5-2018

The Perceived Impact of the See Me as a Person Curriculum from the Facilitators' Perspectives

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The Perceived Impact of the *See Me as a Person* Curriculum from the Facilitators' Perspectives

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Thesis submitted in partial fulfillment of the requirements for the degree of

Master of Arts in Occupational Therapy

May 2018

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The Perceived Impact of the "See Me as a Person" Curriculum from the Facilitators' Perspectives

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Acknowledgements

I am grateful to my thesis advisor, Kristi Haertl for continuously exuding positivity and always sharing her passion; it truly is contagious. I also would like to recognize my thesis readers, Kary Gillenwaters and Karen Sames, for sharing their time and knowledge. I would like to thank Creative Health Care Management for their partnership in this project and allowing me a glimpse into their incredible organization. I am also deeply grateful for the wisdom I gained from my undergraduate education at Luther College. Especially, I would like to acknowledge Dr. Breitenstein. The mantra of his clinical psychology class, "The connection heals," helped guide me down this exciting path, and will inform my practice with patients for years to come.

I would like to express gratitude to my parents who have always modeled hard work and valued education. I am thankful to my family, friends and partner who continuously go out of their way to support my ambitions. Their encouragement has given me the drive to dream big and have the confidence that I might someday reach those dreams.

Dedication

To all healthcare providers: May we never lose sight of what really matters.

To all patients: We see you. We hear you. We are with you.

Abstract

The purpose of this study was to examine the impact of the *See Me as a Person* (*SMAAP*) curriculum from the facilitators' perspectives. Therapeutic use of self (TUS) and client-centered practice have long been a part of many healthcare professions, including occupational therapy (OT). The *SMAAP* curriculum was developed based on the Relationship-Based Care model (RBC) to help foster a relationship-based care culture in organizations. This phenomenological qualitative study was designed using interviews and inductive and deductive analysis. The main research question and additional sub-questions aimed to explore the various impacts of the curriculum. A sample of five facilitators of the *SMAAP* curriculum was recruited through Creative Health Care Management (CHCM). Participants were interviewed about their perceptions of the impacts of the *SMAAP* workshop from the facilitators' perspectives. The study found that components learned during the *SMAAP* workshop could be translated into practice, however, there are often barriers including variance in organizational culture, leadership transitions, and time constraints that make implementation difficult. The study also found that there are particular learning opportunities in the workshop that facilitators found most effective while also identifying ideas to enhance the curriculum. The *SMAAP* workshop is a valuable tool that can be used to help healthcare professionals re-awaken caring behaviors in practice. It is important because previous research shows the positive outcomes of implementing RBC including higher quality of care and cost effectiveness. Overall, the content of the *SMAAP* workshop appears to have a positive impact on organizations.

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Introduction

The collaboration between a client and therapist to achieve desired outcomes has long been a part of many helping professions including occupational therapy (OT), physical therapy, social work, and nursing (Whalley Hammell, 2013). Throughout literature and across disciplines, various terms are used to describe this interaction, including therapeutic use of self (TUS) and client-centered practice.

TUS is heavily influenced by early psychological theories such as the early psychoanalytic theories of Freud, Greenson, and Zetzel (Martin, Garske, & Davis, 2000; Seymour, 2012). Over the years, research in TUS has confirmed that therapeutic relationships impact outcomes of therapy in a variety of disciplines (Martin et al., 2000; Taylor, Lee, Kielhofner & Ketkar, 2009). Another term frequently used when discussing the patient/clinician relationship is client-centered practice. Carl Rogers coined the phrase *client-centered practice* in 1939, and his work was some of the first to explore the concepts of acceptance and genuineness in the therapeutic relationship in psychotherapy (Seymour, 2012). Both of these terms have been widely used and interpreted in various disciplines throughout history. Relationships have become a central part of care as practitioners become more aware of the positive implications of TUS and client-centered practice. For example, the Relationship-Based Care (RBC) model was founded on the principle of relationships with oneself, colleagues, and clients (Koloroutis, 2013).

