scores between the three groups as evidenced by the one way between groups ANOVA performed on total mean scores(Table 8): $F(2,36)=3.40, p \leq .05$. Sharing mean however no longer revealed a significant statistical difference between groups: $F(2,36) = 3.00, p > .05$. While the caring subscale continued to show a statistically relevant difference between groups: $F(2,36) = 4.52, p \leq .05$.

Table 8
ANOVA post PA random group assignment ($N=39$)

		<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>Sig.</i>
Total mean	Between Groups	2.33	2	1.17	3.40*	.045
	Within Groups	12.47	36	.35		
	Total	14.80	38			
Sharing mean	Between Groups	2.68	2	1.34	3.00	.066
	Within Groups	16.47	36	.46		
	Total	19.15	38			
Caring mean	Between Groups	4.50	2	1.74	4.52*	.018
	Within Groups	13.87	36	.40		
	Total	17.35	38			

* $p \leq .05$

The repeat descriptive analysis and Tukey HSD post hoc analysis after random PA selection again reveals MDs ($M=3.40$, $SD=.92$), scored higher on total PPOS scoring, followed by PAs ($M=2.92$, $SD=.41$) then NPs ($M=2.82$, $SD=.43$). Evaluating sharing scores, MDs ($M=3.34$, $SD=.96$) scored highest, but only a negligible difference from PAs ($M=3.10$, $SD=.57$) and NPs ($M=2.70$, $SD=.52$) (Table 9). Table 10 provides the mean and standard deviation descriptive analysis measures for all provider groups against the sharing, caring and total PPOS scores.

Table 9
HSD Post Hoc Analysis (N=39)

Dependent Variable	Current Profession (I)	Current Profession (J)	Mean Difference (I-J)	SE	Sig.
Total Mean	NP	PA	-.09	.22	.92
		MD	-.60*	.25	.049
	PA	NP	.09	.22	.92
		MD	-.51*	.24	.09
	MD	NP	.60*	.24	.049
		PA	.51*	.24	.09
Sharing	NP	PA	-.40	.25	.28
		MD	-.66*	.28	.06
	PA	NP	.40	.25	.28
		MD	-.30	.28	.60
	MD	NP	.66*	.28	.06
		PA	.30	.28	.60
Caring	NP	PA	.22	.23	.61
		MD	-.50*	.26	.01
	PA	NP	-.22	.23	.61
		MD	-.76*	.25	.01
	MD	NP	.53	.26	.11
		PA	.76*	.25	.01

* $p \leq .05$

Table 10
Descriptive analysis post PA random assignment (N=39)

	Profession	N (%)	M	SD
Total mean	NP	14 (35.9)	2.82	.43
	PA	15 (38.5)	2.92	.41
	MD	10 (25.6)	3.40	.92
	Total	39 (100)	3.01	.62
Sharing mean	NP	14 (35.9)	2.70	.52
	PA	15 (38.5)	3.10	.57
	MD	10 (25.6)	3.34	.96
	Total	39 (100)	3.00	.71
Caring mean	NP	14 (35.9)	3.00	.48
	PA	15 (38.5)	2.80	.44
	MD	10 (25.6)	3.51	.95
	Total	39 (100)	3.02	.68

Caring subscale measures revealed NPs ($M=3.00$, $SD=.48$) scored higher than PAs ($M=2.80$, $SD=.44$), and closer to their MD ($M=3.51$, $SD=.95$) colleagues. Interestingly NPs score higher on the caring dimension of the PPOS, which assess the extent to which providers believe that caring about emotions and facilitating good interpersonal relationships are key, along with caring about the person as a whole rather than just about their medical condition. A multiple linear regression analysis was performed to assess which variable(s) might be making a statistically significant unique contribution to the variance in the dependent variable results (PPOS scores). Additionally, this analysis allows for improve discernment of the relative contribution of each independent variable. These variable included NPs vs MDs, PAs vs MDs, age, gender and years since completing formal training/school.

The coefficients (Table 11) results did not detect a violation in the multicollinearity assumption supported by VIF values ≤ 10 and Tolerance values of $\leq .10$ thus continued evaluation of the data took place. However, in evaluation of the variable(s) which had the strongest contribution to score variability the NP vs MD ($B = -.49$, $t = -2.46$, $p \leq .05$) variable had the most impact, followed

within a small degree by the PA vs MD ($B = -.43, t = -2.15, p \leq .05$) (Table 11). The Pearson correlation matrix did not reveal any significant correlation between variables. (see Table 12).

Table 11
Coefficients^a

Model	Unstandardized Coefficients		Standard Coefficients	t	Sig.	Collinearity Statistics	
	B	SE	Beta			Tolerance	VIF
Constants	3.64	.50		7.29	.000		
Age	-.084	.084	-.26	-1.00	.32	.38	2.63
Years since completing formal training/school	.090	.12	.18	.724	.47	.39	2.54
Gender	-.05	.20	-.04	-.24	.82	.98	1.04
NPvsMD	-.63	.26	-.49	-2.46	.02	.62	1.62
PAvsMD	-.55	.25	-.43	-2.15	.04	.62	1.63

a. Dependent Variable: Total Mean

Table 12
Pearson Correlation Coefficient

	Total mean	Age	Years since completing formal training/school	Gender	NP vs MD	PA vs MD	
Pearson Correlation	Total Mean	1.00	-.01	.07	-.05	-.27	-.13
	Age	-.01	1.0	.79	-.16	-.13	-.09
	Years since completing formal training/school	.07	.79	1.00	-.10	-.12	-.05
	Gender	-.05	-.16	-.10	1.00	-.03	.12
	NP vs MD	-.23	-.13	-.12	-.03	1.00	-.60
	PA vs MD	-.13	-.09	-.05	.12	-.60	1.00
Sig. (1- tailed)	Total mean		.49	.34	.37	.08	.22
	Age	.49	.	.000	.16	.22	.28
	Years since completing formal training/school	.34	.000	.	.27	.23	.38
	Gender	.37	.16	.27	.	.43	.23
	NP vs MD	.08	.22	.23	.43	.	.000*
	PA vs MD	.22	.23	.38	.23	.000*	.
N		39	39	39	39	39	39

