

“Talking Control” as a Method to Improve Patient Satisfaction with Staff Communication in the Dialysis Setting

DeeDee Velasquez-Peralta, LMSW, Anna Ramirez, MPH, CPH, Heartland Kidney Network, Kansas City, MO; Judith Beto, PhD, RD, FADA LD, Loyola University Health Systems, Maywood, IL

Heartland Kidney Network developed the Take 5 to Tune In project utilizing the technique of “talking control” to improve communication between staff and patients in the dialysis facility. Face-to-face talking control encounters with a five-minute minimum were conducted with patients from June 1, 2014, through September 30, 2014. Five questions from the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) experience of care survey were used to evaluate the success of the project. Overall, there was an increase of 5 percentage points in the combined rate of positive responses to the five ICH CAHPS questions. Talking control is an effective and simple means to improve dialysis provider communication and patients’ satisfaction with their care.

INTRODUCTION

Heartland Kidney Network promotes high quality care for dialysis and kidney transplant patients in Iowa, Kansas, Missouri, and Nebraska. To ensure that quality standards are met, Heartland Kidney Network leads and coordinates quality improvement activities (QIAs) throughout the four-state area. Patients’ perceptions of the quality of healthcare they receive are highly dependent on the quality of their interactions with their healthcare clinicians and team (Institute for Healthcare Communication, 2011). As described in the Institute of Medicine’s report Crossing the Quality Chasm (2001), patient-centered care is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Effective communication is a cornerstone of high-quality patient-centered care (Guastello & Hale, 2014). In order to respond to the unique needs, values, and preferences of individual patients, healthcare professionals should incorporate communication skills, such as open-ended inquiry, reflective listening, and empathy in their interactions with patients.

Positive communication techniques work in partnership with other key elements to have an impact on patient satisfaction. In a review of medical literature, Carolyn Thiedke, MD, examined the patient-related factors, physician-related factors, and system-related factors impacting patient satisfaction with family physicians (2007). The physician-related factors contributing to patient satisfaction include:

- **Communication:** Healthcare providers take a problem seriously, explain information clearly, and try to understand the patient’s experience.
- **Expectations:** The patient has the opportunity to tell his or her story.
- **Control:** The patient is encouraged to express their ideas, concerns, and expectations.

- **Decision-making:** The patient’s social and mental functioning is acknowledged as much as physical functioning.
- **Time spent:** Patient satisfaction rates improve with length of time spent.
- **Technical skills:** Physicians’ technical skills impact on patient satisfaction varied in the studies reviewed.
- **Appearance:** Patients appear to respond to a physician’s appearance, preferring semi-formal attire and a smile.

The study suggests that treating patients with dignity and inviting them to partner in healthcare decisions can improve patient satisfaction. The dialysis setting differs in that although the physician is required to visit monthly, they are not “primary” care providers. Patient satisfaction for dialysis patients also includes the staff (nurses, dialysis technicians, social workers, and dietitians) who provide care on a daily basis. Patients are more likely to be satisfied with their care when they feel that providers listen carefully, spend time with them, show respect, and demonstrate concern about them as a person.

BACKGROUND

Heartland Kidney Network has found that there are many factors that contribute to patients filing a grievance regarding staff communication. Patients’ experience of care and perception of staff interactions are impacted by the people providing care, the dialysis setting itself, and the culture of the dialysis facility. Per the CMS contract requirements, Heartland Kidney Network conducted a focused audit of grievances reported to the Network from July 1, 2013, through March 31, 2014. Review of 30 grievances identified a common area of concern related to poor staff communication. Of the 30 grievances, 11 grievants (37%) reported communication as a concern. Of those 11, 8 (72%) stated staff did not provide explanations for treatment or actions

taken, four (36%) reported staff did not listen to them, and two (18%) reported that staff were slow to respond. Through root cause analysis, the Network identified additional factors contributing to poor staff-patient communication which included:

- Facility staff members do not take enough time to listen to patients.
- Facility staff members do not follow up with patients after a concern is addressed to assess patient satisfaction.
- Facility staff members assume that the patient understands without confirming comprehension.
- Facility staff members feel rushed.
- Staffing ratios have changed; there are fewer facility staff members to care for more patients.
- Educational opportunities for facility staff members are limited due to availability and affordability. Many organizations no longer provide paid time off to attend conferences.