The present qualitative research study aimed to explore the perceived impact of the *See Me as a Person* (*SMAAP*) curriculum from the facilitators' perspectives. Previous research has indicated the importance of RBC (Boulding, Glickman, Manary, Schulman & Staelin, 2011; Groah, 2014; Jackson, Chamberlin & Kroenke, 2001; Weng et al., 2011; Winsett & Hauck, 2011; Woolley et al., 2012). However, research also shows that there are significant barriers to

implementing RBC (Bauer-Wu & Fontaine, 2015; Cropley, 2012; Lown, Rosen, & Marttila, 2011). In order to facilitate use of RBC, Mary Koloroutis and Michael Trout (2013) founded the *SMAAP* curriculum and made it into a workshop to provide learning experiences to healthcare professionals around the world. Because the *SMAAP* curriculum is based off of the RBC model, one may infer that components of the *SMAAP* curriculum regularly in healthcare practice has positive and significant outcomes for both patients and healthcare providers.

Literature Review

This literature review will first explore the concepts of TUS and client-centered practice and will discuss their connection to OT practice. The literature review will then highlight the general impact of TUS and client-centered practice on OT. Furthermore, the RBC model will be defined and examined in the context of healthcare settings. Both positive outcomes and barriers will be considered. Finally, the literature review will discuss the components and role of the *SMAAP* curriculum. The conclusions from this study will be useful for health care professions, including OT.

Therapeutic Use of Self

The definition of TUS differs among disciplines. From a psychotherapy perspective, TUS is defined as, "the collective and affective bond between therapist and patient" (Martin et al., 2000, p. 438). Other terms are used for TUS to describe the relationship and processes between the therapist and the client including, *therapeutic alliance, working alliance, helping alliance developing rapport, intentional self,* and *therapeutic/conscious use of self* (Martin et al., 2000; Seymour, 2012). While these terms are used interchangeably throughout literature, for the sake of clarity, the present study will use the term TUS defined as a practitioner's, "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 653).

Client-Centered Practice

Carl Rogers (1946) described how the therapist's actions, attitudes, and roles influence therapy. He explained how someone who has developed attitudes that support the wellbeing of the client could better conduct client-centered therapy. Rogers (1946) claimed that the more individuals were able to hold attitudes that valued and respected each individual person, the

easier it was to learn client-centered techniques. As decades passed, researchers highlighted the importance of the history of client-centered practice. Researchers have taken Rogers' work as a call to examine the best way to morally conduct therapy (Grant, 1990). Therefore, therapists have continually shaped the definition of client-centered therapy over the years. Law, Baptiste, and Mills (1995) developed an early definition of client-centered practice. They defined it as, "an approach to service which embraces a philosophy of respect for and partnership with people receiving services (p. 253)." Another early definition created by a different researcher stated that client-centered therapy, "fully respects clients' right to determine their path in life. It makes no assumptions about what people need or how they should be free. It respects clients as authors of their own lives and provides them with a space to rewrite their story" (Grant, 1990, p. 82). TUS and client-centered therapy both have a rich history in psychotherapy practices, however the concepts have been used in other disciplines including OT.

Relationship to Occupational Therapy

Therapeutic use of self. Taylor (2008) identified that within the field of OT there are many terms and definitions that are often used when referring to the TUS. The *Occupational Therapy Practice Framework* (AOTA, 2014) identified TUS as one of the processes used by occupational therapists when delivering services to clients during evaluation, intervention and/or targeting of outcomes. Cole and McLean (2003) interviewed 129 occupational therapists about how they define TUS as well as how they use TUS in practice. From their research, Cole and McLean (2003) defined TUS from an OT perspective as, "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy, and mutual respect" (p. 49). The study found that unlike previous studies, *collaboration* was added to the definition alongside more commonly used terms such as trust,

empathy, rapport, communication, and understanding (Cole & McLean, 2003). Other researchers identified additional ways in which one can use TUS in OT practice including setting attainable goals and helping the client recognize his or her strengths and limitations (Holmqvist, Holmefur, & Ivarsson, 2013). Considering multiple definitions with slightly different meanings makes it understandably difficult for practitioners to fully comprehend the extent of TUS due to the absence of a clear, universal definition. Holmqvist et al. (2013) concluded that a single comprehensible definition of TUS could help occupational therapists become more intentional about how they use themselves throughout rehabilitation. Taylor (2008) asserted that the broad scope of TUS could be one of the contributing factors to the ambiguity of the term. Furthermore, Taylor (2008) noted that there was a lack of clarity on how TUS should be utilized relating to occupational engagement outcomes in OT. Because occupation separates OT from other disciplines that use TUS, it is crucial that occupational engagement is at the center of the definition when used in OT. To address this concern, Taylor (2008) constructed the Intentional Relationship model (IRM) to use as a framework for TUS in OT practice.