* $p \leq .05$

These relational results however should be viewed with extreme caution given the very small sample size of providers as whole but particularly the MDs ($N = 10$). This results is however contrary to the stereotype that older physicians take a more authoritative position toward patient relationships and more consistent with evidence showing no difference in PPOS scores with older more experienced providers (Cvengros, Christensen, Hillis & Rosenthal, 2007; Krupat et. al., 2000). This does not suggest that older, more experienced NPs or PAs do not exhibit the same attitude toward PCC, but given the demographics of this sample size, wherein very few NPs or PAs fit the same age and experience range, room for greater variability exists.

The regression model summary reveals the total variance explained by the model was not significant at 18.3%, ($F(5,33) = 1.50$ $p > .05$), $R^2 = .183$. Given the small samples size the adjusted $R^2 = .059$ is presented here again revealing a negligible 6% of the PPOS score variance can be attributed to the variables measured (Table 14).

Table 13

Multiple regression model summary^b

Model	R	R_2	Adjusted R_2	SE of the estimate
1	.428 ^a	.183	.059	.61

a. Predictors: (Constant), PAVsMD, years since completing formal training/school, Gender, NPvsMD, Age.

b. Dependent Variable: Total mean

Table 14

ANOVA^a for multiple regression model

Model	SS	df	MS	F	Sig.
Regression	2.71	5	.54	1.50	.22 ^b
Residual	12.10	33	.367		
Total	14.81	38			

a. Dependent Variable: Total Mean

b. Predictors: (Constant), NPvsMD, Years since completing formal training/school, Gender, PAVsMD, age

Therefore, although being an NP vs MD or PA vs MD had some contribution to score variability, these including the other variables do not play a very strong statistically significant part in PPOS score variability. Holding all other variables constant, the findings of this regression further note that being an MD within this respondent group has statistical significance consistent with the prior analysis findings.

Upon secondary analysis of the data post recoding of the questions 13 and 17, with retention of question nine ($\alpha = .738$). A brief review of the further statistical analysis of this data utilizing this new alpha is presented below. A one way ANOVA was conducted to explore the impact of provider profession on total PPOS scores ($N=80$). There was a statistically significant difference found at the $p \leq .05$ level: $F(2, 77) = 5.50, p \leq .05$. It is revealed that MDs ($M=3.17$) scored highest on total PPOS scores compared to PAs ($M=2.59$) and NPs ($M=2.43$). A one way ANOVA was also conducted evaluating the provider sharing subscale dimension scores ($N=80$). Statistically significant findings were noted at the $p \leq .05$ level: $F(2, 77) = 4.76, p \leq .05$. Similar to prior findings MDs ($M=3.31$) scored highest followed by PAs ($M=2.90$) and NPs ($M=2.42$). A one way ANOVA was performed to discern the provider caring subscale dimension scores ($N=80$). Statistical significance was found at the $p \leq .05$ level: $F(2, 77) = 6.91, p \leq .05$. These findings are congruent with the initial data analysis. MDs ($M=3.04$), continued to score highest, while NPs ($M=2.45$) scored higher in caring scores than their PA ($M=2.33$) colleagues.

A one way ANOVA was performed assessing the providers years since completing formal training and total PPOS scores. No statistically significant results were found, thus years since completing formal training had no impact on provider PPOS scores: $F(4, 75) = .241, p = >.05$. Similarly when a one way ANOVA was performed evaluating provider age and PPOS scores, no statistically significant difference was noted: $F(8, 71) = .742, p = >.05$. Lastly, a one way ANOVA was performed to the relationship between age and provider PPOS scores. No

statistically significant difference was found between providers on this variable: $F(1, 78) = 1.72$, $p = .05$. Given the profoundly similar results noted here and the previous data analysis performed further analysis utilizing a multiple linear regression was not performed.

Chapter 5 Discussion and Implications for practice

The purpose of this study was to examine the relationships between provider attitudes toward patient centered care as measured by the PPOS tool and demographic factors (age, years since completion of formal training and gender). The implementation of the PPOS tool in measuring attitudes toward PCC among physicians and medical students abounds (Krupat, Hiam, Fleming & Freeman, 1999; Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000). However, to date, no studies have been published that examine the relationship between NPs, PAs and MDs utilizing the PPOS tool. There is evidence noting the high quality of care, NP competency and lower cost of care provision within the emergency department (Carter & Chochinov, 2007). The extent to which the foundational caring education and attributes garnered and exemplified throughout nursing training translates into NP practice deserves further investigation. However, there is evidence to suggest that patients view NPs as those who spend more time with them, listened more and communicated better, improving patient compliance and following of treatment recommendations (Brown & Grimes, 1995; Kinnersley, et.al., 2000). The evidence of higher PPOS caring scores among NPs could be attributed to consistency of adherence to nursing theoretical foundations such as Watson's Theory of Human Caring, wherein holistically caring for the patient and their family, establishment of a trusting relationship and provision of supportive, protective and positive environment as a moral ideal becomes paramount within the patient interactive process (Watson, 2006).