Based on the results of the focused audit, Heartland Kidney Network developed an innovative quality improvement activity (QIA) to improve staff and patient communication in the dialysis setting. The Network conducted the Take 5 to Tune In project from May 2014 to September 2014.

The Take 5 to Tune In QIA utilized the technique of "talking control" to improve patient and staff communication. Talking control has been utilized successfully in healthcare settings, including primary care and mental health, as a comparator in the evaluation of cognitive-behavior therapy. In a study of depressed older people in primary care, therapists were asked to show interest and warmth while encouraging participants to discuss neutral topics such as hobbies, sports, and current affairs. Therapists did not challenge dysfunctional beliefs, give advice, engage in problem solving, or suggest behavioral tasks (Serfaty, Haworth, Blanchard, Buszewicz, Murad, & King, 2009).

The only study to use talking control in the dialysis setting was in 2012 (Beto, Schury, Nicholas, Moravcik, Baldovino, & Bansal, 2012) at a single independent non-for-profit dialysis center, using the method developed by Serfaty (Serfaty, Csipke, Haworth, Murad, & King, 2011). Talking control consisted of general conversations about lifestyle without the specific intent of educational change. Beto describes talking control as a cognitive behavioral technique used to drive information sharing. It is similar to "befriending," in that it allows staff to develop rapport with patients by engaging them in patient-led "free-floating" conversations. The "talk" is controlled by focusing on factual information while providing warmth and interest, but not focusing on underlying beliefs or emotional problems. In Beto's study, patients were randomly approached to participate until 50 patients were recruited. Two waves of talking control were completed dur-

ing dialysis treatment for a 10–12-week period. Sessions of either 5–10 minutes or 20–30 minutes per week were held over 12 months by a group of 26 interdisciplinary health professionals, including 18 students. A cart with rotating items (pens, notebooks, pill boxes, visual aids, games, brochures, and single serve food items) was used to initiate conversations about potential general lifestyle topics. The results included a 12% increase in the dialysis facility patient satisfaction score from the prior annual patient satisfaction survey, including a higher score on staff involvement in their care compared to pre-talking control. Beto proposed that talking control may be an effective, low-cost patient support technique that can involve all members of the interdisciplinary team.

PROJECT DESIGN

The Network's Take 5 to Tune In QIA was modeled after Dr. Beto's study (Beto, 2014) because it had been successful in including all staff and its ease of use. Several adaptations were made to address CMS timelines, Network limitations, and possible barriers to facility engagement. These included the length of time for the sessions (facility staff often report they do not have enough time). There was no use of a "getting better" cart to minimize the work required by facility staff. The Network's resources were limited and the project only lasted for 4 months.

Following patient selection, facility staff and patients volunteered to participate in the project for 4 months. Staff was asked to complete a five-minute talking control session with each patient who volunteered monthly during their dialysis treatment.

The purpose of the sessions was not to determine an action or intervention but to provide an opportunity for patients to feel that staff was interested in them as individuals. The goal was for the patient to have a positive experience, and was not focused on the content of the discussion. For instance, if the patient shared having gone to a wedding, the staff would not ask if they had gone over their fluid goal, but instead ask about the couple or where the wedding was held.

FACILITY SELECTION

Heartland Kidney Network is the End-Stage Renal Disease (ESRD) Network for the states of Iowa, Kansas, Missouri, and Nebraska. The dialysis patient population in January 2014 was 15,017. The QIA's goal was to include 10% of patients in the Network's four-state service area. The criteria for participation included facilities from the four states that had one or more grievances in the identified topic area of "communication" from July 1, 2013, through March 31, 2014, and facilities with more than 75 patients that had any grievance in 2013. Transplant centers were excluded, as well as facilities with a history of multiple grievances due to a documented mental health diagnosis affecting a patient's perception. Through this process, 17 facilities serving 1,517 patients were selected for participation. Participants includ-

ed both facilities belonging to large dialysis organizations (LDOs) and independent providers. Facilities 1 and 15 were the two independently owned providers, while the others were owned by one of two LDOs serving the region. Three facilities operate in rural communities (facilities 1, 10, and 17) and the remainder in urban areas.