The Intentional Relationship Model. The IRM was developed by Taylor (2008). The model consists of four elements: the client, the interpersonal events that occur during therapy, the therapist, and the occupation. The model is intended to address the interplay between these factors of the client-therapist relationship. It helps explain how the relationship can be enhanced despite challenges that might occur, while also navigating how the relationship impacts the client's occupational engagement. The IRM also makes an important distinction between how TUS is used in psychotherapy and how it should be used in OT. In psychotherapy, the interpersonal connection is the main focus, while in OT the primary focus is occupational engagement. TUS is a therapeutic tool one can use along with other OT models to reach the

outcome goal of occupational engagement (Taylor, 2008). The IRM helps OT practitioners understand the role of TUS in their practice. It also provides a framework that can be used as a tool to help practitioners develop their TUS skills.

Client-centered practice. Much like TUS, some OTs claimed that client-centered practice has long been used in OT practice. However, after a literature review in 1995, Law et al. failed to find an OT definition of client-centered practice despite OT guidelines urging practitioners to use client-centered practice. With this inconsistency, it is unrealistic to expect therapists to implement and fully utilize client-centered practice (Law et al., 1995). Therefore, Law et al. (1995) developed a definition of client-centered practice for OT by explaining,

> "Client-centered practice is an approach to providing occupational therapy, which embraces a philosophy of respect for, and partnership with people receiving services. Client-centered practice recognizes the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which a client lives" (p. 253).

More recently, Boyt Schell, Gillen, and Scaffa (2014) developed another definition of client-centered practice. They defined it from an OT perspective as an, "approach to service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy" (p. 1230). Both of these definitions explore the necessity for collaboration between therapist and client. They also highlight the importance of the clients' lived experience when making decisions. These definitions provide therapists with more guidance toward implementing client-centered care into their practice.

Some researchers still believe that existing OT client-centered practice definitions are inadequate. Instead, they believe that occupational therapists are practicing in ways that are not truly client-centered (D'Cruz, Howie, & Lentin, 2016; Gupta & Taff, 2015; Whalley Hammell,

2013). Whalley Hammell (2013) claimed that occupational therapists have defined client-centered practice without integrating clients' perspectives. After reviewing the scarce research that exists on client-centered practice from the clients' perspective, Whalley Hammell (2013) found similarities between clients' and practitioners' definitions of client-centered practice. For example, when asked, clients described client-centered care as being a "collaborative practice undertaken by therapists who clearly value and respect their clients" (p. 175). However, Whalley Hammell (2013) cautioned that there is little current evidence that proves OT is truly client-centered. Therefore, occupational therapists need to further explore their claims to being client-centered because, "occupational therapy discourse and literature appears premised on the assumption that if we are 'doing' occupational therapy, we are inevitably engaged in client-centered practice" (p. 176). Whalley Hammell (2013) made important arguments that should be further explored for OTs to be sure they are engaged in client-centered and evidence-based practice.

D'Cruz et al. (2016) responded to the need for more research on client-centered practice by conducting a study considering client-centered practice from the clients' perspective. They found that clients want therapists to "value and invest in the development of relationships with clients, connecting with each client as a person, not just a client" (p. 36-37). While this feedback is important, other researchers found that implementing client-centered practice is often met with personal and systemic barriers including commitment from the whole organization and individual therapist's attitudes about change (Gupta & Taff, 2015; Wilkins, Pollock, Rochon, & Law, 2001). In addition to microsystem challenges, there are also macrosystem barriers to implementing client-centered practice.