This thread of caring interwoven within the deep relational fabric of nursing's elemental processes, exists existentially and its unconscious provision gets implicitly provided. These attributes utilized by NPs may be unconsciously performed yet remain at the core of care provision. Additionally, Nicoteri (2003), notes in nursing theoretical frameworks rooted in nursing, medicine and social science guide NP practice and the blending of nursing and medicinal practice to support the holism NPs provide. Thus, caring methodology supported by and integral to NP practice may not have been lost when incorporation of the medical model into NP care provision occurred within this cohort. There is little research available on NP communication styles, however there is evidence to suggest that NPs communicate in a more patient centered, and holistic, differentiating them from their physician colleagues (Lawson, 2002; Johnson, 1993). As discussed previously, some authors surmise that due to the sheer foundation of a nurse's education a natural transition to patient centered attitudes and communication would be maintained at the NP level (Summers, 2002). However, in actual clinical practice other research notes a diminished exhibition of patient-centered attitudes once functioning within the NP role (Berry, 2009). Situational patient provider communication and time constraints appear to be salient factors in providing consistent and ongoing patient centered communication and may be attributed to the associates results presented above (Berry, 2009; Buchholz, Purath & Rittenmeyer, 2009).

Sharing dimensions reflect the belief that providers and patients should share power and control and that practitioners should share as much information as possible with patients. The rationale for the higher sharing scores among MDs and PAs versus NPs is unknown. Given the poor item performance of question nine which asks providers specifically about sharing "power" is one element requiring further investigation within this population. The concept and perceived definition of power within the patient provider communication process is difficult to qualify as

it can be variably defined by each provider. As Elwyn, Edwards, Kinnersley and Grol (2000), the concept of power is particularly difficult to explore within the consultation process. Further research into attitudes toward sharing among NPs may produce more evidence to illuminate this concept. Shared decision making and provider willingness to engage in this behavior is indeed complex, multidimensional and contextual. Charles, Whelan, Gafni, Willan and Farrel (2003), found in their conceptual framework of shared treatment decision making (STDM), that shared decision making was an interactive, dynamic process with several definitions. The authors find most physicians in their study adhered to four categorical definitions. It can be viewed as a paternalistic (the physician dominates the process), two-way communication (information is shared, but the physician makes the final decision), patient dictated (information is shared and the patient is the sole decision maker) and lastly one in which the decisions are shared by the patient and physician simultaneously and together find negotiate a decision to implement (Charles et. al., 2003). The significant majority of their respondents chose the latter concept of sharing wherein both parties have equal input.

To understand sharing attributes better among healthcare professions, a systematic literature review by Légaré, Retté, Gravel and Graham (2008), on barriers to implementation of shared decision making across a preponderance of health care professional demographics and inclusive of the demographic within this project is worth noting. The authors found time constraint to be the most significantly cited barrier in implementing shared decision making, followed by agreement with the applicability shared decision making based on the characteristics of the patients and the clinical situation. Thus, given the rapid paced, high volume characteristic of the urgent care environment these elements may be factors in the perceptions of the providers surveyed. Within this urgent care system the provider is the sole practitioner typically accompanied by one or two ancillary staff members. Factors to which prevent the NPs in this

survey from scoring higher on perceptions of sharing with the Urgent Care environment could be a manifestation of the actual or perceived time constraints which consistently serve as a barrier to engagement in this process. Similarly, NPs are increasingly functioning alone in retail clinics managing a host of semi-urgent complaints at a lower cost, without any decreased efficacy or patient outcomes (Mehrotra, Wang, Lave, Adams & McGlynn, 2008; Rohrer, Garrsion & Angstman, 2012). However, there is no evidence reviewing urgent care practice among NPs which contextually function different than the emergency department (host of ancillary staff, services and MDs in close proximity) and retail clinics (less acute patients, minor surgical procedures or need for x-ray interpretation). This unique and poorly studied environment holds yields a host of differentially complex clinical, social and patient interactive components worthy of further study. Additional research is needed to determine the barriers to NP sharing within the context of the urgent care environment.

The theoretical framework Theory of Reasoned Action and Behavior underlying the considerations implicit to this project would suggest that providers who exhibit greater positive attitudes toward patient centeredness would, if found contextually and organizationally appropriate have a greater intention to engage in patient centered communication. Furthermore, if the positive linear engagement of providers toward patient centeredness hold true within the theory's framework, then it would be expected that these providers would be well intentioned to engage in such behavior if other salient factors hold true. These would include the providers perception of how easy or difficult it is to engage in these behaviors within the urgent care clinic setting, perceived subjective environment pressure to engage in this behavior and the context in which this behavior is exhibited. The latter elements, outside of the provider's control, push and pull the provider in different ways and provide a prospective rationale for engagement in the particular behavior under evaluation. As Légaré et.al. (2008), acknowledged, there are three

consistent factors most frequently purported by healthcare workers as facilitators to implementation of shared decision making in clinical practice. These include the motivation by the health care professional (equating to provider attitude in this project's framework); perception that putting shared decision making into practice leads to improved patient outcomes (individual intention coupled with organizational environmental stimuli regarding this factor-social pressure to improve patient outcomes/satisfaction scores) and lastly the perception that putting shared decision making into practice will lead to improved health care processes (providers perceived control and beliefs they can improve health care).

Although, there are no diffuse relevant studies documenting the impact of shared decision making on health indicators (O'Conner, et. al., 2007), there are a preponderance of studies projecting improved patient satisfaction, improved long term outcomes and patient adherence when this factor is instituted clinically (Hack, Degner, Watson & Sinha, 2006; Thislethwaite & van der Vleuten, 2004). According to the urgent care system's administrative personnel, the MDs within this project primarily function as supervising physicians splitting their time between clinical practice (less than full time hours), and administrative duties. Whereas the NPs and PAs surveyed typically work full time (12hrs/day). This project did not query the providers to differentiate between those that work a full time schedule (40hrs/week) verses those that work a part time schedule (<32hrs/week). Thus, there is a potential that the higher affinity toward sharing, caring and patient centeredness as a whole could be attributed to less hours worked, less perception of time constraint, increased interest in maximizing patient outcomes and positive patient satisfaction scores. Holding dual roles (MD administrative oversight) and clinical practice among MD providers may serve as barrier reduction attribute in the shared decision making process, intention to engage in patient centered behavior and overcoming negative social norms toward this behavior. Would these same physicians under different

working arrangement circumstances continue to exhibit the high level of PPOS scores produced under these conditions? Further study is necessary to deeply consider these factors.

