Improving Therapeutic Communication in an Outpatient Psychiatric Clinic to Reduce No-Shows

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Abstract

An important concern for healthcare providers within outpatient psychiatric clinics is patients missing their appointments and are considered “no-shows” to those appointments. Individuals suffering from mental illness have a higher no-show rate related to multiple barriers. A modifiable barrier for patients suffering from mental illness is the ineffective communication between the patient and health care provider leading to poor adherence to treatment plans. Evidence-based studies confirm that effective therapeutic communication has positive benefits in improving patient-provider relationship to improve healthcare outcomes, compliance with treatment plan and decreased appointment no-shows. The purpose of this project was to implement a training on principles associated with therapeutic communication in an outpatient psychiatric clinic to decrease the number of no-shows at the four-week medication management follow up following an initial psychiatric evaluation. The Donabedian Model framed this project to improve each medication management provider’s knowledge of therapeutic communication to reduce the amount of medication management no-shows. The project consisted of providing education on the principles of therapeutic communication to four providers, who are all psychiatric nurse practitioners, and assessing their knowledge through a pre-intervention and post-intervention quiz. A retrospective chart review was accomplished gathering pre-intervention and post-intervention data of the amount of medication management no-shows after an initial psychiatric evaluation. An analysis of the results of the pre- and post-intervention quiz was completed and the paired sample t-test yielded a p-value of 0.016, indicating a statistically significant increase in provider’s knowledge on therapeutic communication. The retrospective chart review results comparing pre- and post-intervention data resulted in a decrease of 14.1% in medication management no-shows post educational intervention. Although, there was a decrease

post-intervention, results from both Chi-square and Fisher's exact test indicated that the change was not statistically significant with a Chi-square p-value of 0.107 and a Fisher's exact p-value of 0.154. Although results indicated the intervention was not statistically significant, outcomes suggested each participants knowledge of therapeutic communication improved and positively impacted in the reduction of medication management no-shows. Outcomes suggest that providing education on therapeutic communication remains an effective tool in improving provider's knowledge of the subject and can provide positive impact of the quality of care provided to patients with severe mental illness.

Keywords: no-show in mental health clinic, no show patients, missed appointments, patient compliance, psychiatric clinic appointments, no-show, therapeutic communication, improving communication, and therapeutic relationship

Improving Therapeutic Communication in an Outpatient Psychiatric Clinic to Reduce No-Shows

Outpatient psychiatric clinics provide comprehensive behavioral health and psychiatric care for patients. An outpatient psychiatric clinic is defined as a facility that provides outpatient mental health services on an individual, group or family basis, usually in a clinic to provide mental health treatment for all clients/patients (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Ongoing treatment and consultation are provided by psychiatric providers to enable patients to receive effective and efficient care through achieving a state of balanced mental health. Providers provide mental health treatment and services through medication management, supportive therapy and other treatment modalities that enable mentally ill patients to improve their mental health outcomes.

A significant obstacle to providing quality care in improving one's mental health within an outpatient psychiatric clinic is the amount of medication management no shows (MMNS) following the initial psychiatric evaluation (IPE). No-shows are defined as a patient who do not appear for their scheduled appointment (Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaeh, 2016). Also referred to as missed appointments, no-shows can lead to many challenges and can range from 2 to 30% of cases in primary care settings, while the no-show rates of adult patients in mental health care settings care range from 33 to 42% in the outpatient setting (Clouse, Williams, and Harmon, 2017). Missed appointments or no-shows can be burdensome for patients as it continues to be linked with poorer health outcomes (Williamson, Ellis, Wilson, McQueenie, & McConnachie, 2017). Along with poorer health outcomes, no-shows have been shown to create negative outcomes associated with disease management through operational difficulties, financial costs, reduced productivity and nonadherence to treatment plans (Davies et al., 2016).

A contributing factor to no-shows is poor patient-provider communication, which can lead to several negative outcomes within health care that include discontinuing care, missed appointments, nonadherence, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources (Vermeir et al., 2015). Poor communication between the patient and the provider has shown to result in nonadherence to patient's treatment plan leading to a MMNS and poor communication alone has been associated with an up to 19% risk of appointment nonadherence (Zulig et al., 2015). Therapeutic communication has shown to improve patient-provider communication as it directly impacts the quality of care provided by the provider (Rassaghi and Afshar, 2016). Therapeutic communication refers to the interpersonal communication skills of listening to each patient, answering their questions correctly and providing patient-centered care (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). This can include discussion of treatment expectations, showing empathy and creating a stronger therapeutic alliance (Bhui et al., 2015). A therapeutic relationship between a provider and their patient can be considered the basis of implementing quality psychiatric care as effective communication is central to psychiatric assessment, diagnosis, treatment adherence and recovery (Bhui et al., 2015). Therefore, collaboration efforts among providers, such as incorporating the Doctor of Nursing Practice (DNP) project of implementing a training on principles associated with therapeutic communication in an outpatient psychiatric clinic, will be facilitated to improve therapeutic communication skills provided by providers to reduce MMNS rates. Through changes in training protocols along with implementing the DNP project, providers will gain insight into methods and techniques for improving therapeutic communications with patients and why improved communication is important to patient care.

Background

A significant concern for healthcare providers within outpatient clinics is patient no-shows or missed appointments. Patients not attending or no-showing to their scheduled appointments affect delivery of care, cost of care, resources, and result in poor outcomes through missing screenings and delayed disease detection (Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaeh, 2016). Consequently, no-shows increase appointment wait times, reduce availability for appointments, reduce patient satisfaction and lead to negative relationships between patient and provider that can result in health care complications, decompensation or hospitalizations due to lack of appropriate follow up (Mclean et al., 2016). Individuals who frequently do not show up to scheduled medical appointment have decreased utilization of preventative services and poorer outcomes compared to those who show up to scheduled appointments (Crutchfield & Kistler, 2017). Not only do patient no-shows affect patient health outcomes, but it also affects health care organization costs with one study conducted by Kheirkhah, Feng, Travis, Tavakoli-Tabasi & Sharafkhaeh (2016) stating "the average cost of no-show per patient was one hundred and ninety-six dollars in 2008" (p.1).

Unfortunately, no-show rates are higher for individuals suffering from serious mental illness (SMI) such as schizophrenia, bipolar disorder and severe major depression due to this population having higher risk for poor adherence to treatment plan (Gunzler et al., 2017). Transportation, financial difficulties, forgetting the appointment, difficulty making appointment and poor communication are common barrier for why SMI patients missing their scheduled appointment (Ramlucken & Sibiya, 2018). The main barrier for patients suffering with SMI that is modifiable include ineffective communication with health care professions; which leads to negative outcomes and finding it difficult to adhere to their treatment plan of compliancy with

medications or attending appointments (Papageorgiou, Loke and Fromage, 2017).

Effective communication and therapeutic interpersonal relationships are vital to successful mental health interventions (Kornhaber, Walsh, Duff, & Walker, 2016). Effective communication is an important component of clinical leadership in nursing. Good communication skills are an important part of a nurses' core competencies, which is important for nursing practice in providing patient-centered care and affect how health care is provided in mental health (Furnes, Kvaal and Hoye, 2018). Communication among mental health patients have been found to form an integral part of quality provided during patient care and patient interaction. A study conducted by Papgeorgiou, Loke and Fromage (2017) established that mental health professionals and people with severe mental illness find it difficult to communicate with each other effectively about symptoms, treatments and their side effects. The researchers concluded that effective use of communication skills in mental health interactions could be associated with increased patient satisfaction of providers and improved adherence to treatment plans (Papgeorgiou, Loke, & Fromage, 2017). Unfortunately, poor communication between patients and providers can potentially discourage patients from attending appointments and adhering to treatment plans (Mclean et al., 2016). As a result, providers must understand important components in effective therapeutic communication to improve client's adherence to treatment.

Problem Statement

Poor and non-therapeutic communication between the provider and patient within an outpatient psychiatric clinic is leading to MMNS or missed follow-up appointments after IPE. Nonadherence to treatment plan, patient no-shows, decreased patient satisfaction and poor use of resources are a result of poor communication (Tiwary, Rimal, Paudyal, Sigdel, & Basnyat,

2019). Patients with a higher tendency to no-show will have poorer outcomes compared to those with fewer no-shows (Hwang et al., 2015). With an increase in patient no-shows, patient difficulties associated with access to care, continuity of patient care and effective management of their disorders will increase (Davies et al., 2016).

An intervention is necessary to improve the no-show rate to improve patient health outcomes. A way to improve no-show rates is through improving the therapeutic relationship between the patient and provider with research showing that decreasing missed appointments or no-shows can improve clinical efficiency and lead to improved health outcomes for patients (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). Through the implementation of a training on principles for improving therapeutic communication skills among providers, the quality of patient-provider communication will improve adherence to their treatment plan resulting in a decrease of no-shows (Popa-Velea & Purcarea, 2014).

Purpose Statement

The purpose of this project is to implement a training on principles associated with therapeutic communication in an outpatient psychiatric clinic to decrease the number of no-shows at the four-week medication management follow up following an IPE. The training will be specific to medication management providers working in an outpatient psychiatric clinic. The goal of the training is to provide a training on the basic elements of therapeutic communication, in order to expand the provider's knowledge base and to improve quality of patient-provider therapeutic communication skills through measuring the reduction of no-shows after IPE. The proposed project is expected to improve therapeutic communication provided to patients during initial psychiatric evaluation to decrease the medication management follow up no show rate.

Project Question

Among (P) psychiatric medication management providers working in an outpatient psychiatric clinic, does (I) training on therapeutic communication in comparison to (C) no training (O) decrease no show rates after initial psychiatric evaluation (T) over a span of four weeks?

Project Objectives

Objective One

Implement the sixty-minute training to at least four providers on principles of therapeutic communication and evaluating knowledge by a pre- and post-intervention quiz by first week of project implementation.

Objective Two

100% of providers trained on principles of therapeutic communication will agree to have implemented the principles of therapeutic communication learned in the outpatient psychiatric clinic training on all IPE by end of week one.

Objective Three

The outpatient psychiatric clinic MMNS rate will be lower at the 4-week medication management follow up as measured by comparing the total number of no-shows noted in electronic health record system (EHRS) than that of the 3-month period prior to the educational intervention.

Significance

Poor therapeutic communication between a provider and patient have been a major contributor to patient nonadherence with treatment plans, appointment no-shows and decreased patient satisfaction (Tiwary, Rimal, Paudyal, Sigdel, & Basnyat, 2019). Studies have shown that

poor patient-provider communication leads to decreased patient satisfaction of provider and has been linked with up to a 19% risk of nonadherence to mental health appointments (Zulig et al., 2015). Unfortunately, nonadherence to mental health appointments or patient no-shows have been associated with negative health outcomes for patients suffering with mental health disorders (Williamson, Ellis, Wilson, McQueenie, & McConnachie, 2017). New research has shown that improving the use of therapeutic communication with patients dealing with mental health disorders have been connected with increased patient satisfaction of their providers and adherence to scheduled appointments (Papgeorgiou, Loke, & Fromage, 2017).

Search Terms

A comprehensive literature search was conducted to identify key concepts and studies that contribute to no-shows in an outpatient psychiatric clinic with identifying causes and prevention. The literature search was completed using PubMed and CINAHL. The search terms used included: no-show in mental health clinic, no show patients, missed appointments, patient compliance, psychiatric clinic appointments, no-show, therapeutic communication in mental health, therapeutic communication training, improving communication, therapeutic relationship, therapeutic communication and adherence. Additional references were gathered searching reference lists of researched articles.

Review Coverage & Justification

The quality of research was prioritized with systematic reviews, best practices and large-scale randomized control trials being targeted for review and inclusion. The inclusion criteria were studies completed within the last 5 years, full text and limited to studies completed in the English language from systematic reviews or studies in academic, peer reviewed journals. A few exceptions were made for exemplary studies conducted in earlier years. Exclusion criteria

included articles older than 10 years, in another language other than English, and did not address reducing no-shows or missed appointments.

Review of Literature

The purpose of this literature review is to distinguish key concepts and studies that contribute to addressing the impact of no-shows on patient care outcomes in an outpatient psychiatric clinic. Limitations presented itself throughout the search with very few quality studies being found that were associated with no-shows within outpatient psychiatric clinics. Due to limitations, parameters were extended to address no-shows throughout all specialties within a medical outpatient clinic. Through the inclusion of these additional studies, a variety of themes become apparent to be discussed in the remainder of this literature review. The themes associated with the impact of no-shows include poorer outcomes, increased appointment wait times and increased financial burden on the mental health facility.