METHODS

On May 12, 2014, a project kick-off webinar was conducted by Dr. Beto and Network staff with facility administrators and social workers identified as project leads. The project leads were trained on the talking control method and project requirements were reviewed. Each facility received an implementation packet with a project overview, staff in-service guide entitled *Take 5 To Tune In* (2014), session tracking form, patient invitation, pre- and post-questionnaires, note cards, and two five-minute sand timers. The Network provided simplified conditions, guidelines, and expectations of the project as shown in **Table 1**.

In May 2014, project leads conducted an in-service for facility staff. All staff was encouraged to participate, including nephrologists, direct care staff, and support staff. Patients were invited to participate in the project as a way to get to know staff better. Staff randomly selected each patient to speak with by drawing a name blindly from a group of patient names. The timing for each patient's monthly Take 5 to Tune In talking control session was unplanned to allow for flexibility. Sessions were held from June 1, 2014, through September 30, 2014.

Sessions were a minimum five-minute face-to-face conversation between a staff member and a patient during dialysis treatment. To provide ongoing support for the project, dialysis staff members were encouraged to attend monthly check-in meetings with Heartland Kidney Network staff and other project participants. These check-in meetings served as a place for facilities to share best practices, and learn from the successes of other participating facilities. This was also an opportunity for the Network to identify any barriers facilities were experiencing, and to assist with strategies for improvement. The feedback collected during these calls was documented in meeting minutes. Facilities were required to track and submit the number of sessions held, as well as patient and staff comments, monthly to the Network through an online survey tool.

Table 1. Conditions, Guidelines and Expectations for Talking Control Sessions

Conditions	<ul style="list-style-type: none"> • Encounters will be random, staff randomly selecting the patient and time • Staff members are seated at eye level at the chairside during a dialysis treatment • A time limit is set at the onset (five minute minimum) • Fellow staff members will provide coverage to allow staff to be fully engaged and free from distraction while participating in a session
Guidelines and Expectations of Staff	<ul style="list-style-type: none"> • Sessions are patient-led • Staff shows enthusiasm and interest towards the patient • Staff "lends a sympathetic ear" towards the patient allowing him/her to share their feelings but then steers the conversation away from more emotional topics • Staff is non-judgmental • Staff focuses on neutral topics such as hobbies, news, or holidays • Staff uses a neutral tone, words, and body language • Staff encourages the patient to talk about their family and friends • Staff uses self-disclosure in moderation
Staff Should Avoid	<ul style="list-style-type: none"> • Setting an agenda for the session • Focusing on a key problem area or treatment-related concern • Trying to collaborate with patients to solve problems • Providing handouts or written materials • Giving specific advice • Providing a plan of action

This project was approved as a Quality Improvement Activity by the Network's Centers for Medicare & Medicaid Services Contract Officer Representative.

MEASURE

The Take 5 to Tune In project utilized the number of grievances related to communication, and the results of five questions from the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) (CMMS & AHRQ, 2005) survey to measure the impact of the project. Grievance data from the patient contact utility (PCU), the CMS-designated case review system for ESRD Networks, was collected monthly from May through September 2014.

The ICH CAHPS survey is a standardized questionnaire produced by the Agency for Healthcare Research and Quality (AHRQ). This survey is designed to measure the experiences of people receiving in-center hemodialysis care from Medicare-certified dialysis facilities. The survey asks questions about dialysis facility staff regarding communication, professionalism, competence, and caring. Patient responses to the questions could be "always," "usually," "sometimes," "never," "yes," or "no." Facilities were provided with the option of either distributing a pre-questionnaire to collect patient responses or sharing their results from the 2013 ICH CAHPS survey. Five questions related to staff interactions were utilized to establish the baseline measure for this QIA. After the project was completed, facilities conducted a post-survey with all facility patients using the same five ICH CAHPS questions. The five questions selected to measure the effectiveness of the Take 5 to Tune In project are shown in **Table 2**.