As eluded to in prior discourse within this paper, nursing's roots lie within a confluence of social science based theoretical foundations inclusive of phenomenology, sociology, ethnography among other social methodologies. Thus, at its core lie the general social disciplines, which posit caring, humanistic and psychosocial rationality as the foundation for the patient interaction process. As nurses advance toward advanced practice nurse practitioner roles incorporation of hard science, medical model inclusivity and a working knowledge of disease and pathophysiologic processes become necessary. Within this new dual role dynamics, a balanced approach to operation, within a realm of theoretical and clinically based research processes become the new model of clinical practice in which NPs operate. Greene (2004) explored the perceptions of caring through evaluation of male NPs and female NPs to elucidate whether there was a statistical difference in their perception of caring in clinical practice. The author found no statistically significant difference between these genders, similar to findings in this study. However, the author did find a discord among the practitioners who found themselves pressed for production and efficiency feeling these elements may impact their ability to sufficiently utilize the foundational caring elements from which they were trained.

Rolfe (2001), ponders if a theory-practice gap emerges within the context of the new NP the nurse now operates. The author suggest the necessity of nurses to exist within a complementary paradigm, which incorporates the existing sociological metaparadigm theories incorporated within nursing and the functional clinical research necessary to foster a sound therapeutic encounter. The NPs surveyed for this project scored higher on the caring subscale items suggesting that NPs, whose previous nursing experience and education consisted of application of theoretical practices placing the individual at the center of the clinical concern,

may have maintained these attributes within current clinical practice. Brykczynski (1985), produced seminal work on clinical judgment domains necessary for successful knowledge acquisition and clinical competency for NPs. The author lists an essential domain necessary for maximizing patient participation and control in their health care. This domain includes fostering a collaborative relationship with patients inclusive of open acknowledgement of clinical uncertainty, developing a personal approach to the patient, individualize teaching per clinical circumstance and have a willingness to share responsibility in planning interventions. The author suggests that incorporation of these elements into the clinical practice relationship are attributes necessary for expert holistic advanced nursing practice. The NPs within this project function within clinical roles only in fast paced high patient volume urgent care clinics. Although the NPs show some affinity toward patient centeredness, the long hours and high volume may diminish their perceived ability to provide this type of care, affect intentions and social desire to engage in patient centered behavior. Additional study on urgent care NPs, their perception of time, time management and ability to maintain holism within the advanced clinical role is necessary for further illumination of this concept. Secondarily, the majority of the NP respondents practiced only two to five years at the time of the survey. Benner (2004), utilizes the Dreyfus skill acquisition model to describe and articulate the nature of skill acquisition and provides an overview of the practical knowledge incorporated in development of expert practice. She discusses time, clinically complex decision making and repeated skillful articulation of an event or clinical scenario as salient factors in moving a practitioner to the expert level. As discussed by Watson (2006) who felt the future of medicine lies more within the caring realm than focus on medicine, NPs who are uniquely well faceted to connect these elements in the new age of PCC modalities can achieve excellence.

At this level the practitioner is able to rationally meld nursing and medically relevant knowledge to participate in sharing of knowledge, promote patient advocacy, maximize holistic care provision while seamlessly morally and emotionally engage the patient and their problem. Thus, the lower sharing subscale and total PPOS scores may be attributed to the relatively short duration of clinical practice. It is unknown whether additional years of practice, increased skill acquisition and maximal management of high volume patient flow in a single provider environment would yield higher scores. Further research is necessary to provide clarity in this regard.

It is hoped that the results of this project will serve as a foundation from which additional studies can burgeon. Additional research would be useful in consideration of nursing and nurse practitioner curriculum development aimed at bridging the theory-clinical practice gap. Solidifying the connection of foundational theoretical tenets from which nursing is derived is essential and beneficial throughout advanced nursing practice education. There is an abundance of research on medical students and physicians attitudes toward patient centeredness, their communication and shared decision making styles in clinical practice (Charles, Whelan, Gafni, Willan & Farrel, 2003; Krupat, Putnam & Yeager, 1996).

However, more studies are needed to determine evaluate the theory-clinical practice gap among NPs and the consistency to which theoretically based tenets of caring, sharing and holism are continually practiced beyond the nursing role. Moreover, additional studies would further elucidate the attitudes NPs have toward the provision of PCC, the dynamic contextual nature and relational social constructs by which their intention to engage in this behavior lies. Lastly, further research is necessary to ascertain the links between communication processes and clinical practice context within not only urgent care but other new and burgeoning health care settings (retail clinics, tele-health services). The rich and dynamically complex nature of NP practice can

benefit from the recognition and promotion of theoretically based and evidence based knowledge that can complement and support advanced practiced education and interprofessional clinical practice.