Impact of the problem

Historically, a major topic of concern in an outpatient psychiatric clinic is the amount of patient no-shows as no-shows or missed appointments delay health services, reduce appointment availability, increase wait-times, increase costs, and compromise the continuity and quality of health care received by patients (McLean et al., 2016). These negative effects of patient no-shows lead to poor health outcomes and decrease adherence to maintaining compliance with medications and appointment attendance (Papageorgiou, Loke and Fromage, 2017).

Poor outcomes. No-shows can have a detrimental effect on patient health outcomes. This is a significant issue in the psychiatric outpatient clinic setting as studies have shown that patients with long-term mental health conditions, who missed more than two scheduled appointments a year, have a greater than eight-fold risk of mortality compared to those patients

who have not missed any scheduled appointments (McQueenie, Ellis, McConnachie, Wilson, & Williamson, 2019). It has been shown that individuals who no-show to their appointments have poorer health outcomes and are less likely to utilize primary care preventive health care services compared those individuals who show up to medical appointments (Crutchfield & Kistler, 2017).

Increased wait times. No-shows can have a negative impact on patients through increasing wait times and delaying care for others when appointment slots go unused, which in turn, reduces access to others that need an appointment slot (Mohammadi, Wu, Turkcan, Toscos, & Doebbeling, 2018). No-shows have become problematic for mental health appointment waitlists, as it has shown that within most areas of the country, many psychiatrists are not taking any new patients due to provider shortages and for those that are taking new patients, about 50% of patients seeking new services are asked to wait longer than a month (National Mental Health Association [NMHA], 2015). Poor health outcomes and a decrease in utilizing primary care preventative health services are higher with individuals who no-show to their appointments compared to those who show up to medical appointments. (Crutchfield & Kistler, 2017).

Financial burden. No-shows have been shown to create negative outcomes within healthcare with each no-show resulting in revenue and reimbursement loss (Triemstra & Lowery, 2018). One of the largest health care delivery systems in the United States, Veterans Health Administration, estimated that the cost of no-shows or missed appointments on an annual basis is $564 million (Davies et al., 2016). Even with smaller organizations, no-shows have shown to have significant financial consequences with a study conducted on Adolescent and Young Adult Medicine Clinic in Grand Rapids, where it showed that their annual bill and reimbursement loss from no-shows or missed appointments cost them $170,100 and $51,289 (Triemstra & Lowery, 2018). Not only do no-shows negatively impact financial costs of organizations, but it negatively

impacts provider income by underutilizing providers time resulting in not generating any income for that visit and losing up to 27% of revenue per patient (Mohammadi, Wu, Turkcan, Toscos, & Doebbeling, 2018).

Addressing the Problem with Current Evidence

No-shows or missed appointments can occur for a variety of reasons, but evidence has shown that individuals suffering from serious mental illness have an increased rate of no-shows compared to those not suffering from mental illness (Gunzler et al., 2017). Unfortunately, evidence has also shown that these same individuals do not always adhere to their treatment plan (Papageorgiou, Loke and Fromage, 2017). For those individuals suffering from serious mental illness, common barriers for patients missing appointments or no-showing include transportation issues, financial strain, forgetting their scheduled appointment and work commitments (Ramlucken & Sibiya, 2018).

An important modifiable barrier to recognize that can potentially discourage patients with mental illness from attending their scheduled appointment and maintaining compliance with their treatment plan is their poor therapeutic relationship with the provider (Mclean et al., 2016). Interactions with patients with serious mental illness can be challenging and can lead to negative outcomes associated with ineffective communication and a poor therapeutic relationship (Papageorgiou, Loke and Fromage, 2017). The patient's initial visit with a new provider is crucial as the therapeutic relationship and communication impacts attitudes and behaviors necessary in establishing a positive patient-provider relationship (Dang, Westbrook, Njue, & Giordano, 2017). Ineffective communication between the patient and provider results in the establishment of a poor therapeutic relationship with studies showing this correlation to nonadherence to treatment plans, poor use of outpatient resources, patient no-shows, and

decreased patient satisfaction (Tiwary, Rimal, Paudyal, Sigdel, & Basnyat, 2019).

Prevention. Preventing all no-shows from occurring is difficult, but there are methods of reducing no-shows such as establishing an improved therapeutic patient-provider relationship or creating an office no-show policy centralized around either enforcing a no-show fee or termination of care (Van Dieren, Rijckmans, Mathijssen, Lobbestael, & Arntz, 2013).

An office no-show policy enforcing a no-show fee has shown to be effective with reducing appointment no-shows in an outpatient psychiatric office with one study showing a significant decrease in no-shows from 21.5% to 14.6% after the no-show fee was enforced for every no-show (Van Dieren, Rijckmans, Mathijssen, Lobbestael, & Arntz, 2013). Another effective office no-show policy is through incorporating a rule to discharge patients from the office after several no-shows, as another study done on enforcing this rule has improved no-show rates from 25% to 18% (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016).

Initial patient-provider interaction built around patient trust and rapport contribute to improved care and enhance the patient's ability to be involved in their care (Dang, Westbrook, Njue, & Giordano, 2017). Unfortunately, poor patient-provider communication can potentially decrease patient attendance and adherence to treatment plans, but studies have shown that effective therapeutic communication can help prevent patient nonadherence to treatment plans (Mclean et al., 2016). A preventative measure is to teach methods of therapeutic communication skills, as research has shown that teaching methods to develop therapeutic communication skills to providers has improved their ability to use interpersonal skills, such as listening, connecting with patients, answering patient's questions correctly and providing patient-centered care, to improve the therapeutic patient-provider relationship (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). Establishing a therapeutic relationship on initial patient-

provider encounter is important for establishing trust and rapport as it contributes to better experiences, improved involvement in decisions about their care, increased likelihood of taking medications prescribed and returning for follow-up visit (Dang, Westbrook, Njue, & Giordano, 2017).

Current management. Current management of said problem at the designated practicum site does not include any formal training on therapeutic communication and how it impacts patient-provider relationships. Although no formal training is provided within designated practicum site, communication skills are fundamental and implemented into the curriculum during nursing education (Furnes, Kvaal and Hoye, 2018). Incorporating a therapeutic communication training will improve encounters from providers to patients with improving the therapeutic communication techniques of integrating verbal and nonverbal communication with interpersonal skills to help patients cope with mental health disorders (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017).

Current recommendations. There is much data supporting how no-shows impact the quality of care being provided to patients. There are several viable solutions to help decrease no-show rates within the outpatient psychiatric clinic, which include improving patient-provider communication, implementing follow up reminders through follow up phone calls or follow up text messages (Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaeh, 2016) and incorporating no-show policies threatening to terminate treatment after several no-shows or imposing a no-show monetary fine (Van Dieren, Rijckmans, Mathijssen, Lobbestael, & Arntz, 2013).

Effective communication between providers and patients suffering with mental illness have been correlated with improved patient satisfaction ratings, improved treatment plan

adherence, improved perception of provider and improved appointment attendance (Papgeorgiou, Loke, & Fromage, 2017). Evidence has shown that improving a provider's communication with the use of therapeutic communication techniques has led to improved patient care outcomes with improving the nurse-patient relationship and having both parties engaged in the healthcare treatment plan (Fakhr-Movahedi, Rahnavard, Salsali, & Negarandeh, 2016). Studies have shown that effective therapeutic communication between the two, has improved clinical efficiency by improving health outcomes through the establishment of their therapeutic relationship (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). As the patient and provider communication improves, the therapeutic relationship between them will improve leading to increased improved outcomes from receiving patient-centered care (Furnes, Kvaal and Hoye, 2018).

Research supports the use of follow-up reminders for scheduled appointments to increase appointment attendance and has shown that reminders have improved no-show rates through improving the engagement with patients and providers (Clouse, Williams and Harmon, 2017). Research conducted by Robotham, Satkunanathan, Reynolds, Stahl, & Wykes (2016), revealed that electronic notifications has been heavily studied in showing an improvement in attendance overall and showing a reduction in no-shows with 23% of patients who received notifications were more likely to attend their appointment compared to those who received no notification. The researchers concluded that a single notification is effective alone, but that multiple notifications add significantly to the effectiveness of reduction in no-show rates (Robotham, Satkunanathan, Reynolds, Stahl, & Wykes, 2016).

The implementation of a no-show policy is another common intervention utilized among outpatient practices in improving adherence through punishment of undesired consequences such

as being termination from practice after several no-shows or implementing a service no-show fee (Alyahya, Hijazi, & Nusairat, 2016). When clients are exposed to no-show polices, it reduces their no-show beavhior in adhering to their regularly scheduled appointment to avoid being discharged or have a fee imposed on them (Van Dieren, Rijckmans, Mathijssen, Lobbestael, & Arntz, 2013).

Upon researching the varied success of these options, the intervention chosen for this outpatient psychiatric clinic patients with serious mental illness is through implementing a training on principles associated with therapeutic communication.

Benefits of Current Recommendations. Various studies have shown a decrease in patient no-shows with the improvement of therapeutic communication between the provider and patient (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). It is researched that patients with mental illness become discouraged from adhering to treatment plan or appointments due to their poor therapeutic relationship with their psychiatric provider (Mclean et al., 2016). There have been studies linked to the benefits of implementing a therapeutic communication training on basic components of therapeutic communication by developing required skills through listening, empathizing and providing patient-centered care (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). The training will be aimed at improving provider communication skills, as studies have shown improved therapeutic communication leads to increased patient satisfaction of providers (Papgeorgiou, Loke, & Fromage, 2017). The training helps improve the therapeutic patient-provider relationship, which can lead to improved health outcomes for patients (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). With the process of improving the providers therapeutic communication, a therapeutic patient-provider relationship will be constructed in striving towards improved health outcomes by increasing

adherence to treatment plans, decreasing patient-no shows and to improving patient satisfaction (Tiwary, Rimal, Paudyal, Sigdel, & Basnyat, 2019).

Issues still under investigation. Research is still evaluating whether the therapeutic communication will be effective with patients suffering higher acuity mental disorders such as mania, psychosis, suicidality or homicidal (Popa-Velea & Purcarea, 2014). If it is found that it is, more research must be conducted to determine how it affects these patients that are higher in acuity.

Issues not yet addressed. Although therapeutic communication is addressed during nursing school, there is no universal guideline for implementing and educating about therapeutic communication to non-nursing providers (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). Research must be evaluated to determine whether these providers are competent enough to incorporate the basic components of therapeutic communication while providing high-quality psychiatric services.

Controversies. A controversy in implementing the therapeutic communication training is addressing the particularities of effectively addressing somatic conditions, which can restrain patient's ability to listen, explain or understand (Popa-Velea & Purcarea, 2014).

Review of Study Methods

Studies by Papgeorgious, Loke, and Fromage (2017) and Furnes, Kvaal, and Hoye (2018) support the positive impact of implementing a training to mental health professionals covering the basic components of therapeutic communication into practice as studies have shown it helps lead to improved provider communication and increased patient satisfaction of their providers. Papgeorgious, Loke, and Fromage (2017) utilized a case-control methodology, examining the effectiveness of a therapeutic communication training for mental health professionals who work

with individuals with severe mental illness. The study found significant improvements in patient-provider communication for those professionals that received the communication training course compared to those who did not receive training as measured by the Scale to Assess the Therapeutic Relationship in community mental health care (STAR) (Papgeorgious, Loke, & Fromage, 2017). The study provided evidence that the professionals who received the training had improvement in their patient satisfaction ratings and improvement in patient-reported therapeutic relationship with those professionals (Papgeorgious, Loke, & Fromage, 2017). In the study by Furnes, Kvaal, and Hoye (2018), knowledge of basic therapeutic communication and skills have improved when a training on therapeutic communication was implemented into their curriculum. The study found significant improvements in the healthcare professionals communication skills within the field of mental health and created provider awareness of implementing techniques necessary within mental health nursing (Furnes, Kvaal, & Hoye, 2018).