Gupta and Taff (2015) argued that, "the profession's values of client-centered practice are at odds with the values of biomedicine and the corporate culture that drives the health industry in the US" (p. 244). The researchers claimed that in a market economy such as the US, client-centered practice is unrealistic because of systemic pressures like insurance plans that determine the extent of services a practitioner can provide (Gupta & Taff, 2015). While client-centered practice is essential in OT, research shows that it is not seamlessly ingrained in OT practice as most practitioners might believe.

Impact of Client-Centered Practice and Therapeutic Use of Self

Therapeutic use of self in occupational therapy. Many occupational therapists report that TUS is one of the most important skills used in their OT practice. Cole and McLean (2003) surveyed a sample of 129 occupational therapists and concluded that 96.5% of the sample agreed with the statement that, "therapeutic relationships are critical to functional performance" (p. 41). In another study by Taylor, Lee, and Kielhofner (2009) in a sample of 568 occupational therapists, they found that over 80% of the sample agreed with the statement that, "therapeutic use of self was the most important skill in their practice," and that over 90% agreed that, "their relationships with clients affected occupational engagement" (p. 202). These studies suggested that the majority of occupational therapists believe in the importance of TUS.

While some researchers explored the importance of TUS among occupational therapists, a preliminary multiple-case study mixed-methods approach by Morrison and Smith (2013) explored how clinician TUS impacted the client interaction throughout therapy. Like previous researchers, Morrison and Smith (2013) concluded that the interpersonal connection is a vital first step in the therapeutic process. With the established importance of TUS in OT practice, it is important to examine how OTs are trained in TUS.

Therapeutic Use of Self and Client-Centered Practice in Occupational Therapy Education

While TUS appears to be an integral aspect of OT practice as outlined in the *Occupational Therapy Practice Framework* (AOTA, 2014) and the research by Morrison and Smith (2013), many researchers have found that occupational therapists feel that they are not adequately taught TUS during their OT education even though TUS is considered necessary in entry-level OT education (Cole & McLean, 2003; Davidson, 2011; Seymour, 2012; Taylor et al., 2009). In a study including over 500 occupational therapists, results claimed that half of the sample did not feel they were sufficiently trained in TUS before they became practitioners (Taylor et al., 2009). In a different survey of over 100 respondents, the researchers found that the majority of participants gained interpersonal communication skills as practitioners rather than throughout their OT education (Cole & McLean, 2003).

Interestingly, after collecting survey and interview data from various OT programs in the United States, Davidson (2011) concluded that TUS is regularly implemented in entry-level education. The participants collectively felt that implicit teaching methodology (i.e. instructor modeling, lecture, and reading) was too frequently the main mode for teaching TUS leading to lack of interactive learning opportunities for students to engage with TUS material (Davidson, 2011). The study also examined instructional content. They found that the least frequently taught content was, “those related to potential conflict, such as: setting limits, conflict negotiation, dealing with clients’ attempts to coerce or manipulate, dealing with potential aggression, and sharing bad news” (Davidson, 2011, p. 97). The researcher found this unsettling because those cases all have the potential to harm the patient and/or the therapist. Therefore, based on Davidson’s (2011) research, OT students are exposed to TUS content throughout their education,

however, it is limited in methodology and content that could be crucial in guiding the practices of new OT practitioners.

Since some researchers and practitioners feel that TUS is not covered adequately throughout OT curriculum, it is important to note opportunities other researchers and practitioners have discussed for further training in TUS. Seymour (2012) claimed that occupational therapists foster these skills through a combination of, "further training and other continuing professional development (CPD) activities, effective and specific supervision in the use of self, and learning from colleagues and clients" (p. 57). Taylor et al. (2009) also concluded that the majority of their participants gained their background in TUS throughout their fieldwork training and when working within interprofessional teams.

Some researchers have found similar results when examining client-centered practice in OT curricula. Fleming-Castaldy (2015) claimed that OT education too often focuses heavily on the person and the practitioner when considering a client-centered perspective rather than being mindful of a macro perspective, which might include social, economic and political factors. Fleming-Castaldy (2015) claimed that there are currently plenty of strategies in OT education for implementing client-centered practice at a micro level (interpersonal/group interactions), but there are very few strategies for teaching client-centered practice on a macro level. It is important to consider the micro and macro levels when teaching client-centered practice in OT curriculum to ensure current and future OTs are engaged in best practice.