PCC is a salient factor in enhancing provider-patient communication, quality of care, the patient care experience and patient adherence. Haidet et al. (2001) proposes and integration of clinical activity, role modeling, debriefing both positive and negative clinical encounters and teaching interventions linking PCC with increased quality of care, may enhance patient outcomes. Efforts to maximize the provision of this care benefits the patients, providers and have broader influences within the scope of collaborative interprofessional practice team development and education. With the complex multifaceted components of PCC, further elucidation of the antecedent context may yield promise in future health care education curriculums and continuing education. Inclusion of the psychosocial elements of care provision within the medical care dynamic can positively affect the patient, their family and the provider. Important implications to NP practice include further uncovering of the practice orientations utilized by NPs in this practice setting compared to their counterparts may help to elucidate additional rationales for positive patient outcomes. Moreover, examination of NPs and practice provider's attitudes toward PCC in the urgent care practice environment may help nursing educators in crafting PCC inclusive communication skills within their program development.

Chapter 6 Limitations

There are several limitations of this project worth noting. The urgent cares system chosen for this project has multiple locations across all of North Carolina and Arizona. The clinics chosen to survey were only located within North Carolina and no differentiation was made between the rural or urban clinics. The results of this survey are not generalizable to any other

medical practice, provider cohort, organization or facility. The responses could vary depending on geographic location within the United States, rural versus urban practice and volume of clinic patients. There may be other prominent demographic factors that can cause considerable variation in results and confounding results. This was a convenience sample of medical providers who may know the researcher by virtue of my employment within the same medical system, although no communication with any of the respondents before or after the survey has occurred. The perceptions of providers studied may be generally more positive due to this fact. Given the fluctuating number of providers discussed in aforementioned text, the exact number of NPs, PAs or MDs surveyed is unknown, therefore it is unclear how many respondents chose not to respond to the survey. Additionally, there was no differentiation made between full time or part time medical providers although the survey went out to all providers listed as actively practicing, those who practice part-time may not have received the request or were less likely to respond. These part time providers may also hold a second job in a different type of setting, which may alter their responses based off their daily clinical experiences and frame of reference. Also, using this type of self-perception survey may not be the ideal way to measure patient-centeredness in urgent care system providers. Consideration of other outcome measures such as observational studies, pre-post PCC education measures and patient satisfaction measurement in this environment could be employed.

The MDs surveyed function in dual administrative (supervising physician) and part-time clinically based roles. These MD providers are not owners but are employees of the organization and charged with ensuring their supervisees maintain positive patient outcomes, safe clinical practice, collaborative practice agreements and engage in appropriate clinical decision making. Thus, their responses could be a reflection of their perceptions of how the ideal medical provider should be and not how they would individually practice if functioning in a clinical role only. The

PPOS instrument used has never been used before to measure these attributes among NPs or PAs. Another limitation of the study was the time frame the survey was released for review. Due to time constraints, data was only collected from September-January, 2014-2015. There were multiple major holidays within this time frame along with the urgent care system acquiring several new clinics. Secondly, this is historically flu season and the urgent care clinics experience significantly more volume during this time span. This time frame along with the organizational change factors may have affected the sample size, respondent willingness or ability to participate in the survey. Given patient volume and time constraints are cogent elements within provider's attitudes toward this concept, evaluating them at a slower time of year could possibly yield greater response and divergent results. The organizational shift could have involved employment uncertainty, job reclassification, and additional MD responsibilities accounting for the low respondent rate. Surveying respondents at a time of organization stability and no impending major holidays may have provided a much larger sample size. It is important to note that this project evaluated provider attitudes toward PCC only and not actual patient centered behaviors. Thus, it is difficult to actually predict the clinical significance of provider PPOS scores without further study. Previous studies with the PPOS tool noted higher patient centered attitudes were associated with higher patient satisfaction (Krupat, 1999). Further testing on the congruence of patient centered attitudes among providers and patient satisfaction and treatment plan adherence would produce notable results.

The PPOS tool itself yielded lower than expected internal validity when used with this particular group of providers. The variability in answers toward question nine, which specifically asks about the concept of power within the provider patient relationship significantly reduced the initial validity of the instrument. In future researchers would have to consider this particular question, the validity of the instrument as a whole and the concept of power as it relates to

provider attitudes. Additionally, this research had to recode two questions which also reduced the tool validity within this cohort. It is unknown whether the PPOS tool validity would maintain its internal consistency when proposed to other groups. Consideration of tool development for use within the urgent care environment and with a diverse group of providers holds promise for future research.

Chapter 7 Conclusion

As NPs continue to take the lead in the development and management of urgent care centers, it has become apparent during this study, that understanding interprofessional provider team attitudes, could improve patient care delivery and health status by enhancing communication between health team members and patients. In addition, NP educational development could also be enhanced.

This author is in agreement with Barry & Edgman-Levitan (2012), who challenge present and future clinicians to abandon paternalistic attitudes toward the patient experience and replace them with training to become more effective coaches or partners with the patient provider communication process. As the discussion and visions of patient centered care become more ubiquitous within health care environments, a profound challenge remains in moving from the element of stagnant verbosity to a dynamic a fluid reality, in which patients are actually engaged in the decision making process. Moreover, within this new fast paced and modern healthcare delivery system, wherein patient acquire and share important medical data via novel means (smart phones, data streaming devices), and settings outside of the traditional provider office. Having a set of providers who are willing to embrace these omnipresent changes is paramount. Nursing educators should continue to develop and foster intercollaborative initiatives to enhance the quality of patient care. The differentially associated attitudes on the total scale and

corresponding subscales justify future evaluation of these elements singularly across intercollaborative provider groups. Furthermore, the evidence from this project reveals parity in attitudes among male and female providers regardless of discipline. The relationship with this finding to the individual provider attributes, organizational culture or prior training are difficult to postulate and serve as additional potential factors in the behavioral intentions process.