Studies conducted by Abdolrahimi, Ghiyasvandian, Zakerimoghadam, and Ebadi (2017) and Bhui et al. (2015) provides support that the implementation of therapeutic communication techniques into practice of listening to each patient and providing patient-centered care directly impacts the quality of care being provided by the providers. Abdolrahimi, Ghiyasvandian, Zakerimoghadam, and Ebadi (2017) applied a case-control methodology evaluating the efficacy of healthcare professionals implementing therapeutic communication skills into their practice when providing care. The study found that therapeutic communication and the key techniques has positive benefits for healthcare professionals in improving patient's satisfaction of care, satisfaction of providers, improving emotional relationship, and improved treatment compliance by applying the Walker & Avant concept analysis approach (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). Through implementing the Walker & Avant concept analysis

approach, evidence supported that implementing therapeutic communication techniques has a positive impact on care being provided to patients (Abdolrahimi, Ghiyasvandian, Zakerimoghadam, & Ebadi, 2017). In the study by Bhui et al. (2015), a systematic review of twenty-one studies was conducted providing evidence that the implementation of therapeutic communication techniques has showed positive patient benefits in the care they experienced from providers, knowledge of their disorder, treatment options and their adherence to treatment plan. The study showed that techniques used can improve therapeutic communication and becomes central to psychiatric assessment, diagnosis, treatment adherence and outcomes (Bhui et al., 2015)

Studies by Dang, Westbrook, Njue, and Giordano (2017) and Razzaghi and Afshar (2016) support the positive benefits of implementing therapeutic communication to help improve communication in improving treatment compliance and improved patient health outcomes. Dang, Westbrook, Njue, and Giordano (2017) utilized a case-control methodology, examining the effectiveness of a positive patient-provider relationship after initial first visit on compliance and health outcomes. The study determined that establishing trust and rapport during initial patient-provider interaction has positive impact on improving attendance and improving adherence to treatment plans (Dang, Westbrook, Njue, & Giordano, 2017). The study provided evidence that the professionals who established trust and rapport had increased likelihood of returning for follow-up visit after initial visit and being compliant with treatment plan (Dang, Westbrook, Njue, & Giordano, 2017). The study by Razzaghi and Afshar (2016) concluded that the patient-provider role has a central role in the patient outcome and has a positive impact on promoting positive patient experience within the healthcare system. Razzaghi and Afshar (2018) applied a case-control methodology, examining the effectiveness of therapeutic communication training on

multiple physicians in their healthcare practice. The study found that a positive patient-provider relationship is built around establishing trust, peace, and feeling the provider's attention, which promotes a therapeutic relationship (Razzaghi & Afshar 2016). This study established the importance of a therapeutic relationship in patient outcomes and patient compliance to treatment and involvement in their care (Razzaghi & Afshar 2016).

Significance of Evidence to the Profession

The significance of this topic to the profession is the negative impact of no-shows on patients within an outpatient psychiatric clinic. Evidence has shown that no-shows negatively impact patients suffering from mental health disorders by leading to poorer health outcomes, decreased adherence to treatment plans, delay in health services and decreased quality of care received (McLean et al., 2016). Studies have shown that patients who consistently miss their scheduled medical appointments have been associated with poorer health outcomes and increased mortality compared to those who routinely attend their scheduled appointments (McQueenie, Ellis, McConnachie, Wilson, & Williamson, 2019). Along with poorer health outcomes, no-shows have been financially problematic to our profession by creating financial burden on organizations and providers through worsening our revenue loss from decreased reimbursement (Triemstra & Lowery, 2018).

Although preventing all no-shows from happening can be difficult, evidence has shown that there are preventative measures that can be applied to decrease the number of no-shows through the implementation of improving the therapeutic relationship between the patient and provider (Van Dieren, Rijckmans, Mathijssen, Lobbestael, & Arntz, 2013). Research has shown that patients suffering from mental health disorders have poor compliance to treatment plan and appointments due to their poor relationship with their provider with not trusting provider

(Mclean et al., 2016). With that in mind, the purpose of the project is to implement an educational intervention of teaching the basics of therapeutic communication to providers to improve the therapeutic patient-provider relationship, as studies have shown that applying techniques of therapeutic communication can improve communication skills to positively influence patient's adherence to treatment plans and appointment attendance (Mclean et al., 2016). Through implementing therapeutic communication techniques among providers, the project will be aimed at establishing patient trust and rapport to improve the patient-provider relationship and enhance the patient's engagement in their care with increasing compliance to their treatment plan with reducing the number of no-shows (Dang, Westbrook, Njue, & Giordano, 2017).

Summary of the Literature Review

In summary, patient no-shows or missed appointments remain a critical problem with negatively affecting patient outcomes and must be resolved in order to adequately care for patients suffering from serious mental illness (McLean et al., 2016). This literature review has discovered that there are clear benefits to the implementation of therapeutic communication to help improve communication in establishing a positive patient-provider relationship (Dang, Westbrook, Njue, & Giordano, 2017). Evidence has proven that the implementation of a therapeutic communication training to improve patient-provider communication has been correlated with improved patient health care outcomes (Papgeorgiou, Loke, & Fromage, 2017). Through the implementation of this training on basic components of therapeutic communication, studies have shown benefits in improving patient-provider relationships, improving adherence to treatment plans and improving appointment attendance, resulting in reduced no-shows (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016).

Theoretical Framework

The theoretical framework that will guide this DNP project is the Donabedian Model. The Donabedian Model focuses on incorporating a framework for examining the quality of healthcare provided from health services through the study of structure, process and outcome (Gardner, Gardner, & O'Connell, 2014). The Donabedian Model was chosen to assist in guidance of improvements in structure of care and in the clinical process, in order to improve patient health outcomes (Moore, Lavoie, Bourgeois, & Lapointe, 2015).

Historical Development of the Theory

Avedis Donabedian, a physician and health service researcher at the University of Michigan, developed the Donabedian model in 1966 placing focus on the physician-patient interaction to assess quality provided by the physician (U.S. National Library of Medicine, 1998). Prior to developing his model, Donabedian's worked in public health, teaching and research, but later realized the absence of a scale to measure quality of medical care being provided (Moore, Lavoie, Bourgeois, & Lapointe, 2015). With realizing the absence of a developed scale, Donabedian developed the Donabedian model as a systematic approach to assess the quality of work provided by healthcare practitioners (Donabedian, 1988). Donabedian's systematic approach incorporated three major tenets that includes: structure, process, and outcome (Berwick & Fox, 2016). Since its development, the Donabedian Model continues to have a significant role within the field of quality assurance and quality improvement in health care with it being utilized by different sources such as: Health Plan Employer Data and Information Set, Joint Commission and American Nurses' Association (Kobayashi, Takemura, & Kanda, 2011). The Donabedian Model continues to be essential for multiple organizations in providing a guide to implementing quality care initiatives within a variety of nursing settings

such as administrative, clinical, financial and quality assurance (Allen-Duck, Robinson, and Stewart, 2017). With nursing evolving, the Donabedian model continues to applicable in achieving optimal health outcomes of patients and to improve the quality of medical care provided by nurses (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017).

Applicability of Theory to Current Practice

The Donabedian model has been utilized in multiple facets of health care but has played a significant role within nursing in assessing quality of nursing service and focusing on patient experience and patient-provider interaction (Kobayashi, Takemura, & Kanda, 2011). Current literature has studies of the Donabedian model being utilized to improve patient-provider communication, attendance of nurses to the health needs of patients, professional conduct of nurses and provider friendliness with patients (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017). Evidence has shown that the Donabedian model continues to be recommended as a tool to be utilized when implementing and measuring quality assurance interventions for improving mental health care (Kilbourne et al., 2018). This model promotes an emphasis on the interpersonal relationship and interaction between clients and professionals within one of the major tenets and has been studied for the use within mental health settings (Tomizawa, Shigeta, & Reeves, 2017). The model has been implemented extensively for quality improvement purposes in patient care and has shown to improve patient-centered care when focusing on patient-provider interaction (Santana, et al., 2018). With focus centered around patient-centered care, patient-provider communication and quality improvement, the Donabedian model serves as an ideal conceptual model for this project.

Major Tenets

The major tenets of the Donabedian Model include structure, process and outcome.

Donabedian's definition of quality of care can be assessed through the use of the triad of structure, process and outcome with these tenets being applicable to the Donabedian Model based around the idea that the good structure should promote good process and good process should eventually promote good outcomes in health care (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017). Through the use of these major tenets, quality of care provided by providers can be assessed and represented within healthcare (Kobayashi, Takemura, & Kanda, 2011).

Structure. Structure is defined as the professional or organizational resources delivering health care provided to patients (Donabedian, 1988). The setting, staff, equipment, and organization are represented within the structure (Donabedian, 2005). Within structure, it is defined that setting and organizations represent the variety of health care facilities within the nursing continuum and include the nursing staff and the equipment used by the staff (Nocella, Dickson, Cleland, & Melkus, 2017). Structure also includes available resources associated with the provision of healthcare and the resources utilized by nursing staff (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017).

Process. Process is referred to as the interventions or actions that are done to and for the patient and can consist of diagnosis, treatment, preventative measures, preventative care, and patient education (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017). Processes include how care is delivered, clinical processes performed and can encompass the manner the healthcare is delivered (Moore, Lavoie, Bourgeois, & Lapointe, 2015). Process within nursing involves the delivery of care provided by nursing staff and includes the communication between the nurses and patients, the nurses professional conduct, the friendliness of the nurses and the quality of examination conducted by the staff nurse (Ameh, Gomez-Olive,

Kahn, Tollman, & Klipstein-Grobusch, 2017). Ultimately, the definition of process for nurses include the clinical processes performed in the healthcare setting (Moore, Lavoie, Bourgeois, & Lapointe, 2015).

Outcome. The outcome summarizes the effects of the previous two tenets on patients after given set of interventions and are the desired result of care provided by the healthcare provider (Moore, Lavoie, Bourgeois, & Lapointe, 2015). Donabedian described outcomes as either technical or interpersonal, where technical outcomes consist with physical and functional aspects of care through improvement of disease complications, while interpersonal outcomes consist of patient's satisfaction with care and influence of care have improved quality of care perceived by the patient (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017). Within nursing, Donabedian defined outcome as the status of the patient following the given set of nursing interventions completed for the patient (Moore, Lavoie, Bourgeois, & Lapointe, 2015). From the provided nursing interventions, the outcome is the desired results of the care provided by the nursing staff (Ameh, Gomez-Olive, Kahn, Tollman, & Klipstein-Grobusch, 2017).

Theory Application to the DNP Project

The Donabedian model can be applied to multiple health care settings and various levels of delivery systems (Berwick, 2016). The Donabedian model serves as an ideal conceptual model for this DNP project, as the tenets guide the implementation of the project.

Structure. Structure, the first tenet of the Donabedian model, will provide guidance and enhance this project by addressing the importance of understanding how the first major tenet is utilized. The project lead gains advantage by understanding that structure encompasses both professional and organizational resources available when providing care to patients (Donabedian,

1988). The project lead understands how the first major tenet is utilized and will implement knowledge at this project side by identifying the components of the structure available to be implemented. The DNP project has identified four essential components for the structure tenet. The first component identified is the development and implementation of the basics of therapeutic communication educational intervention among medication management providers. The second component is obtaining location, date and time of educational intervention to be conducted. The third component is obtaining pre and post-intervention measurement tool to be used. The last component is determining which providers can attend training.

Process. The second tenet of the Donabedian model, process, will provide guidance and enhance this project by addressing the importance of understanding how process is incorporated within healthcare. The project lead will be able to understand components of how the care is delivered within this practice and can incorporate the second tenet by understanding how the interventions or actions done for the patients can be changed to improve the delivery of care (Moore, Lavoie, Bourgeois, & Lapointe, 2015). Donabedian believes that the interaction between the provider and patient is a key element in this tenet when determining quality of care being provided (Tomizawa, Shigeta, & Reeves, 2017). The project lead will use this second tenet to implement an intervention to improve care. The project lead will use this model to guide the intervention of implementing a basics of therapeutic communication educational training and the use of learned techniques into practice. Also, the project lead will identify the four essential components for this tenet. The first component is making sure each medication management provider attends the basics of therapeutic communication educational intervention. The second component is implementing the pre-intervention measurement tool. The third component is conducting the basics of therapeutic communication educational training. The last component is

implementing the use of basics of therapeutic communication throughout every initial psychiatric evaluation.

Outcome. Outcome, the last tenet of the Donabedian model, will provide guidance and enhance this project by addressing the importance of understanding the effects of the previous two tenets are after implementing a set of interventions (Moore, Lavoie, Bourgeois, & Lapointe, 2015). The lead will understand how outcome is determined by the quality of the intervention accomplished. The project lead has advantage using this tenet by understanding that the interventions can determine results of the outcome and whether set of interventions are successful. The project lead will identify one essential component for this tenet in this project. The first component identified is utilizing the tool to analyze number of no-shows after initial psychiatric evaluation compared to after the intervention.

Project Design

This DNP project will use a quality improvement (QI) approach. The QI approach aims at making a positive impact for patients by improving safety, efficacy, and experience of care (Jones, Vaux, & Olsson-Brown, 2019). A QI approach was chosen as the project design because it provides a framework about how to improve health care through improving quality, safety, and values of health care towards establishing outcomes with a given intervention (Ogrinc et al., 2016). Through this framework, the project lead will be able to improve the healthcare of patients through a given intervention. The population of interest are the medication management providers at the project site. The desired outcomes of this project will be measured by having a lower MMNS rate at the 4-week medication management follow up evidenced by a decrease in the total number of no-shows noted in the EHRS compared to the 3-month period prior to the intervention completion.