Literature shows that occupational therapists believe TUS and client-centered practice are important in OT practice. However, therapists do not feel adequately prepared to practice TUS when they graduate from OT school (Davidson, 2011), and some educators do not believe that OT students are trained in multiple perspectives regarding client-centered practice (Fleming-

Castaldy, 2015). While enhancing TUS and client-centered education in OT curriculums would be ideal, there are ways OTs can further foster and maintain their skills as practitioners such as practicing relationship-based care.

Relationship-Based Care

The terminology *relationship-based care* is used as a model where relationships are the central focus in order to achieve organization-wide transformation of quality of patient care (Koloroutis, 2013). The RBC Model was developed and trademarked by Creative Health Care Management (CHCM) (See Appendix A). The RBC Model was born out of the field of nursing, but it is now used across disciplines. It is intended to act as a framework for, "aligning values and operations, and an individual way of being" (Koloroutis, 2013, p. 15). One unique aspect of the RBC Model is that RBC does not focus solely on the relationship between the practitioner and client, such as is the focus of TUS research. Rather, it also emphasizes the practitioners' relationships with themselves as well as their colleagues (Koloroutis, 2013). This difference places a greater emphasis on organizational change within health care settings, which promotes a relationship-based culture within the organization. Koloroutis and Abelson (2017) wrote a book, *Advancing Relationship-Based Cultures*, which aims to continue conversation about how to use RBC as a tool to create an optimal healthcare system. As OT research highlighted, prioritizing relationships is essential for the profession (D'Cruz et al., 2016; Morrison & Smith, 2013). For more information about the RBC Model see Appendix B.

Relationship-based care in healthcare settings. Some hospitals are beginning to adopt the RBC Model (Koloroutis, 2014). However, other places are working on implementing only pieces of the RBC Model. For example, some hospitals are placing greater emphasis on clinician wellbeing (Bauer-Wu & Fontaine, 2015). Others are focusing more on the practitioner/client

relationship (Lown et al., 2011), while still others are highlighting relationships among colleagues (Winsett & Hauck, 2011). These researchers have not all claimed to follow the RBC Model (Koloroutis, 2004). However, there are significant parallels to the RBC Model within their research through the focus on either the relationship with self, colleagues or clients.

Bauer-Wu and Fontaine (2015) found that a compassionate care initiative helped to address, "burnout, moral distress, increased potential for errors, and high turnover and decreased satisfaction of clinicians in healthcare" (p. 21). In this particular initiative, they addressed clinician wellbeing in the form of burnout, which aligns with the care of self component of the RBC model (Koloroutis, 2004)

While implementing RBC in the hospital, unit directors evaluated employees based not only on their caring behaviors toward patients, but additionally on their caring behaviors toward other employees on the unit, which is an element of the RBC Model (Koloroutis, 2004). A participant explained the caring behaviors by stating "it was no longer acceptable to discuss and/or complain about someone/something to others" (Winsett & Hauck, 2011, p. 289). Instead, employees were encouraged to hold one another accountable for their actions by addressing problems that arise directly with one another. They found that as they transitioned to an RBC culture, caring for patients improved but they also noted that communication among nurses, physicians and other healthcare professionals improved (Winsett & Hauck, 2011). Therefore, hospitals are beginning to implement RBC in their practice through focusing on the three relationships outlined in the RBC Model. Furthermore, research has indicated that there are significant implications that occur as a result of RBC.

Outcomes. Researchers have identified multiple outcomes of practicing RBC. The two main outcomes of implementing RBC are higher quality of care and cost effectiveness. While research does not yet directly connect these categories to OT, they are both important considerations and have the potential to impact OT practice.