Nursing leaders should consider salient educational supplementation and reform for fostering of long term sustainable attitudes toward patient centeredness. Integration of meaningful patient centered didactic training beyond the idealistic theoretical discourse to ongoing secondary clinical reinforcement may help NPs engaged in urgent care practice roles rise to the challenge of this and other non-traditional healthcare delivery systems. Assessment of individual and organizational facilitators or barriers helps to gain a better understanding of additional elements complicit to adoption of patient centered provider attitudes. Moreover, adopting the data gathered through empirical query in this regard helps in the transformation of knowledge process.

Utilizing the researched gathered here via the use of information technology and applying this new knowledge to maximization of patient outcomes within this setting is necessary for meeting the DNP essential goals (Zaccagnini & White, 2014). Furthermore, the outcome of this scholarly inquiry may help bolster existing organizational and practice standards in this and other environments, further adding to models of evidence based care provision. Facilitating use of this knowledge for and within intercollaborative practice teams may also effect the knowledge integration process and strengthen those collaborative relationships. The evidence detailed herein revealed that age, gender or years since completing formal training had not effect on provider attitudes toward patient centeredness. This suggest within intercollaborative teams equality exists except for being a member of the particular profession itself. Nursing leaders specifically DNP

trained innovators, can assist these teams in understanding the purpose, rationale and application of these research findings, create unique conceptual and theoretically sound solutions to any discipline related deficiencies noted, for improvement of the patient experience. It is hoped that the integration of this research to the body of nursing science will profoundly impact practice, improve health care delivery and bolster patient safety, while creating sustainable individual and organizational quality improvement. The mechanism by which this occurs is not quick, but with steadfast resolve, ongoing use of scientifically based research and commitment of nursing leaders, innovators and educators the paradigm can shift toward refined health care delivery of the highest quality.

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Appendix A: DNP Essentials

DNP Project Work	Essentials of Doctoral Education for Advanced Practice Nursing
Utilization of the Theory of Reasoned Behavior and Planned Behavior to determine the nature and significance of provider attitudes toward patient centered care.	I. Scientific Underpinnings for Practice
Evaluation of care delivery approaches by intercollaborative practice team members. Developing quality improvement initiatives based off nursing science and translation of gained knowledge to influence practice.	II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
Critically appraised existing literature to formulate practiced based research. Examined data from practice behavior to design evidence based interventions. Disseminating research findings to improve health outcomes. Scheduled to present findings at the National Black Nurses Association Conference August, 2015.	III. Clinical Scholarship and Analytical Methods for Evidence Based Practice
Utilized technologically based systems to garner, critically analysis and appraise data captured.	IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
Will execute plans for evidence based research findings dissemination to stakeholders in political leadership forums.	V. Health Care Policy for Advocacy in Health Care
Working closely with the practice's Director of Quality Assurance and Education, Dr. Sekhar Kommu, MD to transform new knowledge to practice. Presented findings to the Regional Medical Director group and discussed strategies to create system change and quality improvement based of evidence	VI. Interprofessional Collaboration for Improved Patient and Population Health Outcomes.

<p>based knowledge gained. This included formation of an intercollaborative practice group to address patient provider communication and attitudes toward patient centered care.</p>	
<p>Assessed provider demographic data to understand communication patterns in clinical practice care delivery. Plans to integrate knowledge for improvement of population health via patient centered care education inclusive of cultural diversity, health promotion and environmental/occupational health</p>	<p>VII. Clinical Prevention and Population Health for Improving the Nation's Health Clinical Prevention and Population Health for Improving the Nation's Health</p>
<p>Completion of the DNP degree with plans to specialize in provider care provision, systems and organizational improvement strategies.</p>	<p>VIII. Advanced Nursing Practice</p>
<p>Reference</p>	<p>DNP Essentials adopted from: Zaccagnini, M., & White, K. (Eds.). (2013). <i>The doctor of nursing practice essentials</i>. Jones & Bartlett Publishers.</p>

Appendix B

IRB Approval Letter

Notification of Exempt Certification

From: Social/Behavioral IRB
To: [Wendell John](#)
CC: [Sonya Hardin](#)
Date: 11/3/2014
Re: [UMCIRB 14-001696](#)
Providers Perceptions of Patient Centered Care within an Urgent Care System

I am pleased to inform you that your research submission has been certified as exempt on 11/2/2014 . This study is eligible for Exempt Certification under category #2 .

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification request at least 30 days before the end of the five year period.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

Appendix C

Project approval forms

East Carolina University Doctor of Nursing Practice
Scholarly Practicum Project Approval

Committee Members/Affiliation/Expertise:
Dr. Sonya Hardin, PhD, RN NP-C/East Carolina University College of Nursing-Health Care Systems expert.

Dr. Donna Lake, PhD, RN/East Carolina University College of Nursing-Interprofessional care and collaboration with health care systems/Quality improvement expert.

Dr. Sekhar Kommu, MD, Fastmed Urgent Care/Administrative Quality improvement and Compliance Committee member.

Date submitted to DNP Program Director: 9/7/14

Program Director Comments/Decision:

Approve: Return for additional information/revisions:

Signature: [Handwritten Signature] PhD Date: 9/7/14

09/2013 cak

Appendix C

Project approval forms

DNP - Appendix H - Approval of Scholarly Project Committee Form

East Carolina University
College of Nursing
DNP in Nursing Program

Wendell C. John has selected the following scholarly project committee members:

(Student's name)

Committee Role	Rank/Role	Date/Signature
1. Chair	Sonya Hardin/Professor	<i>Sonya Hardin</i>
2. Committee Member	Donna Lake, PhD, RN	<i>Donna Lake, PhD, RN</i>
3. Community Advisor	Dr. Sekhar Kommu, MD/Quality Improvement Committee Fastmed Urgent Care.	<i>Sekhar Kommu MD</i>
4.		