The quality improvement project will take place in an outpatient psychiatric clinic in Southern California. No-shows or missed appointments occur for multiple reasons, but evidence has displayed that individuals suffering from mental illness have an increased rate of no-shows in comparison to those without mental illness (Gunzler et al., 2017). The clinic estimates that approximately 30% of patients' no-show to their scheduled medication management follow-up (K. Saucier, personal communication, February 21, 2020). Studies have shown that patient no-shows continue to negatively affect the health outcomes of patients suffering from serious mental illness (McLean et al., 2016).

The utilization of therapeutic communication among patients with mental health disorders continues to show a positive impact on the patient's adherence to their scheduled follow-up appointments and enhanced satisfaction of their mental health providers (Papgeorgiou, Loke, & Fromage, 2017). Providing Trainings on the basic components of therapeutic communication have shown benefits in improving patient-provider relationships, improving attendance adherence and improved patient health outcomes (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). The purpose of this project is to decrease MMNS rate for patients suffering from mental illness within an outpatient psychiatric clinic by implementing a therapeutic communication training for medication management providers to improve communication skills when providing care.

Data collection for this QI project will contain the utilization of the Principles of Therapeutic Communication Quiz. The Principles of Therapeutic Communication Quiz will be used as a tool to be utilized pre- and post- intervention to measure knowledge and skills of medication management providers towards therapeutic communication. The project variables include the administration of the intervention and the impact on the intervention on the no-show

rates. Content validity for the project tool, Principles of Therapeutic Communication Quiz, was established through the content validity index (CVI). An intervention will be executed by implementing an educational tool to improve the medication management providers' knowledge on therapeutic communication. The data analysis will be conducted utilizing IBM SPSS statistical software, in which, a Fisher's Exact Test will be calculated. A measurement of patients who presented to their scheduled medication management follow-up will be tallied in the chart audit tool and compared to the number of MMNS prior to intervention. The objective of the project will address the three project objectives by implementing a sixty minute training to at least four medication management providers on the principles of therapeutic communication, evaluating their knowledge with a pre- and post-intervention quiz and ensuring each provider trained will agree on utilizing techniques learned from the training into all of their scheduled IPE. The data analysis will utilize pre- and post- intervention scores and compare them to determine if an increase in therapeutic communication happened or not. From the data analysis results from the use of SPSS statistical software, a decrease of initial MMNS by 10% after the intervention through comparing the total number of no-shows noted in the EHRS than that of the 3-month period prior to the educational intervention will serve as evidence of improved therapeutic communication.

Population of Interest

The population of interest includes all the medication management providers that work at the outpatient psychiatric clinic in Los Alamitos. The medication management providers are all psychiatric mental health nurse practitioners and work part-time. The inclusion criteria include medication management providers that have active California nurse practitioner or medical licenses that specialize in psychiatry. The medication management providers must work with

patients who are prescribed medications after an initial psychiatric evaluation and schedule a medication management follow up at the project site. The inclusion criteria were selected to determine that the participants were individuals that provide direct patient care with patients that are prescribed medications on initial psychiatric evaluation. The exclusion criteria are the therapist, psychologist and medical assistant that work at the project site that do not conduct initial psychiatric evaluations with medication management services.

Setting

The setting is an outpatient psychiatric clinic in Los Alamitos, California. The practice averages 100 patient visits a month by the psychiatric mental health nurse practitioners with additional visits by the therapist and psychologist. The clinic has been in business for 6 months. The project site owner is a psychiatric mental health nurse practitioner, who works two days a week. There are three other part-time mental health nurse practitioners that work each work two days a week. They have one front office medical assistant that works full-time, one part-time therapist and one part-time psychologist. Marketing is done mainly through Psychology Today with their providers setting up individual profiles. Psychology Today is a website that allows potential patients to find providers based on their location, specialties, treatment modalities and experience. Besides Psychology Today, the practice owner was able to grow her business through previous patients that followed her from other practices, word of mouth and internal referrals from provider to provider. As a newer practice, the practice owner is interested in identifying measures to implement to help decrease the number of MMNS, as it is a private pay clinic. It’s hours of operation are mostly by appointments only for the medication management providers, but they are open Monday to Saturday based on providers availability. Written permission to perform project at practice site was obtained from the practice owner (Appendix

A).

Stakeholders

The stakeholders include the mental health patients receiving medication management services at the outpatient psychiatric clinic, the owner, and the three other psychiatric mental health nurse practitioners. The mental health patients receiving medication management services are stakeholders because they receive the care provided by the medication management providers. The owner is a stakeholder because she provides knowledge about care and provides medication management services to her patients. The other three psychiatric mental health nurse practitioners are stakeholders because they also provide medication management services to the patients. All four mental health nurse practitioners will benefit from the intervention in improving their communication skills. Weekly skype or phone sessions will be done throughout the development of this project until completion to help with team building and to review each section of the project to receive buy-in and support. The project lead will arrange follow-up trainings.

Recruitment Methods

The medication management providers will be recruited by the project lead. The project lead will speak with the other three medication management providers through their monthly medication management providers meeting and inform them of proposed intervention with the support of the project site owner. The project lead will provide a pre- and post-intervention quiz at the meeting. The pre- and post-intervention quizzes will not be identified by names but will be identified through participant numbers to maintain confidentiality. During the meeting the project lead will conduct an intervention to educate the project site owner and medication management providers about the importance of therapeutic communication and the importance

of each provider utilizing therapeutic communication with each patient they encounter. Since meeting will be done during monthly mandatory meeting, the meeting will be conducted after working hours without compensation. Due to no patient health information being discussed, an informed consent will not be necessary. Medication management providers data will be protected because no personal information will be on any documents except identification numbers. The results will be entered and stored on a USB flash drive that can only be accessed by the project lead. Once data is analyzed, the USB flash drive will be kept in a secure location for five years after study completion and disposed accordingly. There are no added incentives to participate in this project.

Tools/Instrumentation

Pre- and Post- Intervention Quiz/Score Sheet

The pre- and post- intervention quiz (See Appendix B) will be offered in a paper-based format to be taken before and after the educational intervention. The quiz consists of a brief fifteen question multiple choice Principles of Therapeutic Communication Quiz created by the project lead in 2020. Due to minimal valid or reliable tools found in research towards medication management providers, the project lead developed a tool using data gathered from evidence-based information about therapeutic communication. A CVI was conducted and gained approval for use in this project from three separate expert raters (See Appendix C). The tool will measure knowledge and skills of medication management providers towards therapeutic communication. A score of at least 80% is required to successfully pass the quiz. The results will be entered on the score sheet that the project lead will only have access to (See Appendix D). The score sheet will contain participant number, pre-quiz score and post-quiz score.

Chart Audit Tool

A chart audit tool was constructed for data collection (See Appendix E). The chart audit tool is a table format tool used to collect data of those that showed up to medication management follow to those that had a MMNS. The tool will be utilized pre-intervention and post-intervention. The audit will determine those that showed up to medication management follow-up. The project lead will appoint the only front office medical assistant to be the designated data collector and will enter data into an excel database that will be stored on a USB flash drive. The USB flash drive will only be accessible to the project lead and designated data collector and will be kept in a secure location for five years after study completion.

Educational Tool

An education tool will be utilized in a form of a printed PowerPoint document (Appendix F). The tool will be distributed to each medication management provider at the monthly medication management provider meeting and be presented by the project lead. The tool is used to educate about the importance of understanding the Principles of Therapeutic Communication when taking care of patient with mental health disorders. This educational training will provide facts and information about utilizing therapeutic communication appropriately for their patient population.

Statistical Software

Project data will be analyzed using IBM SPSS Statistical Software (IBM Corp., Version 25.0). IBM SPSS is a statistical software used for the analysis of statistical data (Bruland and Dugas, 2017). The software will be utilized to analyze pre- and post-intervention data to determine the significance of the intervention. The project lead will use IBM SPSS statistical software to conduct a Fisher's Exact Test, Chi-square, and Paired T-test to determine if the

intervention incurred a significant effect.

Data Collection Procedures

Data collection of the pre- and post- intervention quizzes will be managed by the project lead. A chart audit will be done to evaluate and determine the percentage of MMNS at the project site. The data will be collected the Monday prior to the monthly medication management provider's meeting. The project lead will receive help from the only front office medical assistant to help as the designated data collector. The designated data collector will review the most recent appointments that were initial medication management follow-ups after their initial psychiatric evaluations for the past three months prior to intervention. The data will be collected and reviewed before the implementation of the educational training to gather data on the amount of MMNS prior to intervention.

Once data has been gathered and evaluated, the project lead will be able to provide the pre-intervention Principles of Therapeutic Communication Quiz at the monthly medication management provider's meeting twenty minutes prior to the start of the intervention. After the pre-intervention quiz has been administered, data will be collected and recorded into the designated score sheet.

Once pre-quiz results have been recorded, the project lead will hand out a printed PowerPoint document and administer a training on Principles of Therapeutic Communication based on the printed PowerPoint document. Once the Principles of Therapeutic Communication training has been provided, a post-quiz will be administered. The results from the post-quiz will then be collected and recorded into the designated score sheet. Only the project lead will have access to the scores on a password secured USB flash drive. After data has been recorded, the project lead will enter and analyze statistical data using IBM SPSS to conduct a Fisher's Exact

Test to determine if the educational intervention incurred a significant effect.

On the 30th day after the implementation of the educational training on Principles of Therapeutic Communication, data will be collected. The project lead and designated data collector will review all the appointments that were initial medication management follow-ups after their initial psychiatric evaluations post intervention and determine the amount of MMNS. The amount of MMNS compared from pre-intervention to post-intervention will be analyzed. The data will then measure the rate at which the training on Principles of Therapeutic Communication affected MMNS. Information reviewed will contain no patient information or details. Additionally, project lead will have no direct access to confidential patient health information, which helps maintain patient privacy.

Intervention and Project Timeline

The timeline for this DNP project is five weeks. The implementation of the project intervention and data collection will occur over a five-week period in July-August 2020 (Figure 1). Once implemented, data analysis will be accomplished soon after intervention has been concluded.

Week 1

Week 1 (July 8- 14) - On Monday of week one, the project lead will review the proper use of the chart audit tool. The project lead will email a reminder to participants of time, date, and location of educational session. The project lead will conduct a retrospective chart review (RCR) of the initial medication management follow-ups after having an initial psychiatric evaluation for the past three months prior to the start of the intervention for baseline data collection. The project lead will utilize the chart audit tool to collect data on which patients showed up to their appointments and which patients did not show up to their appointments. The

intervention will be conducted Monday of week one during the monthly medication management provider's meeting that will take place once the clinic closes at 5 PM. The pre- and post-intervention quizzes and the educational component will be administered by the project lead. The meeting along with quizzes and intervention will take place from 5 PM to 7 PM at the outpatient psychiatric clinic. The project lead will compile a list of initial psychiatric evaluations completed throughout the week after the intervention.

Week 2

Week 2 (July 15-21) - The project lead will compile a list of the number of patients that has their initial medication management follow-up scheduled this week, only if they had their initial psychiatric evaluation post intervention. Data collection will cease after 4 weeks.

Week 3 and 4

Week 3 (July 22-28) and Week 4 (July 29-August 4) - The project lead will continue to compile a list of the number of patients that has their initial medication management follow-up scheduled these two weeks, only if they had their initial psychiatric evaluation post intervention. Data will be collected and tracked until the last day of week 4. The project lead will continue to provide support to medication management providers.

Week 5

Week 5 (Aug 5-11) - Analysis of data collected will be conducted from the pre- and post-intervention quizzes by the project lead in order to compare the means of the quiz scores from each provider. The project lead will also analyze the post-intervention data provided on the Chart audit tool and will evaluate the data utilizing SPSS. An evaluation report of findings will be completed utilizing Fisher's Exact Test, Chi-square, and Paired T-test. The evaluation of project will be completed by the end of this week.