Table 2. ICH CAHPS Questions Pertaining to Patient Satisfaction with Staff Interactions

Question Number	ICH CAHPS Question
1	In the last 3 months, how often did dialysis center staff listen carefully to you?
2	In the last 3 months, how often did the dialysis center staff show respect for what you had to say?
3	In the last 3 months, how often did the dialysis center staff spend enough time with you?
4	In the last 3 months, how often did you feel the dialysis center staff really care about you as a person?
5	In the last 3 months, how often did you feel comfortable asking the dialysis center staff everything you wanted about dialysis care?

RESULTS

From June 1, 2014, through September 30, 2014, 1,278 Take 5 to Tune In sessions were conducted. This is equivalent to at least 6,390 minutes or 106 hours of one-to-one patient and staff interactions. The monthly average percentage of patient participation was 24% per facility.

PCU data were reviewed monthly, and analyzed to determine the number of grievances related to communication. During the project, there were no grievances reported to the Network regarding communication for the 17 facilities. Data from the five ICH CAHPS questions were collected and analyzed for the 14 facilities that completed the project. Two facilities (Facilities 15 and 16, serving 87 patients), out of the original 17, did not submit post-assessment data, and one facility (Facility 17, serving 22 patients) closed. Data analysis included the percentage of positive responses ("Always," "Usually" or "Yes") to each of the five ICH CAHPS questions per facility pre- and post-intervention. The average percent positive response rate of the five questions was then calculated per facility for pre- and post-data. This data allowed the Network to determine the aggregate improvement of the 14 facilities for the five ICH CAHPS questions. The goal for improvement was to increase the rate of positive responses to the questions by five percentage points.

Facilities had an average of 83% positive responses on all five questions prior to the intervention. Following the intervention, the group's average rate of positive responses increased to 88% (**Figure 1**). The Network's goal was met. Post-intervention data also revealed an overall improvement for seven facilities (Facilities 3, 4, 5, 7, 9, 11, and 14), an overall decrease for six facilities (Facilities 1, 2, 6, 8, 12, and 13), and one facility with no change (Facility 10). Of the facilities that showed an improvement, there was an average of a 14% increase, while the facilities that showed a decline averaged a 6% decrease in positive responses (**Figure 2**). Facilities 4, 5, and 9 presented the greatest opportunities for improvement in satisfaction, and each did. As shown in **Figure 2**, Facility seven had an 11 percentage point increase in the percentage of positive responses. Facility 14 had a seven percentage point increase of positive responses and reported that over 75% of its patients participated in the project. Facility 14 planned to continue conducting Take 5 to Tune In sessions with patients after the conclusion of the project as standard practice, and presented its success to its dialysis company's regional directors for sharing with other dialysis facilities.

Overall, the positive response rate, aggregated across all facilities, improved for each question as shown in **Figure 3**. Question 3 demonstrated a 6% improvement, while questions 4 and 5 both demonstrated 5% improvements.

Individual results were reviewed for each facility. Eight facilities demonstrated improvement in three or more questions. Although six facilities experienced a decline in the aggregate percent of positive responses, every facility but one improved or maintained its score for at least one question. 11 facilities showed improvement in the percentage of posi-

tive responses to question 5. Question 5 is, “In the last three months, how often did you feel comfortable asking dialysis center staff everything you wanted about dialysis care?” One facility maintained 100% positive responses to question 5 and only two facilities showed a decrease.

When the response rate was reviewed, two facilities with a decrease in positive responses (Facilities 8 and 12) had more respondents post-intervention, although when all those with a decrease were reviewed as a group the average difference was -1.33. The aggregate data for Facility 6 changed by -6 in responses; however, when individual questions were reviewed, the facility average percent positive responses improved by 3% from the pre-intervention data.

The location of the facilities did not appear to have an impact the results. Of the three rural clinics, one closed, one showed a decline, and the other showed no improvement or decline. The two facilities that did not complete the project were in urban areas. The results were equally split with seven facilities showing an improvement, and seven a decrease in positive responses.

The facilities with patient participation greater than 60% showed a greater improvement than those with smaller numbers of participants. All facilities (Facilities 7, 9, 14)

that reported an average of 60% or more of patient participation showed an average of 10% improvement. While facilities (Facilities 2, 3, 4, 5, 11, 13) reporting less than 24% had an average of 7% improvement.