Director of DNP Program:

Wendell C. John PhD 7/7/14
Signature and Date

CC: DNP Scholarly Project Committee Chair
Student
DNP Program Office

08/02/13 BL

Appendix C

Project approval forms

DNP - Appendix I -- Form for Selection of Dissertation Advisory Committee Chairperson

East Carolina University
 College of Nursing
 DNP in Nursing Program
 Form for Selection of Scholarly Project Committee Chairperson

Wendell C. John, _B00909890 candidate for the DNP degree,
 Student's name/ Banner ID Number

(Doctor of Nursing Practice in Nursing) has selected the following person as Chair of the Scholarly Project Committee:

Name: Sonya Hardin, PhD, RN, MBA/MHA, MSN, CCRN, ACNS-BC, NP-C
 Rank: Professor, East Carolina College of Nursing
 Other Titles (if applicable)

This signature indicates agreement to serve as Scholarly Project Committee Chairperson for the above-listed student.

DNP Scholarly Project Committee Chair: Sonya R. Hardin PhD RN NP-C
 Signature and Date

APPROVAL

This signature indicates the person selected is approved to serve as chair of scholarly project committee.

Director of DNP Program: BR / PhD 6/18/14
 Signature and Date

CC: Scholarly Project Committee Chair
 Student
 DNP Program Office

08/02/13 BL

Appendix D

Organizational approval letter



935 Shotwell Road
Clayton, NC 27520

(919) 550-0821
(919) 550-0735

Dr. Sonya Hardin
Sonya Renae Hardin PhD RN CCRN ACNS-BC NP-C
Professor
College of Nursing
East Carolina University
600 Moye Blvd.
Greenville, NC 27858

Dr. Hardin this letter is to inform you and all necessary parties that Wendell C. John has permission from the Fastmed Urgent Care organization to conduct a study with the medical providers within any of our NC clinics for the purpose of obtaining information about the delivery of patient centered care for organizational improvement. Our understanding is that once he has IRB approval that a survey will be submitted to our employees for voluntary completion. We will have the opportunity to review the survey material prior to release to our medical providers. This data will be aggregated in a format that ensures the confidentiality of participants. This study will not involve the collection of any personal information, nor will it include the collection of any protected health information.

We look forward to working with Mr. John on his project as a requirement for the fulfillment of the Doctor or Nursing Practice Degree at East Carolina University.

Jessica Pendola
Chief Compliance Officer
Fastmed Urgent Care
935 Shotwell Road
Clayton, NC 27520

Appendix E

Permission for use of PPOS Tool



Krupat, Edward <ed_krupat@hms.harvard.edu>

Mon 09/08/2014 12:38 PM

Inbox

Mark as unread

To: John, Wendell Clavonn;

You replied on 09/08/2014 10:06 PM.

1 attachment



PPOS Combined docum...

60 KB

Bing Maps

+ Get more apps

Dear Wendell,

Thanks for following up on your request. I am happy to have you use the PPOS for the purposes you have described. I am attaching a document with the scale, scoring instructions, and a fairly up-to-date bibliography of PPOS-based papers. Good luck in your work. I look forward to hearing of your findings.

Best,

Ed

Edward Krupat, PhD
Director
Center for Evaluation
Harvard Medical School
384 MEC
260 Longwood Ave.
Boston, MA 02115
617-432-1689 (phone)
617-734-5224 (fax)

Appendix F

Original PPOS instrument

PPOS instrument used with permission from the creator Dr. Edward Krupat.

The PPOS can be filled out by patients and practitioners without any modification of the items or instructions. Information and instructions follow.

Scoring instructions. PPOS scores are reported as mean scores to allow patients' and providers' responses to be used even if one or two scale items are deleted. One Total mean score can be calculated for the 18 items, and two sub-scale scores can also be calculated. The Total Score ranges from "patient-centered" to "doctor-" or "disease-centered." The higher the score the more patient-centered the orientation. Sub-scale scores for Sharing and Caring can also be calculated.

Sharing scores reflect the extent to which the respondent believes that a) practitioners and patients should share power and control on a relatively equal basis, and b) that practitioners should share as much information with their patients as possible.

Caring refers to the extent that respondents believe that a) caring about emotions and good interpersonal relations is a key aspect of the medical encounter, and b) that practitioners should care about the patient as a whole person rather than as a medical condition.

Specific subscale question numbers.

Sharing subscale dimension questions: 1, 4, 5, 8, 9, 10, 12, 15, & 18.

Caring subscale dimension questions: 2, 3, 6, 7, 11, 13, 14, 16, & 17.

The 6 point scale is laid out from left to right as strongly disagree to strongly agree. Strongly disagree (far left) is scored 6 and strongly agree (far right) is scored 1. Three items are reverse worded, and scoring needs to be reversed. These are 9, 13, & 17. Therefore a high score indicates an orientation toward patient-centeredness.

Patient-Practitioner Orientation Scale© Original Version	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. The doctor is the one who should decide what gets talked about during a visit.	0	0	0	0	0	0
2. Although health care is less personal these days, this is a small price to pay for medical services.	0	0	0	0	0	0
3. The most important part of the standard medical visit is the physical exam.	0	0	0	0	0	0
4. It is often best for patients if they do not have a full explanation of their medical condition.	0	0	0	0	0	0
5. Patients should rely on their providers' knowledge and not try to find out about conditions on their own.	0	0	0	0	0	0
6. When providers ask a lot of questions about a patient's background, they are prying too much into personal matters.	0	0	0	0	0	0
7. If providers are truly good at diagnosis and treatment, the way they relate to patients is not that important.	0	0	0	0	0	0
8. Many patients continue asking questions even though they are not learning anything new.	0	0	0	0	0	0
9. Patients should be treated as if they were partners with the provider, equal in power and status	0	0	0	0	0	0
10. Patients generally want reassurance rather than information about their health	0	0	0	0	0	0