Figure 1

Project Timeline

Weeks	Activities
Week 1 (July 8-14)	• Email notification and reminders to all participating medication management providers regarding time, date, and location of educational session • Conduct pre-intervention RCR (baseline information) using Chart audit tool (See Appendix E) • Complete pre-intervention quiz to assess current knowledge of therapeutic communication (See Appendix B) • Conduct educational presentation (See Appendix F) • Complete post-intervention quiz to assess knowledge after educational presentation (See Appendix A)
Week 2 (July 15-21)	• Compile list of the number of patients that has their initial medication management follow-up scheduled this week, only if they had their initial psychiatric evaluation post intervention using Chart audit tool (See Appendix E)
Week 3 (July 22-28) and Week 4 (July 29-August 4)	• Continue to compile a list of the number of patients that have their initial medication management follow-up scheduled this week, only if they had their initial psychiatric evaluation post intervention until end of Week 4 • Provide support for participants
Week 5 (August 5-11)	• Conduct post-intervention RCR using data collected throughout weeks 2-4 • Analyze pre- and post-intervention quiz data by using the pre and post quiz score sheet tool (See Appendix D) • Analyze post-intervention data on Chart audit tool (See Appendix E) • Analysis and evaluation of project data utilizing SPSS and statistician. • Complete evaluation report from finding completed by SPSS using Paired T-test, Chi-square, and Fisher's Exact Test.

Ethics/Human Subjects Protection

To safeguard ethical conduct and human subjects' protection, the project lead has successfully completed the required online Collaborative Institutional Training Initiative (CITI) program modules for basic researchers, which has been approved by Touro University Nevada.

The CITI training is an online resource that provides training on topics related to biomedical and social behavioral research used by thousands of organizations to fulfill federal requirement of training for faculty, staff, and students involved in conducting human subjects research (Hadden, Prince, James, Holland, and Trudeau, 2018). Through the successful completion of this training, increased amounts of care were kept following these guidelines to ensure ethical conduct and human subjects' protection. Also, with this project being a quality improvement project, it is qualified for internal review board (IRB) exemption. A project team determination form will be submitted to determine if research was performed or if a quality improvement methodology was completed to confirm compliance with IRB exemption status. Attendance of educational training or completion of quizzes will be required by all medication management providers. Although no financial compensation will be provided to participants, providers will benefit from participation by learning evidence-based research on therapeutic communication. Risk will be minimized by not having access to patient health information (PHI) and no identifying information will be accessible. To ensure staff confidentiality, identifying data will be absent and instead be given a randomized 3-digit participant code determined by project lead. To ensure patient confidentiality, no identifying patient information will be utilized. Along with not using identifying patient or staff information, the data will be stored on a secure and password encrypted USB flash drive that will only be available to the project lead and designated data collector and will be kept in a protected location for five years after conclusion of study.

Plan for Analysis/Evaluation

This quality improvement DNP project addresses two major opportunities: decreasing MMNS and improving medication management providers' knowledge of therapeutic communication. In determining a decrease in MMNS, an RCR of the most recent appointments

within the past three months that were initial medication management follow-ups prior to the intervention will be utilized as baseline data collection with the use of the chart audit tool. In determining an improvement of providers' knowledge of therapeutic communication, a pre-intervention quiz will be given prior to educational training and a post-intervention quiz will be give after educational training. The project lead will tally the pre- and post-intervention quiz scores using the pre and post quiz score sheet. Once data has been collected, the data from the data collector tool and pre and post intervention quiz score sheet will be analyzed utilizing IBM SPSS Statistical Software (IBM Corp., Version 25.0).

A statistician reviewed the data analysis plan and confirmed the appropriate statistical test to be utilized. To identify if there was a significant increase in knowledge of therapeutic communication, the project lead will analyze the data collected from the pre- and post-intervention quiz scores and compare the means of the quiz scores to determine if the intervention educational tool was effective. A T-test will be conducted to determine if there is a significant increase in provider's knowledge of therapeutic communication. The assumption is that the dependent variable is measured using a continuous scale at the interval level and that the two scores from the medication management providers will be normally distributed. To identify if there was a significant decrease in the amount of MMNS after intervention, Chi-square and the Fisher's Exact Test will be utilized in comparing pre- and post-intervention data collection from data collector tool to determine if the intervention incurred a significant effect. The data collected from the data collector tool from the RCR will create a codebook and analyzed using IBM SPSS Statistical Software. Both, Chi-square and Fisher's exact tests are ideal for analyzing group differences when the variables being compared are categorical/nominal (McHugh, 2013). A Fisher's Exact Test is often utilized in addition to Chi Square when the given sample size is

smaller for a two by two contingency table (Pallant, 2016). Probability value (p-value) expresses the level of statistical significance. If the p-value is less than 0.05 percent, then there is a significance difference between pre- and post-intervention data. Once significance is determined when comparing pre-intervention quiz scores vs post-intervention quiz scores and pre-intervention MMNS vs post-intervention MMNS, the means will be compared which set of scores were higher. If the outpatient psychiatric clinic MMNS rate is lower at the 4-week medication management follow up, this will be an indication that the therapeutic communication educational training was effective in reducing the amount of MMNS.

Significance/Implications for Nursing

The potential significance of the project results can improve patient outcomes and increase the quality of care provided for patients suffering from mental illness. Patients suffering from serious mental illness that do not show up to their scheduled appointments have higher risk for disease decompensation and have poorer health outcomes to those that attend their normally scheduled appointments (Mclean et al., 2016). Evidence has shown that a way to improve attendance is through improving the therapeutic relationship among the patient and provider, especially when it comes to patients that suffer from mental illness (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). The significance of improving therapeutic communication for nursing staff is important for their patient-provider interaction, as evidence has shown ineffective communication between patient and provider results in a poor therapeutic relationship leading to poor patient outcomes, decreased adherence to treatment plans, worsened patient satisfaction and increased patient-no shows (Tiwary, Rimal, Paudyal, Sigdel, & Basnyat, 2019). This project can positively impact nursing by providing nursing providers improved therapeutic communication skills being provided to patients suffering from mental illness throughout all

their encounters. Advanced Practice Psychiatric Nurses focus on health promotion through placing emphasis of implementing therapeutic techniques within their patient-nurse therapeutic relationship to help improve the quality of care for patients suffering from mental illness (American Psychiatric Nurses Association, 2017). Through the application of this project, medication management nursing providers will be given the opportunity to improve the use of therapeutic communication within their practice to reduce the amount of MMNS. By incorporating the basic components of therapeutic communication, the therapeutic patient-provider relationship will be strengthened through the providers' ability to listen, empathize and provide patient-centered care (Abdolrahimi, Ghivasvandian, Zakerimoghadam, & Ebadi, 2017). By establishing a positive patient-provider interaction and relationship established around trust and rapport, the patient care experience will result in improved care received (Dang, Westbrook, Njue, & Giordano, 2017). The result of this project can show that the educational intervention can improve each provider's knowledge of therapeutic communication and improve the therapeutic relationship with patients to decrease MMNS. This can potentially lead to other outpatient psychiatric clinics implementing a therapeutic communication educational plan into their practice to improve each provider's ability to therapeutically communicate with patients.

Analysis of Results

The goal of this quality improvement project was to implement an educational intervention within an outpatient psychiatric clinic to improve each providers' knowledge of therapeutic communication leading to an improved therapeutic relationship between the patient and provider. The incorporation of therapeutic communication improves the providers ability to provide therapeutic patient care leading to an improved patient provider relationship (Abdolrahimi, Ghivasvandian, Zakerimoghadam, & Ebadi, 2017). With the improved therapeutic

relationship between the patient and provider, the project aimed to decrease the number of no-shows or MMNS following the initial psychiatric evaluation through the comparison of patient shows vs no-shows. Four providers provided the data to be analyzed in this project. The data analyzed includes knowledge on the principles of therapeutic communication before and after the educational intervention, as well as the rate of pre-intervention MMNS vs post-intervention MMNS. Analysis of the information collected was completed utilizing IBM SPSS version 25 and done so using descriptive statistics. Necessary assumptions and violations were checked before running the t-test, chi-square and Fisher's exact tests.

Educational Intervention Pre and Post Quiz

Four medication management providers' knowledge of therapeutic communication were analyzed through the completion of a pre and post educational intervention quiz. Each provider completed the fifteen-question pre-intervention quiz immediately prior to the educational intervention and completed the post-intervention quiz immediately after the educational intervention. An analysis was done that compared pre-educational intervention scores with post-educational intervention scores to determine if there was a significant difference between both *(Table 1)*. Prior to the educational intervention, the mean score of the four medication management providers was 11.50 ± 1.29, which increased to a mean score of 13.50 ± 0.58 after the educational intervention. To determine if the increase in scores was statistically significant, a paired t-test was carried out as it was the most suitable test to compare means between two groups that are related to each other (pre- and post-educational intervention) and are both continuous variables (Hazra & Gogtay, 2016). The test yielded a t-test statistic of $t(3) = -4.899$ and a p-value of 0.016, indicating that there was indeed a statistically significant increase in quiz scores following the educational intervention (an improvement of 2.00 ± 0.82 mean difference).

The first assumption associated with the paired t-test included an assumption that the dependent variable, which in this case, is the score (pre- and post-educational training) is in a continuous form. Secondly, it is assumed that the data consists of two "matched pairs," that is, pre- and post-educational score. Next, it is assumed that the scores are approximately normally distributed. Lastly, there was no significant outliers in the scores for each group (pre- and post-educational training) and no assumption of normality were violated (Hazra and Gogtay, 2016). Through these results, it signified improved knowledge towards the principles of therapeutic communication contributed from the educational intervention.

Table 1

Paired T-Test Results Comparing Pre- and Post-Intervention Quiz Scores

Scores	N	Mean	SD	Mean difference	SD of mean difference	t-test	p-value
Pre-training score	4	11.50	1.29	-2.00	0.82	-4.899	0.016*
Post-training score	4	13.50	0.58				

p-value is significant at $p < 0.05$

Retrospective Chart Review

Along with comparing means of the quiz scores, the project lead conducted an RCR of the initial medication management follow-ups after having an initial psychiatric evaluation for the past three months prior to the start of the intervention for baseline data. Eighty-one charts were audited for baseline data collection, while thirty-three charts were audited post intervention. The data collected consisted of whether a patient showed up or no showed to their initial medication management follow up. The no shows in this project were considered MMNS. The cumulative charts reviewed for the quality improvement project were one hundred and fourteen. The project lead entered and analyzed statistical data using IBM SPSS and utilized Chi-square and the Fisher's Exact Test to determine if the intervention incurred a significant effect.

Statistical significance is expressed if the p-value is less than 0.05 percent (Pallant, 2016). The figure below *(Table 2)* shows the results of patients showing up or no-showing (MMNS) before and after educational intervention. Prior to the educational intervention, 70.4% ($n = 57$) of participants showed up while 29.6% ($n = 24$) were considered no-shows or MMNS. A reassessment among a 4 week span following the educational intervention showed that the proportion of patients that showed up to their scheduled initial medication management follow up had increased to 84.8% ($n = 28$) while the proportion of those that were considered no-shows or MMNS dropped to 15.2% ($n = 5$). In order to compare pre-training *"shows vs no shows"* with post-educational intervention *"shows/no shows,"* both Chi-square and Fisher's exact tests were run as they are ideal for analyzing group differences when the variables being compared are categorical/nominal, and the Fisher's exact test is even more suitable for very small sample sizes (McHugh, 2013). After analyzing the data, the results indicated that the change was not statistically significant with a Chi-square p-value of 0.107 and a Fisher's exact p-value of 0.154 (both of which are > 0.05). The assumptions for both chi-square and Fisher's exact tests are that the two variables being tested against each other (before and after educational intervention versus show or no show) are in categorical or nominal form and each variable consists of at least two categorical, independent groups with no violations (McHugh, 2013). The implication is that even though there was an improvement in the proportion of no-shows following training, there was no statistically significant relationship between improving therapeutic communication on reducing MMNS as p-value is > 0.05.

Table 2

Chi-square and Fisher's Exact Test on Relationship Between Training and Shows vs No-shows

	Showed	No show/MMNS	Total
Post-training	28 (84.8%)	5 (15.2%)	33 (100.0%)
Pre-training	57 (70.4%)	24 (29.6%)	81 (100.0%)
Total	85 (74.6%)	29 (25.4%)	114 (100.0%)

- Chi square, $\chi^2 = 2.591$, $p = 0.107$
- Fisher's exact test: $p = 0.154$

Discussion

The project question answered was: among psychiatric medication management providers working in an outpatient psychiatric clinic, does training on therapeutic communication in comparison to no training decrease no-show rates after initial psychiatric evaluation over a span of four weeks? The project data collected and analyzed during this project determined there was a decrease in no-show rates after the initial psychiatric evaluation over a span of four weeks by almost 14.1% when comparing data from the amount no-shows over a three month period prior to the educational intervention compared to the four week period post educational intervention. Although there was reduction of 14.1% when comparing the data, the results from both Chi-square and Fisher's exact test indicated that the change was not statistically significant with a Chi-square p-value of 0.107 and a Fisher's exact p-value of 0.154. With the p-values being > 0.05, we fail to reject the null hypothesis as it indicated that there was no statistically significant relationship between improving the therapeutic communication on reducing the amount of MMNS.