Both patient and staff feedback indicated that the project provided positive communication opportunities for all involved. Facility staff shared that although they talk with their patients during each treatment, the sessions provided a unique opportunity because they were able to completely focus on the patient. Participating patients were asked what they liked best about the project.

The responses included such statements as:

- “The staff showed concern about what I had to say.”
- “I enjoyed being able to talk about things that interested me and my family.”
- “Staff was more than willing to listen to things that were interesting to me.”
- “They all seem like family and seem to care about my life away from the dialysis center.”
- “It is good that someone comes and sits with you and is willing to listen to your comments.”
- “Getting to know people and being like family.”

Figure 1. Percentage of Positive Responses for 5 ICH CAHPS Questions Pre- and Post-Intervention

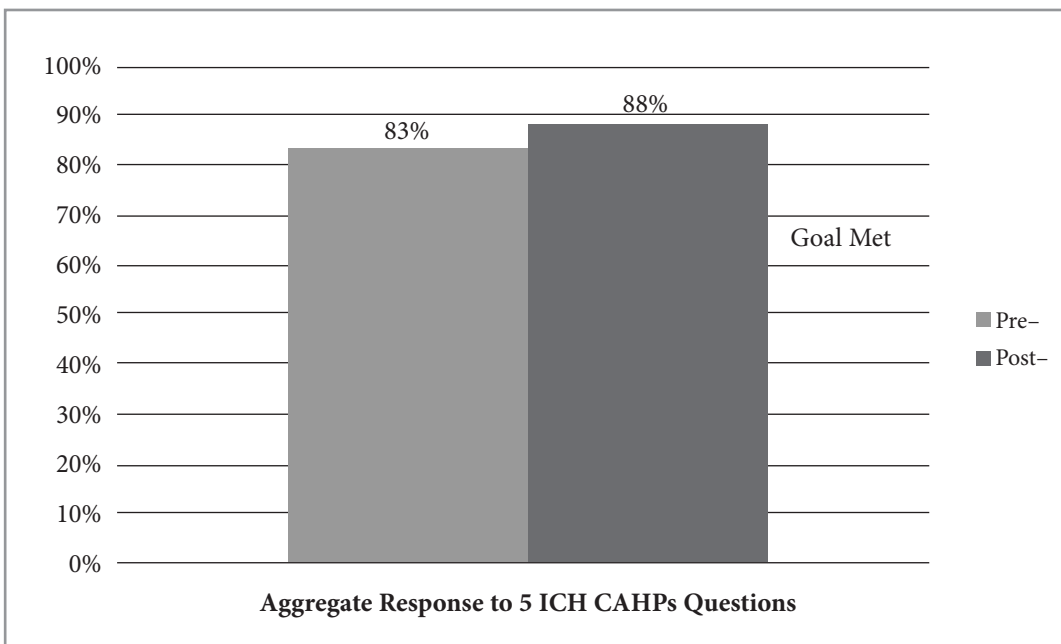
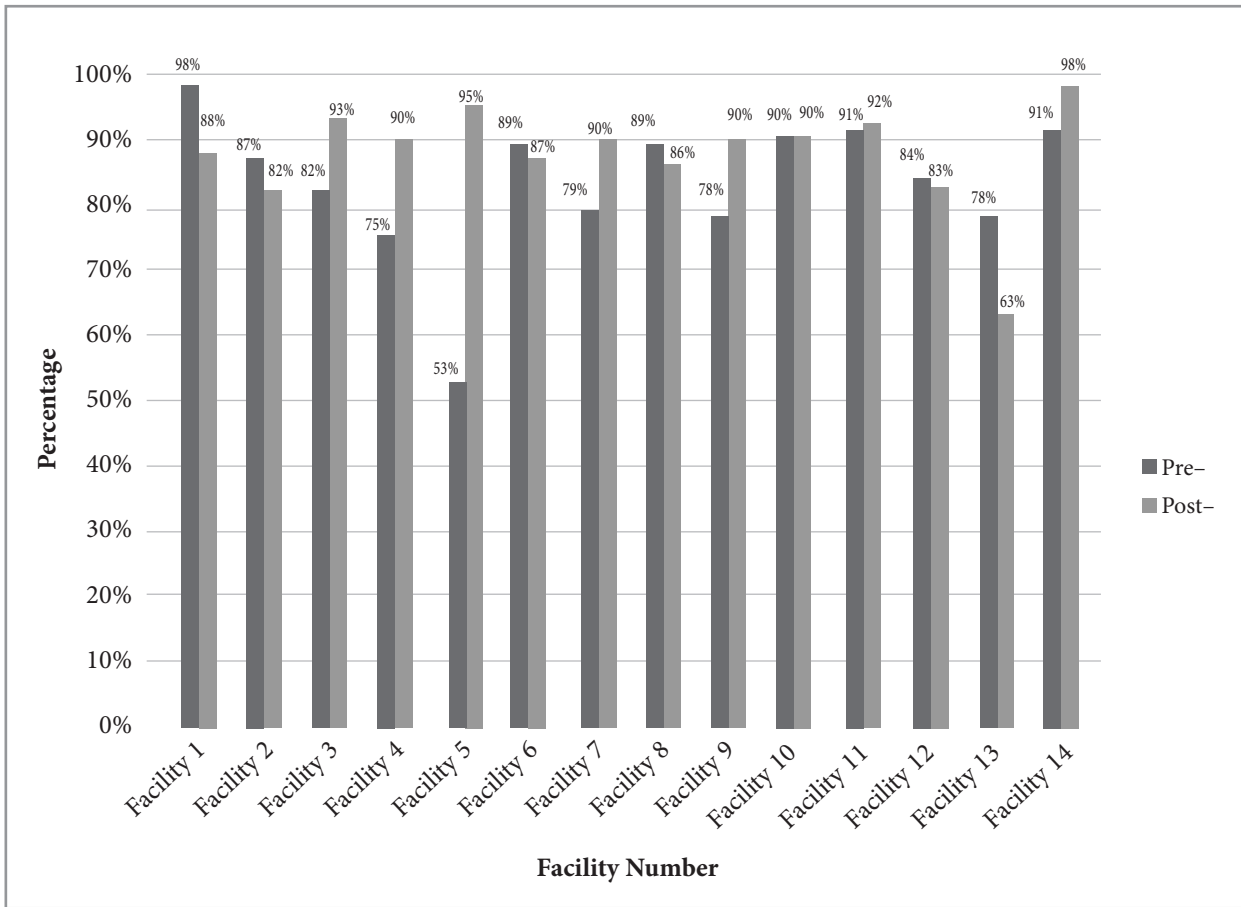