Higher quality of care. RBC and related components have been found to foster a higher quality of care in healthcare settings through a variety of factors including patient safety (Groah, 2014; Woolley et al., 2012), patient satisfaction (Jackson et al., 2001; Lown et al., 2011; Winsett & Hauck, 2011; Weng et al., 2011), and increased adherence to recommended treatments (Lown et al., 2011; Haskard Zolnierek & DiMatteo, 2009). Overall, research shows that after implementing the RBC model, care delivery became more consistent (Cropley, 2012).

Patient safety. One of the ways in which RBC leads to a higher quality of care is through patient safety. Woolly et al., (2012) found that fostering an RBC culture led to an implementation of more preventative measures that contribute to patient safety such as hourly rounding to reposition patients to decrease risk of pressure sores, and offering assistance for the patient to go to the bathroom to help prevent risk of falls. Data from the National Database of Nursing Quality Indicators showed that there was an overall decrease in, "total falls, falls with injury and hospital acquired pressure ulcers" at the hospital after RBC implementation (Woolley et al., 2012, p. 182). Similarly, Groah (2014) found that implementation of RBC reduced the prevalence of hospital-acquired conditions, and helped to improve transitions from the hospital to another setting. The improvement in transitions promoted healing, and clients experienced fewer complications (Groah, 2014).

Patient satisfaction. Increased patient satisfaction after RBC implementation also contributed to higher quality of care (Boulding et al., 2011; Jackson, et al., 2001; Weng et al.,

2011; Winsett & Hauck, 2011). Before implementing RBC, a hospital found that on a 10-point scale their average patient satisfaction was between 8.55-8.81. After implementing RBC for one year, their patient satisfaction scores were over 9.0, which is considered the 99th percentile (Winsett & Hauck, 2011). The increase in satisfaction scores implies that RBC can positively impact patient satisfaction. Similarly Boulding et al., (2011) found that patient satisfaction scores are directly linked to their interactions with healthcare professionals. Other researchers found that immediately after a visit, communication with the doctor was the strongest predictor of satisfaction (Jackson et al., 2001). These findings show that the relationship between client and practitioner is significant when determining patient satisfaction. Existing research shows that implementation of RBC has positively impacted patients' quality of care through increasing patient satisfaction.

Adherence to recommended treatments. In a report from 2003, the World Health Organization determined that the provider-patient relationship was one of the four factors influencing adherence to treatment. Years later, researchers explored how the practitioner-patient relationship, particularly communication, could impact patient's adherence to recommended treatments (Haskard Zolnierek & DiMatteo, 2009). They conducted a meta-analysis that concluded that patient adherence to treatment is related to physician communication. Clients of physicians who communicate effectively have a 19% higher adherence (Haskard Zolnierek & DiMatteo, 2009). They also found that training physicians to be more effective communicators could improve treatment adherence by 12% (Haskard Zolnierek & DiMatteo, 2009). RBC can play a significant role in helping to create a culture of communication among healthcare professionals and their clients, including OT, which has the potential to increase quality of care through adherence to treatment recommendations.

Cost effectiveness. Another outcome of RBC is cost-effectiveness, which has become an important factor in healthcare. In 2012, healthcare reform mandated that reimbursement for services would be determined by, "the quality of the relationships created through pay-for-performance, patient satisfaction reporting, and quality indicators" (Cropley, 2012, p. 338). Given the present-day political climate and healthcare debates, there may be changes that influence reimbursement. Some factors that contribute to cost-effectiveness include a decrease in staff turnover (Cimiotti, Aiken, Soloane, & Wu, 2012; Winsek & Hauck, 2011), a decrease in re-admission (Burt, Berry, & Quackenbush, 2015; Boulding et al., 2011; Cropley, 2012), and reduction in malpractice claims (Levinson, Roter, Mullooly, Dull, & Frankel, 1997).

Decrease in staff turnover. It is widely known that healthcare professionals often experience high stress situations and hold great deals of responsibility in the workplace. One study conducted with nurses found that prior to implementing RBC, a hospital's nurse turnover rate was 9.4%. After one full year of RBC implementation, the turnover rate dropped to 1.9% (Winset & Hauck, 2011). These findings suggest substantial savings on organizational replacement costs for nursing staff. Hospitals that decreased burnout by 30% experienced a significant decrease in hospital-acquired infections, which saved almost $68 million annually (Cimiotti et al., 2012). While it has not yet been studied with other healthcare professionals, it is possible RBC could reduce organizational replacement costs for additional healthcare professionals.