11. If a provider's primary tools are being open and warm the provider will not have a lot of success.	0	0	0	0	0	0
12. When patients disagree with their provider, this is a sign that the provider does not have the patient's respect and trust.	0	0	0	0	0	0
13. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values.	0	0	0	0	0	0
14. Most patients want to get in and out of the providers office as quickly as possible.	0	0	0	0	0	0
15. The patient must always be aware that the provider is in charge.	0	0	0	0	0	0
16. It is not that important to know a patient's culture and background in order to treat the person's illness.	0	0	0	0	0	0
17. Humor is a major ingredient in the provider's treatment of the patient.	0	0	0	0	0	0
18. When patients look up medical information on their own, this usually confuses more than it helps.	0	0	0	0	0	0

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Appendix G

Modified PPOS

TITLE OF THE SURVEY: PATIENT PROVIDER ORIENTATION SURVEY.

PRINCIPLE INVESTIGATOR: WENDELL C. JOHN, RN, MSN, FNP-C

Informed Consent Form: Please read the following informed consent form. If you choose to volunteer in this anonymous survey, you may proceed with the questions. If you choose NOT to participate, then you may simply close your Internet browser and no further actions is necessary.

Purpose of the Survey: Patient Provider Orientation Survey contains statements which refer to beliefs that people might have concerning providers, patients, and medical care. The survey measures the roles that providers and patients each play in the course of their interaction.

Participants: You are being asked to participate in this survey because you are a Health care Provider with the designation of Nurse Practitioner (NP), Physician Assistant (PA) or Medical Doctor (MD)/Doctor of Osteopathy (DO), working within a North Carolina Urgent Care System.

The survey is strictly anonymous and no identifying information will be available to the

surveyor. Responses cannot be tracked back to you or anyone else. Every question is important, however you have the option of omitting any question.

Procedures: If you volunteer to take the survey, you will be asked to complete the survey electronically. Survey completion will take approximately 15 minutes of your time. You may complete the survey at a time and location best suited for you.

Benefits of Participation: There are no direct benefits to you as a participant in this study. However, you may feel positively about assisting in advancing the science of health care through this research.

Risks of Participation: The risk of participation in this study are minimal. This is an anonymous electronic survey asking questions about beliefs people may have concerning providers, patients and medical care. It is possible that you may feel slightly uncomfortable answering certain question(s).

Cost/Compensation: There is no cost for participation and no compensation is provided.

Voluntary Participation: Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study and withdraw at any time. If for any reason you have a concern that your survey responses can identify you, you may omit that or any response. You may choose to cease participation at any time during the survey.

Confidentiality: Even though this study is completely anonymous, all data gathered in this study will be stored in a locked password protected web folder for three (5) years after completion of the study. After five years the data will be completely destroyed. No personal information or confidential information is requested. No reference (oral or written) linkage to you can occur or will be made with this study. No IP addresses will be retained from any participant. The

computer system utilized for survey examination is protected by a password protected with adequate firewall protection.

Participant Consent: By clicking on the “Agree” button below, you acknowledge understanding of your rights and responsibilities as participant. By click “Disagree” you are opting out of survey participation.

Please call the Wendell C. John at (919) 672-2943 for any research related questions or the Office of Research Integrity & Compliance (ORIC) at (252) 744-2914 for any questions about your rights as a research participant.

Patient-Practitioner Orientation Scale© Modified Version	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. The doctor is the one who should decide what gets talked about during a visit.	0	0	0	0	0	0
2. Although health care is less personal these days, this is a small price to pay for medical services.	0	0	0	0	0	0
3. The most important part of the standard medical visit is the physical exam.	0	0	0	0	0	0
4. It is often best for patients if they do not have a full explanation of their medical condition.	0	0	0	0	0	0
5. Patients should rely on their providers' knowledge and not try to find out about conditions on their own.	0	0	0	0	0	0
6. When providers ask a lot of questions about a patient's background, they are prying too much into personal matters.	0	0	0	0	0	0
7. If providers are truly good at diagnosis and treatment, the way they relate to patients is not that important.	0	0	0	0	0	0
8. Many patients continue asking questions even though they are not learning anything new.	0	0	0	0	0	0
9. Patients should be treated as if they were partners with the provider, equal in power and status	0	0	0	0	0	0
10. Patients generally want reassurance rather than information about their health	0	0	0	0	0	0

11. If a provider's primary tools are being open and warm the provider will not have a lot of success.	O	O	O	O	O	O
12. When patients disagree with their provider, this is a sign that the provider does not have the patient's respect and trust.	O	O	O	O	O	O
13. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values.	O	O	O	O	O	O
14. Most patients want to get in and out of the providers office as quickly as possible.	O	O	O	O	O	O
15. The patient must always be aware that the provider is in charge.	O	O	O	O	O	O
16. It is not that important to know a patient's culture and background in order to treat the person's illness.	O	O	O	O	O	O
17. Humor is a major ingredient in the provider's treatment of the patient.	O	O	O	O	O	O
18. When patients look up medical information on their own, this usually confuses more than it helps.	O	O	O	O	O	O

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East Carolina University
College of Nursing
Doctor of Nursing Practice
Final Scholarly Project Approval

Student Name: Wendell C. John

Title: Provider Perceptions of Patient Centered Care in an Urgent Care Environment

Private Defense Completed on: June 10th 2015

Public Defense Completed on: June 16th, 2015

Final Project/Final Paper Approval:

As the Chair of this student's Doctor of Nursing Practice Scholarly Project Committee, I have reviewed and approved this student's project and final paper and agree that he/she has met the project expectations, including the DNP Essentials, and has completed the project.

DNP Committee Chair Signature:

Sonya R Hardin

Date

7/18/15