Figure 2. Percentage of Positive Responses for 5 ICH CAHPS Questions for Participating Facilities Pre- and Post-Intervention



When facility staff members were asked what they liked about the project, responses included:

- “It was fun and did not take long.”
- “It was relatively easy to find time to sit and talk with patients.”
- “It is fun to talk about other things and get to know patients better.”
- “Patients remember and look forward to it month to month.”
- “The patients seemed to enjoy some one-on-one time and talked about a lot of things.”
- “The ‘difficult’ patients are even enjoying it.”

Staff shared several concerns and barriers to the project including:

- “Staff turnover has been a challenge.”
- “Staff and patient vacations and hospitalizations were a challenge.”
- “We already do this [talk to our patients].”
- “Community issues impacting the mood in the facility.”
- “There have been a lot of initiatives with the organization and, with new staff training, time has been the barrier.”
- “Project lead is responsible for multiple units and time constraints have been the biggest barrier.”
- “Patients not wanting to do paperwork.”
- “Patients reluctant to share about themselves.”
- “Patients want to sleep through treatment.”
- “Sometimes it’s hard to get away.”

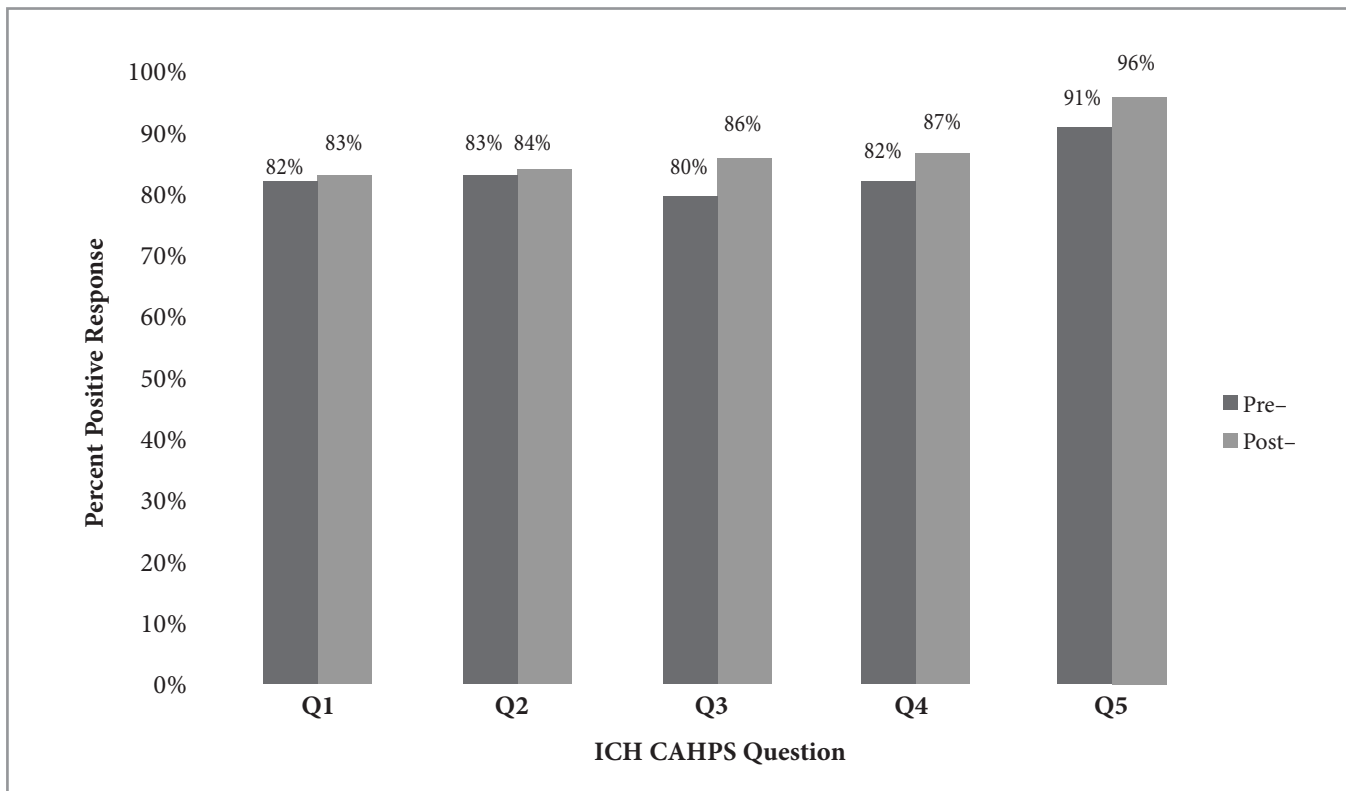


Figure 3. Aggregate Improvement for Each of 5 ICH CAHPS Questions Pre- and Post-Intervention

LIMITATIONS

This project had several limitations that should be considered when planning future implementation. First, the data reviewed represented a small sample size of 30 grievances. This was due to the pre-set parameters by the CMS contract for an audit time period of 15 months. Review of multiple years of data may have provided additional information on the types of grievances received and specific issues presented. Facilities were selected from the small sample size of those that had grievances reported. Secondly, some of the facilities were resistant because leadership did not feel patient grievances were valid. This included the two facilities that did not complete the project by failing to submit the post-assessment results to the Network. These facilities were required to continue the project and follow it within their Quality Assurance and Performance Improvement (QAPI) activities for the remainder of 2014.

Additionally, limited resources, Network staff time constraints, and distance to facilities, were limitations. Although Network staff provided webinar training for project leads, on-site training for each of the facilities was not completed. This limited the ability of the Network to ensure that facility staff were trained effectively, felt confident using talking control, and that the project was implemented as directed. Reliance on anecdotal reporting was a significant limitation.