Although it was determined there was no statistically significant relationship between improving therapeutic communication on reducing the amount of MMNS when answering the project question, the implementation of the project was still found to be successful in meeting all

three objectives. The first objective was met with implementing a sixty-minute training to at least four providers on therapeutic communication and them being evaluated with a pre- and post-intervention questionnaire. Through the implementation of the educational intervention, data revealed an overall increase in competency among each provider in knowing the principles of therapeutic communication through the analysis of the pre- and post-intervention quiz results with the average score increasing by 13.4% after the intervention was completed. Not only was there an improvement in intervention quiz scores, but a paired t-test of the scores indicated to be statistically significant with a p-value of 0.016 when comparing the pre-educational intervention scores and the post-educational intervention scores signifying the educational intervention increased providers knowledge on therapeutic communication. With each provider becoming more competent on the principles of therapeutic communication, the second objective was met with the providers successfully implementing the principles of therapeutic communication on all IPE during the four weeks after the educational intervention was implemented. Along with determining an overall increase in competency among each provider and successfully implementing knowledge learned into practice, the analyzed data revealed that the third objective was met because the clinic's MMNS rate was lower at the 4-week medication management follow up of 15.6% compared to the 3-month period prior to the intervention of 29.7 %. Data displayed a reduction of 14.1% when comparing pre- and post-intervention data.

Although there was a reduction of no-shows, other factors or barriers leading to MMNS must be considered besides only therapeutic communication due to the Chi-square and the Fisher's Exact Test not being less than 0.05. Other common barriers for why patients suffering with SMI miss their scheduled appointments or "no-show" include financial difficulties, lack of transportation, forgetting their appointment, and difficulty making their appointment (Ramlucken

& Sibiya, 2018). Without any further investigation, this is difficult to determine if these factors contributed to results from this DNP project. It is suggested that future recommendations for future quality improvement projects should factor these common barriers for reducing MMNS.

Significance/Implications for Nursing

The implementation of therapeutic communication within nursing has shown to positively impact the patient-provider relationship for patients suffering with SMI, resulting in improved outcomes, improvement in patient adherence to treatment plans and decreased patient appointment no-shows (Mohamed, Mustafa, Tahtamouni, Taha, & Hassan, 2016). Quality of care improves when an increasing emphasis is placed on therapeutic techniques (American Psychiatric Nurses Association, 2017). With each provider in the clinic being an Advanced Practice Psychiatric Nurse, the project provided significant value for each provider in increasing their competency of therapeutic communication and its successful application within nursing care. The implementation of this DNP project was deemed successful, revealing an opportunity to improve the therapeutic communication of each provider, the reduction of patient no-shows and to provide future potential of advancing the therapeutic patient-provider relationship within nursing care. Project data showed that clinical scholarship and analytical methods were beneficial when implementing this project within an outpatient setting to improve nursing practice and patient outcomes. Given all the data, future projects would need to utilize alternative evidenced-based interventions to address barriers contributing to MMNS among patients suffering with SMI and how these barriers can be addressed properly.

Limitations

Various impediments to project implementation were encountered, arising in part from the newness of this outpatient psychiatric practice. As with many initial quality improvement

initiatives, certain limitations exist that could impact findings (Wong and Sullivan, 2016). The project limitations occurred during the project design, data recruitment, data collection, and data analysis.

Project Design Barriers

When designing the project plan for the outpatient psychiatric clinic, there were some noticeable limitations that influenced the plans for a model quality improvement approach. The main limitation experienced with the project design was the length of time the clinic was open. Due to the clinic being open less than a year, the number of patients being treated, and number of providers were far less compared to already established outpatient psychiatric clinics. A significant contributing factor for attracting new patients to an organization is the organizations history of providing consistent quality service for a longer period (Bahadori et al., 2016). Length of time being open puts other clinics at advantage for attracting higher amounts of patients and limited this particular clinic since it was open less than a year. Another limitation that existed within the project design was the clinic being private pay only, which limited the number of potential patients. With being open less than a year and taking only private pay patients, patient referrals were limited leading to a lower patient volume.

Data Recruitment and Collection Barriers

The project had many positive aspects when it came when it came to data recruitment and collections, but there were some limitations that existed throughout the project. The first limitation experienced for data recruitment and collections is the number of providers within the practice. The number of providers dictates the volume of patients being treated, which limited the sample size of patients being seen before and after the intervention. Having a smaller sample size will give a result that may not be enough to detect a difference between the groups and study

compared to an appropriate sample size (Nayak, 2010). Another limitation was the time frame of data collection, which was four weeks. Although this was a QI project, more charts may have been reviewed if the data collection period was longer, which would have resulted in an increased sample size. Studies with larger and more appropriate sample sizes typically achieve more accurate estimation within the results and can draw improved precision and conclusion of study (Nayak, 2010). By having a larger sample size, this would have yielded a more predictive and accurate result.

Data Analysis Barriers

Data analysis was an important component for this project, but there were some limitations that presented itself that may have impacted the results. The main limitations that existed within data recruitment and collection included having a smaller than expected sample size of patients charts that were reviewed and a small number of providers providing care. One hundred and fourteen patient charts were reviewed and only four providers provided care throughout the entirety of the project. These limitations existed because the project took place in a newly established clinic with a lower patient volume rather than a larger clinic with a higher patient volume, which didn't require as many providers. Another limitation that existed in lowering the patient volume throughout the three-month period of data collected was patients rescheduling their visits due to the COVID-19 pandemic. Given the smaller sample size, analyzed results were impacted. Studies have shown that larger sample size towards interventions compared to smaller sample size typically yield more accurate and predictive results (Grove, Burns and Gray, 2013). By having a lower number of providers resulted in a smaller sample size of patients that may have led to a less desirable outcome.

Another limitation of the project within the data analysis portion of the project was the amount of time the clinic has been open. Due to the clinic being open less than a year, there is a lack

of data from previous years to compare in showing fluctuations of no-shows depending on seasons. Studies have shown that mental health appointments show seasonal patterns with higher appointment usage during winter months and troughs occurring during summer months (Soreni et al., 2019). With being unable to see previous years no-show rates, it’s difficult to have comparison of months.

Dissemination

The dissemination of this quality improvement project findings and outcomes plays a significant role in providing care for nursing, mental healthcare professionals and stakeholders. It is critical that the results of this project be shared among other nurses, mental health care professionals and stakeholders through multiple options. The first option for dissemination of this project will include a final presentation to the nursing faculty and students of Touro University Nevada on October 12, 2020. Prior to the final presentation, the project leader, the clinical, academic and project mentors will review the details and revise accordingly. In hopes of furthering the quality improvement in, the project results will also be disseminated to the outpatient psychiatric clinic staff and leadership team through a series of staff meetings. In addition, the project will be further disseminated through an abstract submission for a poster presentation into a larger mental health professional and nursing audience at the International Society of Psychiatric-Mental Health Nurses’ 2021 Annual conference on March 23-25, 2021. Lastly, the project will be disseminated on the Doctor of Nursing Practice Organization website to enhance professional growth within nursing.

Project Sustainability

The use of the training on Principles of Therapeutic Communication is planned to continue at the project site as one of the mandatory trainings due to the successful decrease in MMNS and overall increase in competency among each provider. The practice site owner believes in reinforcing the information to continue to improve patient care by providing the

training on an annual basis. Studies have shown that ongoing training should be consistently reinforced to improve quality improvement initiatives (Agency for Healthcare Research, 2013). By continuing to reinforce the training and offering therapeutic communication role-playing activities, the overall goal of the practice site owner is to continue to provide high-quality patient care by implementing the use of therapeutic communication throughout every patient interaction.

Conclusion

A significant concern among the mental health providers are the higher rates of missed appointments for patients suffering from severe mental illness. Unfortunately, this rate has steadily increased due to multiple barriers with the lack of therapeutic communication being the main modifiable barrier. This project implemented a training on principles of therapeutic communication in an outpatient clinic with the purpose of improving each provider's therapeutic communication skills to improve the therapeutic relationship between the patient and provider leading to decreased amount of MMNS. After implementing the training, each provider's competency level on therapeutic communication improved significantly, but was not significant on decreasing the amount of MMNS. Unfortunately, MMNS continue to be detrimental to any health care clinic due to the significant impact it has on patient health outcomes and warrants further investigation. Although the results were not significant, the project still managed to successfully meet all three of its objectives and saw a decrease in amount of MMNS when comparing pre and post data leading to improved patient health care.

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Appendix A

Written Permission to Perform Project

AA MENTAL HEALTH
AND WELLNESS GROUP

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Date: 03/22/2020

Re: Medard Sison

Medard Sison is currently conducting his DNP Project at AA Mental Health and Wellness Group. No formal agreement is necessary for Mr. Sison to conduct his DNP project at my practice. Please contact my office with any questions or concerns at (714) 459-2208.

Sincerely,

Kesha Saucier, PMHNP-BC

Owner of AA Mental Health and Wellness Group

Lic # 95003767

5182 Katella Ave, Ste 205, Los Alamitos, CA 90720 ◆ Tel: (714) 459-2208 ◆ Fax: (310) 300-1814

Appendix B

Principles of Therapeutic Communication Quiz

Instructor: Medard Sison Name: ______________________________

Results: ________________________ Date: ______________________________

General Directions

This test consists of fifteen (15) multiple-choice questions. Each question is a multiple-choice question with four answer choices that are graded equally. Read each question and answer choice carefully and choose the ONE best answer. Try to answer all questions. In general, if you have some knowledge about a question, it is better to try to answer it. You will not be penalized for guessing.

Principles of Therapeutic Communication Quiz

1. What is therapeutic communication?

   a. Communication used to advise patients of their wants and needs and is done during every session

   b. One which is perceived by patients to encompass caring and supportive behavior in a safe environment

   c. Caring and supportive communication in which, reassurance, approval and probing or defending is utilized

   d. Ability to discourage client from further expression of feelings or downplaying their thoughts

2. Mental health providers need to know how to gain trust and gather information from ____________ to involve them in an effective treatment plan

   a. Patient

   b. Patient’s family

   c. Patient’s friends

   d. All of the above

3. When implementing the principles of therapeutic communication in practice, providers must place the primary focus on whom?

   a. Themselves

   b. **Patient**
   c. Patient's family
   d. Staff

4. Providers must possess self-understanding and self-awareness to effectively promote _____________.
   a. Rapport building
   b. Alliance
   c. **Therapeutic use of self**
   d. Processing

5. Define the importance of utilizing Non-verbal communication within practice?
   a. Non-verbal communication gives patients time to come up with reasons for what occurred
   b. Non-verbal communication may lead to weak client-provider relationship
   c. Non-verbal communication promotes discussion on expressing uncertainty
   d. **Non-verbal communication plays a significant role in improving one's ability to relate, engage, and establish interaction in practice**

6. How does using *silence help* within a provider-client interaction?
   a. **Promotes client to take control of the discussion, if he or she desires**
   b. Allows client to understand themselves better through the provider doing majority of the talking
   c. Establishes boundaries for clients to not speak until asked questions
   d. Enhances the providers ability determine the need for discussion

7. What is achieved using the problem-solving model?
   a. **Goals**
   b. Feelings

c. Negativity

d. Undesirable outcomes

8. How does *giving broad openings* help provider-client interaction?

a. It provides a specific topic to discuss

b. It allows client to select the topic to discuss

c. It allows client to stay on track within the conversation

d. It allows clients to indicate awareness of their problem

9. What is the most important skill for providers to implement when establishing an interpersonal relationship within a psychiatric facility?

a. Self-awareness

b. Therapeutic communication

c. Respect

d. Empathy

10. It is important to understand as providers that you must only disclose __________ information when it is therapeutic

a. Other patients'

b. Organizational

c. Personal

d. Processing

11. What is ***not*** part of behaviors used in establishing active listening by the provider?

a. Relaxing

b. Touching

c. Uncrossing Legs

d. Closing

12. To listen actively is to be attentive to what client is saying, both _____ and _______.

    a. **Verbally and Nonverbally**
    b. Actively and Verbally
    c. Literally and Hypothetically
    d. Verbally and Persuasively

13. General leads are important because they …

    a. Encourage client to stop talking
    b. Encourage client to think about what they are saying
    c. **Encourage client to continue**
    d. Encourage client to make observations

14. Is reflecting a therapeutic communication technique or a non-therapeutic communication technique?

    a. **Therapeutic communication technique**
    b. Non-therapeutic communication technique
    c. Both
    d. None of the above

15. What is ***not*** an attribute of therapeutic relationships?

    a. Rapport
    b. Trust
    c. Respect
    d. **Truthful**

Appendix C

Content Validity Index

Principles of Therapeutic Communication Quiz

Purpose

The purpose of this education is to improve psychiatric medication management providers' knowledge on the benefits of using therapeutic communication when interacting with patients that have mental health disorders in an outpatient psychiatric clinic. The course will provide education on the importance of providers utilizing components therapeutic communication when interacting with patients. It will also evaluate if the learners' led to change in communication behaviors (decreased no-shows at initial medication management follow up) after course completion.