DISCUSSION

The Take 5 to Tune In project has been recognized as a promising practice due to the innovative approach used. The most common recommendation by the Network to dialysis facilities to improve communication is to provide staff with in-services on professionalism, boundaries, and active listening. Although training is a part of the project, it builds in simple, yet multiple opportunities for patient-staff interactions. This helps the staff build a positive relationship with patients and engenders trust. Although talking control has been utilized successfully in other settings (e.g., primary care and mental health), Dr. Beto's study was the only resource found related to its use in dialysis facilities.

According to the Institute for Healthcare Communication, "The connection that a patient feels with his or her clinician can ultimately improve their health mediated through participation in their care, adherence to treatment, and patient self-management" (Institute for Healthcare Communication, 2011). The improvements made in question 5 demonstrate that participating patients felt more comfortable connecting with their dialysis facility staff and with asking questions about their care after the project.

The Take 5 to Tune In project encouraged patients to express their ideas while providing a safe environment for sharing,

thus improving patient satisfaction with staff interactions. The approach is unique in that, typically, staff-patient interactions in the dialysis facility are initiated by staff who come with an agenda. In contrast, Take 5 to Tune In provides patients with a voluntary, time-limited opportunity for staff's undivided attention, focused on a topic of their choosing. As care providers, staff members have the tendency to use information sharing as "teachable moments"; the talking control sessions required staff to be engaged in what the patient wanted to talk about at the moment. Staff found this to be both difficult and refreshing. Staff from one participating facility indicated that "it was hard to not give advice, but it was fun to just be able to listen." They noted that participating patients enjoyed the time and looked forward to the next session, and many who initially chose not to participate joined later because they "wanted their special time, too."

Ongoing project monitoring through monthly calls allowed the Network to facilitate rapid cycle improvement and the sharing of best practices. Project leads shared strategies they had developed to address common concerns. For example, although all of the facilities received 5-minute timers, some preferred other methods of monitoring time: a clock, cell phone timer, or the dialysis machine timer. Participants encouraged each other by sharing the positive responses they were receiving from patients and staff. Additionally, participating facilities reported that the project encouraged teamwork because of the need to provide coverage for individual staff members to complete Take 5 to Tune In sessions without distraction.

The Network identified some challenges during the project implementation, including facility staff buy-in and project timelines. Lack of time was a barrier for facilities with changing or stretched leadership, but others stated that once training was completed, it was easy to find the time. Staff buy-in was the most significant challenge. Both of the facilities that did not complete the project had project leads who expressed indifference to the project, because they did not feel the grievances were valid. However, the Network found that once a project lead embraced the project and trained staff on how the Take 5 to Tune In sessions were different from their typical interactions, there was an improvement in staff engagement. The need to achieve buy-in caused a delay in some facilities becoming fully engaged. Staff buy-in also may have impacted patient recruitment, because the project may not have been presented in a way that encouraged participation. One facility shared that their patients were more agreeable to participating if it was not presented as a "project" that was being tracked, but that staff was taking extra time to talk with them. Additionally, the limited control the Network had on facility implementation and staff training may be improved by providing opportunities for individual facility staff in-services, and requiring project leaders to verify staff confidence with use of talking control.

CONCLUSION

The Take 5 to Tune In QIA demonstrated that talking control may be a successful strategy to improve communication between dialysis facility staff and patients, as well as improve patients' satisfaction with staff. The use of talking control provided opportunities for patients to have positive interactions in which they felt staff listened carefully, showed respect, and cared about them. Participating facilities learned an innovative method of using ICH CAHPS results to determine potential opportunities for quality improvement. Facilities were encouraged to continue the project as part of their Quality Assurance and Performance Improvement (QAPI) plans. Several dialysis facilities incorporated the talking control sessions into their standard practice, based on the impact of the project. One facility administrator's comment summarizes the impact of the Take 5 to Tune In project:

Being in the project has allowed the facility and staff to move out of their comfort zone to do something different than they have in the past. The project opened the eyes of team-mates; many thought they knew the patients as they talk with them daily, but have found a difference in the conversations. We found that our patients opened up more and shared more information than [we] knew before. Patients really have enjoyed it and want to get more. We are planning to continue to do the project in the facility.

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