Learning Objectives

Upon successful completion of this course, you will be able to:

- Define Therapeutic Communication
- Describe the importance of therapeutic communication and therapeutic provider-client relationship within the mental health care setting
- Recognize the requirements for a therapeutic relationship
- Understand the importance of non-verbal communication, active listening and interpersonal communications
- Integrate important therapeutic communication techniques during provider-client interaction to help problem solve

Population

The population is a general group of psychiatric mental health medication management providers.

Length of the Test

The optimum length for this test is 15 questions.

Difficulty and Discrimination Levels of Test Items

Criterion-referenced tests will be utilized as it measures a scale range and provides an interpretation of what a provider is expected to do with the information provided and helps differentiate the providers health literacy levels of the topic presented on (Kang et al., 2018). With the test being used for continuing education purposes, the difficulty of the questions will range from low to moderate in difficulty.

Scoring Procedures to be Used

The goal is to use a separate answer sheet that will be then utilized to develop an analysis report.

Item Format

The test will be a selected response multiple choice format

Test Blueprint

Content	**Level of Cognitive Skill**				
	K	C	AP	AN	Total
Therapeutic Communication	1		1	1	3
Therapeutic Provider-Client Relationship			1	1	2
Principles of Therapeutic Communication	1		1	1	3
Important Therapeutic Communication Techniques	1	1	1	1	4
Problem Solving with Therapeutic Communication				1	1
Listening Techniques		1		1	
Total	3	2	4	6	15

General Directions

This test consists of fifteen (15) multiple-choice questions. Each question is a multiple-choice question with four answer choices that are graded equally. Read each question and answer choice carefully and choose the ONE best answer. Try to answer all questions. In general, if you have some knowledge about a question, it is better to try to answer it. You will not be penalized for guessing.

Principles of Therapeutic Communication Quiz

1. What is therapeutic communication?

    a. Communication used to advise patients of their wants and needs and is done during every session

    b. One which is perceived by patients to encompass caring and supportive behavior in a safe environment

    c. Caring and supportive communication in which, reassurance, approval and probing or defending is utilized

    d. Ability to discourage client from further expression of feelings or downplaying their thoughts

    Answer: B Therapeutic Communication

    Rationale: Therapeutic communication is defined as one which is perceived by patients to encompass caring, and supportive nonjudgmental behavior, embedded in a safe environment during an often stressful period (Kornhaber, Walsh, Duff & Walker, 2016).

2. Mental health providers need to know how to gain trust and gather information from ____________ to involve them in an effective treatment plan

    a. Patient

    b. Patient's family

    c. Patient's friends

    d. All of the above

    Answer: D Therapeutic Provider-Client Relationship

Rationale: Mental health providers must understand and know how to gain trust and be able to gather important and relevant information from the patient and possibly their friends or family (Kornhaber, Walsh, Duff & Walker, 2016).

3. When implementing the principles of therapeutic communication in practice, providers must place the primary focus on whom?

   a. Themselves

   b. Patient

   c. Patient's family

   d. Staff

   Answer: B Principles of Therapeutic Communication

   Rationale: A provider's primary focus when implementing therapeutic communication in practice is to focus primarily on the patient and not on other people. (Epstein, Borrell, and Caterina, 2000).

4. Providers must possess self-understanding and self-awareness to effectively promote ____________.

   a. Rapport building

   b. Alliance

   c. Therapeutic use of self

   d. Processing

   Answer: C Therapeutic Provider-Client Relationship

   Rationale: Therapeutic use of self is the ability to use the provider's personality in attempt to establish relatedness and to structure interventions. For this to be accomplished, providers must possess self-understanding and self-awareness, in order to effectively promote therapeutic use of self. (Epstein, Borrell, and Caterina, 2000).

5. Define the importance of utilizing Non-verbal communication within practice?

   a. Non-verbal communication gives patients time to come up with reasons for what occurred

   b. Non-verbal communication may lead to weak client-provider relationship

   c. Non-verbal communication promotes discussion on expressing uncertainty

d. Non-verbal communication plays a significant role in improving one's ability to relate, engage, and establish interaction in practice

Answer: D Principles of Therapeutic Communication

Rationale: Therapeutic use of self is the ability to use the provider's personality in attempt to establish relatedness and to structure interventions. For this to be accomplished, providers must possess self-understanding and self-awareness, in order to effectively promote therapeutic use of self. (Epstein, Borrell, and Caterina, 2000).

6. How does using *silence help* within a provider-client interaction?

   a. Promotes client to take control of the discussion, if he or she desires

   b. Allows client to understand themselves better through the provider doing majority of the talking

   c. Establishes boundaries for clients to not speak until asked questions

   d. Enhances the providers ability determine the need for discussion

   Answer: A Important Therapeutic Communication Techniques

   Rationale: Silence help allows clients to take control of the discuss, if he or she so desires to during interaction and conversation (Epstein, Borrell, and Caterina, 2000).

7. What is achieved using the problem-solving model?

   a. Goals

   b. Feelings

   c. Negativity

   d. Undesirable outcomes

   Answer: A Problem Solving with Therapeutic Communication

   Rationale: Therapeutic communication often utilizes the problem-solving model to help patient's understand and focus on achieving their goals (Epstein, Borrell, and Caterina, 2000).

8. How does *giving broad openings* help provider-client interaction?

   a. It provides a specific topic to discuss

   b. It allows client to select the topic to discuss

c. It allows client to stay on track within the conversation

d. It allows clients to indicate awareness of their problem

Answer: B Important Therapeutic Communication Techniques

Rationale: Broad opening is an important technique to utilize among the provider-client interaction due to encouraging the patient to select the topic they want to discuss and work on (Epstein, Borrell, and Caterina, 2000).

9. What is the most important skill for providers to implement when establishing an interpersonal relationship within a psychiatric facility?

a. Self-awareness

b. Therapeutic communication

c. Respect

d. Empathy

Answer: B Therapeutic Communication

Rationale: Studies have shown that provider working with patients suffering from mental health disorders, must recognize that therapeutic communication is the most important skill utilized when establishing an interpersonal relationship (Abdolrahimi, Ghivasvandian, Zakerimoahadam, & Ebadi, 2017).

10. It is important to understand as providers that you must only disclose __________ information when it is therapeutic

a. Other patients'

b. Organizational

c. Personal

d. Processing

Answer: C Principles of Therapeutic Communication

Rationale: Discussing personal information can potentially interrupt the therapeutic process and relationship between a provider and patient. Providers must only self-disclose personal information when it is utilized in a therapeutic manner (Epstein, Borrell, and Caterina, 2000).

11. What is ***not*** part of behaviors used in establishing active listening by the provider?

   a. Relaxing

   b. Touching

   c. Uncrossing Legs

   d. Closing

   Answer: D Listening Techniques

   Rationale: Establishing a proper position through several nonverbal behaviors is important. Through behaviors from SURETY, providers are able to establish active listening through sitting at an angle to the patient, uncrossing legs and arms, relaxing, providing eye contact, touching and providing your intuition, but not with closing (Stickely, 2011).

12. To listen actively is to be attentive to what client is saying, both _____ and _______.

   a. Verbally and Nonverbally

   b. Actively and Verbally

   c. Literally and Hypothetically

   d. Verbally and Persuasively

   Answer: A Listening Techniques

   Rationale: Establishing a proper position through several nonverbal behaviors is important. Through behaviors from SURETY, providers establish active listening by understanding what the patient is saying, both verbally and nonverbally, to facilitate a practical therapeutic space (Stickely, 2011).

13. General leads are important because they …

   a. Encourage client to stop talking

   b. Encourage client to think about what they are saying

   c. Encourage client to continue

   d. Encourage client to make observations

   Answer: C Important Therapeutic Communication Techniques

Rationale: General lead is an important technique to utilize among the provider-client interaction due to encouraging the patient to continue and expand on what they are explaining (Epstein, Borrell, and Caterina, 2000).

14. Is reflecting a therapeutic communication technique or a non-therapeutic communication technique?

    a. Therapeutic communication technique

    b. Non-therapeutic communication technique

    c. Both

    d. None of the above

    Answer: A Important Therapeutic Communication Techniques

    Rationale: Reflecting is an important technique to utilize among the provider-client interaction as it directs questions or feelings back to the client so they may recognize or accept their behaviors (Epstein, Borrell, and Caterina, 2000).

15. What is ***not*** an attribute of therapeutic relationships?

    a. Rapport

    b. Trust

    c. Respect

    d. Truthful

    Answer: A Therapeutic Communication

    Rationale: The 5 attributes that are requirements needed establish a therapeutic communication include: rapport, trust, respect, genuineness and empathy. Truthful is not one of those attributes. (Kornhaber, Walsh, Duff, & Walker, 2016).

Experts Rating Form Instructions

Rating instructions: For each item, please indicate the following:

Please rate how relevant each item is to the overall construct of early sepsis identification and care by placing a number in the first box to the right of each item.

1 = Not relevant at all

2 = Slightly relevant

3 = Moderately relevant

4= Highly relevant

Your honest feedback is appreciated and will be used to enhance the quality of this questionnaire.

Expert Rating Form

Item	Relevance Rating
1. What is therapeutic communication? a. Communication used to advise patients of their wants and needs and is done during every session b. One which is perceived by patients to encompass caring and supportive behavior in a safe environment c. Caring and supportive communication in which, reassurance, approval and probing or defending is utilized d. Ability to discourage client from further expression of feelings or downplaying their thoughts	4
2. Mental health providers need to know how to gain trust and gather information from ____________ to involve them in an effective treatment plan a. Patient b. Patient's family c. Patient's friends d. All of the above	4
3. When implementing the principles of therapeutic communication in practice, providers must place the primary focus on whom? a. Themselves b. Patient c. Patient's family	4

d. Staff	
4. Providers must possess self-understanding and self-awareness to effectively promote _____________. a. Rapport building b. Alliance c. Therapeutic use of self d. Processing	4
5. Define the importance of utilizing Non-verbal communication within practice? a. Non-verbal communication gives patients time to come up with reasons for what occurred b. Non-verbal communication may lead to weak client-provider relationship c. Non-verbal communication promotes discussion on expressing uncertainty d. Non-verbal communication plays a significant role in improving one's ability to relate, engage, and establish interaction in practice	4
6. How does using *silence help* within a provider-client interaction? a. Promotes client to take control of the discussion, if he or she desires b. Allows client to understand themselves better through the provider doing majority of the talking c. Establishes boundaries for clients to not speak until asked questions d. Enhances the providers ability determine the need for discussion	4

7. What is achieved using the problem-solving model? a. Goals b. Feelings c. Negativity d. Undesirable outcomes	4
8. How does *giving broad openings* help provider-client interaction? a. It provides a specific topic to discuss b. It allows client to select the topic to discuss c. It allows client to stay on track within the conversation d. It allows clients to indicate awareness of their problem	4
9. What is the most important skill for providers to implement when establishing an interpersonal relationship within a psychiatric facility? a. Self-awareness b. Therapeutic communication c. Respect d. Empathy	4
10. It is important to understand as providers that you must only disclose __________ information when it is therapeutic a. Other patients' b. Organizational c. Personal	4

d. Processing	
11. What is *not* part of behaviors used in establishing active listening by the provider? a. Relaxing b. Touching c. Uncrossing Legs d. Closing	4
12. To listen actively is to be attentive to what client is saying, both _____ and _______. a. Verbally and Nonverbally b. Actively and Verbally c. Literally and Hypothetically d. Verbally and Persuasively	4
13. General leads are important because they … a. Encourage client to stop talking b. Encourage client to think about what they are saying c. Encourage client to continue d. Encourage client to make observations	4
14. Is reflecting a therapeutic communication technique or a non-therapeutic communication technique? a. Therapeutic communication technique	4

b. Non-therapeutic communication technique c. Both d. None of the above	
15. What is *not* an attribute of therapeutic relationships? a. Rapport b. Trust c. Respect d. Truthful	4

Name: Rhone D'Errico

Date: March 26, 2020

Item	Relevance Rating
1. What is therapeutic communication? a. Communication used to advise patients of their wants and needs and is done during every session b. One which is perceived by patients to encompass caring and supportive behavior in a safe environment c. Caring and supportive communication in which, reassurance, approval and probing or defending is utilized d. Ability to discourage client from further expression of feelings or downplaying their thoughts	4
2. Mental health providers need to know how to gain trust and gather information from ____________ to involve them in an effective treatment plan a. Patient b. Patient's family c. Patient's friends d. All of the above	4
3. When implementing the principles of therapeutic communication in practice, providers must place the primary focus on whom? a. Themselves b. Patient c. Patient's family	4

d. Staff	
4. Providers must possess self-understanding and self-awareness to effectively promote _____________. a. Rapport building b. Alliance c. Therapeutic use of self d. Processing	4
5. Define the importance of utilizing Non-verbal communication within practice? a. Non-verbal communication gives patients time to come up with reasons for what occurred b. Non-verbal communication may lead to weak client-provider relationship c. Non-verbal communication promotes discussion on expressing uncertainty d. Non-verbal communication plays a significant role in improving one's ability to relate, engage, and establish interaction in practice	4
6. How does using *silence help* within a provider-client interaction? a. Promotes client to take control of the discussion, if he or she desires b. Allows client to understand themselves better through the provider doing majority of the talking c. Establishes boundaries for clients to not speak until asked questions d. Enhances the providers ability determine the need for discussion	4

7. What is achieved using the problem-solving model? a. Goals b. Feelings c. Negativity d. Undesirable outcomes	4
8. How does *giving broad openings* help provider-client interaction? a. It provides a specific topic to discuss b. It allows client to select the topic to discuss c. It allows client to stay on track within the conversation d. It allows clients to indicate awareness of their problem	4
9. What is the most important skill for providers to implement when establishing an interpersonal relationship within a psychiatric facility? a. Self-awareness b. Therapeutic communication c. Respect d. Empathy	4
10. It is important to understand as providers that you must only disclose __________ information when it is therapeutic a. Other patients' b. Organizational c. Personal	4

d. Processing	
11. What is *not* part of behaviors used in establishing active listening by the provider? a. Relaxing b. Touching c. Uncrossing Legs d. Closing	4
12. To listen actively is to be attentive to what client is saying, both _____ and _______. a. Verbally and Nonverbally b. Actively and Verbally c. Literally and Hypothetically d. Verbally and Persuasively	4
13. General leads are important because they … a. Encourage client to stop talking b. Encourage client to think about what they are saying c. Encourage client to continue d. Encourage client to make observations	4
14. Is reflecting a therapeutic communication technique or a non-therapeutic communication technique? a. Therapeutic communication technique	4

b. Non-therapeutic communication technique c. Both d. None of the above	
15. What is *not* an attribute of therapeutic relationships? a. Rapport b. Trust c. Respect d. Truthful	4

Name: Dr. Farhad Nikoo, DNP, FNP-BC, PMHNP-BC

Date: 03/26/2020

Expert Rating Form

Item	Relevance Rating
1. What is therapeutic communication? a. Communication used to advise patients of their wants and needs and is done during every session b. One which is perceived by patients to encompass caring and supportive behavior in a safe environment c. Caring and supportive communication in which, reassurance, approval and probing or defending is utilized d. Ability to discourage client from further expression of feelings or downplaying their thoughts	4
2. Mental health providers need to know how to gain trust and gather information from ____________ to involve them in an effective treatment plan a. Patient b. Patient's family c. Patient's friends d. All of the above	4
3. When implementing the principles of therapeutic communication in practice, providers must place the primary focus on whom? a. Themselves b. Patient c. Patient's family	4

d. Staff	
4. Providers must possess self-understanding and self-awareness to effectively promote _____________. a. Rapport building b. Alliance c. Therapeutic use of self d. Processing	4
5. Define the importance of utilizing Non-verbal communication within practice? a. Non-verbal communication gives patients time to come up with reasons for what occurred b. Non-verbal communication may lead to weak client-provider relationship c. Non-verbal communication promotes discussion on expressing uncertainty d. Non-verbal communication plays a significant role in improving one's ability to relate, engage, and establish interaction in practice	4
6. How does using *silence help* within a provider-client interaction? a. Promotes client to take control of the discussion, if he or she desires b. Allows client to understand themselves better through the provider doing majority of the talking c. Establishes boundaries for clients to not speak until asked questions d. Enhances the providers ability determine the need for discussion	4

7. What is achieved using the problem-solving model? a. Goals b. Feelings c. Negativity d. Undesirable outcomes	4
8. How does *giving broad openings* help provider-client interaction? a. It provides a specific topic to discuss b. It allows client to select the topic to discuss c. It allows client to stay on track within the conversation d. It allows clients to indicate awareness of their problem	4
9. What is the most important skill for providers to implement when establishing an interpersonal relationship within a psychiatric facility? a. Self-awareness b. Therapeutic communication c. Respect d. Empathy	4
10. It is important to understand as providers that you must only disclose __________ information when it is therapeutic a. Other patients' b. Organizational c. Personal	4

d. Processing	
11. What is *not* part of behaviors used in establishing active listening by the provider? a. Relaxing b. Touching c. Uncrossing Legs d. Closing	4
12. To listen actively is to be attentive to what client is saying, both _____ and _______. a. Verbally and Nonverbally b. Actively and Verbally c. Literally and Hypothetically d. Verbally and Persuasively	4
13. General leads are important because they … a. Encourage client to stop talking b. Encourage client to think about what they are saying c. Encourage client to continue d. Encourage client to make observations	4
14. Is reflecting a therapeutic communication technique or a non-therapeutic communication technique? a. Therapeutic communication technique	4

b. Non-therapeutic communication technique c. Both d. None of the above	
15. What is *not* an attribute of therapeutic relationships? a. Rapport b. Trust c. Respect d. Truthful	4

Name: Samantha Peckham

Date: 03/26/20

Appendix D

PRE AND POST QUIZ SCORE SHEET

Participant 3 Digit Code	Pre- Score	Post- Score

Appendix E

Chart Audit Tool

Grid for Baseline Data Collection – Data Collector will review total number of appointments that were initial medication management follow-ups 3-months prior to intervention.

	Number of Clients
SHOWED	
NO SHOW	

Grid for Post-Intervention Data Collection – Data Collector will review total number of appointments that were initial medication management follow-ups after intervention.

	Number of Clients
SHOWED	
NO SHOW	

Appendix F

Educational Presentation

By: Medard Sison, PMHNP-BC

- What is Therapeutic Communication?
- Why is Therapeutic Communication Important?
- Therapeutic Provider-Client Relationship
- Components of a Therapeutic Provider-Client Relationship
- Therapeutic Use of Self
- Requirements for Therapeutic Relationship
- Principles of Therapeutic Communication
- Importance of Non-verbal Communication
- Establishing Active Listening
- Interpersonal Communication
- Important Therapeutic Communication Techniques to Utilize During Provider-Client Interaction
- Problem Solving Through Therapeutic Communication
- Video

- Therapeutic communication is defined as one which is perceived by patients to encompass caring, and supportive nonjudgmental behavior, embedded in a safe environment during an often stressful period.
- Therapeutic communication is a tool for provision of healthcare through empathy and respecting interpersonal boundaries

(Kornhaber, Walsh, Duff & Walker, 2016)

What is Therapeutic
Communication?

- Therapeutic communication is defined as one which is perceived by patients to encompass caring, and supportive nonjudgmental behavior, embedded in a safe environment during an often stressful period.
- Therapeutic communication is a tool for provision of healthcare through empathy and respecting interpersonal boundaries

(Kornhaber, Walsh, Duff & Walker, 2016)

The nurse-client relationship is foundational for psychiatric-mental health nursing.

- A therapeutic provider-client relationship is the process by which providers provide care for patients that are in need of psychosocial intervention
- Mental health providers must understand and know how to gain trust and be able to gather important and relevant information from the patient and family
- The use of this information is what is needed to develop an effective plan of care
- As a provider, you must understand the components of the Therapeutic Provider-Client Relationship

(Kornhaber, Walsh, Duff & Walker, 2016)

- Therapeutic Use of Self
- Requirements of Therapeutic Relationship
- Phases of a Therapeutic Provider-Client Relationship

(Epstein, Borrell, and Caterina, 2000)

Therapeutic Use of Self

- Therapeutic Use of Self is defined as the ability to use one's personality in attempt to establish relatedness and to structure interventions
- Providers must possess self-understanding and self-awareness to effectively promote therapeutic use of self

(Epstein, Borrell, and Caterina, 2000)

Requirements for Therapeutic Relationship

- **5 attributes for establishing a therapeutic relationship**

1. **Rapport**
2. **Trust**
3. **Respect**
4. **Genuineness**
5. **Empathy**

(Kornhaber, Walsh, Duff & Walker, 2016)

- Pre-interaction phase
- Orientation/Introductory Period
- Working
- Termination

(Epstein, Borrell, and Caterina, 2000)

- Primary focus is to focus primarily on patient
- Always maintain a professional attitude
- Self disclose personal only in therapeutic purposes
- Preserve patient confidentiality
- Avoid social relationship with patient
- Avoid giving advice
- Avoid being judgmental

(Epstein, Borrell, and Caterina, 2000)

Importance of Non-Verbal Communication

- Non-verbal communication plays a significant role among the provider-patient relationship as it can improve one's ability to relate, engage, and establish interaction in their everyday life
- Understanding the importance of this level of communication may lead to stronger patient-provider relationships

(Epstein, Borrell, and Caterina, 2000)

Establishing Active Listening

- Establishing a proper position through several nonverbal behaviors when listening is important.
- Through these behaviors, Providers establish active listening by understanding what the patient is saying, both verbally and nonverbally and facilitates a practical therapeutic space
- These behaviors include: **SURETY**
  - **S** – Sit at an angle to patient
  - **U** – Uncross legs and arms
  - **R** - Relax
  - **E** – Eye Contact
  - **T** - Touch
  - **Y** - Your intuition

(Stickely, 2011)

Interpersonal Communication

- Interpersonal communication is a transaction between patient and provider with simultaneous participation
- Patient and provider perceive each other, listen to one another and engage to create a meaningful relationship

(Epstein, Borrell, and Caterina, 2000)

Important Therapeutic Communication Techniques to Utilize During Provider-Client Interaction

- **Using silence** - allows client to take control of the discussion, if he or she so desires
- **Accepting** - conveys positive regard
- **Giving recognition** - acknowledging, indicating awareness
- **Offering self** - making oneself available
- **Giving broad openings** - allows client to select the topic
- **Offering general leads** - encourages client to continue
- **Placing the event in time or sequence** - clarifies the relationship of events in time
- **Making observations** - verbalizing what is observed or perceived
- **Encouraging description of perceptions** - asking client to verbalize what is being perceived
- **Encouraging comparison** - asking client to compare similarities and differences in ideas, experiences, or interpersonal relationships

(Epstein, Borrell, and Caterina, 2000)

Important Therapeutic Communication Techniques to Utilize During Provider-Client Interaction

- **Restating** - lets client know whether an expressed statement has or has not been understood
- **Reflecting** - directs questions or feelings back to client so that they may be recognized and accepted
- **Focusing** - taking notice of a single idea or even a single word
- **Exploring** - delving further into a subject, idea, experience, or relationship
- **Seeking clarification and validation** - striving to explain what is vague and searching for mutual understanding
- **Presenting reality** - clarifying misconceptions that client may be expressing
- **Voicing doubt** - expressing uncertainty as to the reality of client's perception
- **Verbalizing the implied** - putting into words what client has only implied
- **Attempting to translate words into feelings** - putting into words the feelings the client has expressed only indirectly
- **Formulating plan of action** - striving to prevent anger or anxiety escalating to unmanageable level when stressor recurs

(Epstein, Borrell, and Caterina, 2000)

Problem Solving Through Therapeutic Communication

Goals are often achieved through the use of the *problem-solving model:*

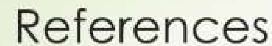
- Identify the patient's problem.
- Promote discussion of desired changes.
- Discuss aspects that cannot realistically be changed and ways to cope with them more adaptively.
- Discuss alternative strategies for creating changes the patient desires to make.
- Weigh risk and benefits of each alternative.
- Help patient select an alternative.
- Encourage patient to implement the change.
- Provide positive feedback for patient's attempts to create change.
- Help patient evaluate outcomes of the change and make modifications as required.

(Epstein, Borrell, and Caterina, 2000)

https://www.youtube.com/watch?v=Vz1224g1HB8

- Effective communication is the core skill in mental health care in primary care settings.
- The utilization of effective therapeutic communication can enhance your relationship with the patient and can be used to help improve the quality of care being provided
- Utilizing the therapeutic communication techniques can make a positive impact on your patients experience

(Epstein, Borrell, and Caterina, 2000)



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