Decreased Readmission. Research has claimed that decreased readmission could reduce healthcare costs. In a study conducted by Jencks, Williams, and Coleman (2009), they found that close to one fifth of Medicare recipients who were discharged from a hospital were readmitted within 30 days. They estimated that unplanned re-admissions cost Medicare about $17.4 billion

in 2004. Additionally, hospitalizations cost approximately one-third of the $2 trillion the United States spends on healthcare (Institute for Healthcare Improvement, 2014). Other researchers observed the costliness and prevalence of readmission and explored whether satisfaction with the discharge process was related to the likelihood of readmission within 30 days (Boulding et al., 2011). They found patients' satisfaction scores were negatively correlated with 30-day readmission. Therefore the researchers concluded that if hospitals were to focus on increasing their patient satisfaction scores from the 25th percentile to the 75th percentile, their sample could have reduced over 14,000 readmissions (Boulding et al., 2011). Other studies have shown practicing RBC was successful in increasing patient satisfaction (Winsett & Hauck, 2011). A study by Burt et al. (2015) also focused on reducing preventable re-hospitalizations within 30 days of discharge. They believed that home health agencies are responsible for limiting re-hospitalizations, and they used the RBC model paired with another model to take action (Burt et al., 2015). They claimed that in order to lower healthcare costs, it is essential to practice RBC with clients and to help them become an active member in managing their illness (Burt et al., 2015). Additionally, Cropley (2012) conducted a study where she examined the relationship between the RBC model and readmission rates within 24 hours and found a significant correlation. Cropley's (2012) research suggests there is a relationship between the RBC model and decreased readmission rates within 24 hours. Due to the costliness of hospital readmissions, fewer readmissions as a result of the RBC model have a significant cost-savings influence.

Reducing malpractice claims. While it appears no research has been done to examine the link between malpractice claims and RBC, some research does suggest that risk for malpractice claims decreases as patient-clinician communication increases (Levinson et al., 1997). The study found that, "what the physician says may be less important than the process and tone of visits for

predicting malpractice claims" (p. 558). Therefore, one can infer that RBC has the potential to help healthcare professionals continue to improve communication skills, which could lead to fewer malpractice claims. Overall, the majority of outcomes discussed directly relate to OT practice, therefore suggesting that implementing RBC could enhance OT practice.

Barriers to relationship-based care. While there are many positive influences of RBC, there are also many barriers to implementing RBC. According to Lown et al., (2011), "53 percent of patients and 58 percent of physicians said that the US health care system generally provides compassionate care" (p. 1774). However they also claimed "seventy-eight percent of physicians said that most health care professionals provide compassionate care, but only 54 percent of patients said they do" (p. 1774). The disparity is concerning because it shows that there is a disconnect between what health care professionals believe to be compassionate care versus clients' perception of compassionate care. However, research shows that health care providers are aware that their compassionate care is not always up to standard. Lown et al. (2011) found that physicians felt that the general healthcare system impacted their ability to administer the kind of care that they would like. Additionally, they found that 53 percent of physicians reported spending less time than they wanted to with their patients (Lown et al., 2011). Bauer-Wu and Fontaine (2015) made an important point stating that cost containment adds stress to healthcare professionals who have the best intentions. They are expected to do high-quality work with limited resources including staff and time. Health care providers are urged to perform expensive and complicated tests and procedures as well as extensive documentation. These tasks all contribute to shifting focus away from RBC (Bauer-Wu & Fontaine, 2015). While there are many barriers to implementing RBC in practice for healthcare

providers, including OTs, Mary Koloroutis and Michael Trout (2012) developed a curriculum that aims to enhance health care providers' ability to practice RBC despite present barriers.

See Me as a Person **Curriculum**

Mary Koloroutis and Michael Trout (2012) developed the *See Me as a Person* curriculum based on the importance of the therapeutic relationship. They explained the therapeutic relationship as when, "the clinician offers care, touch, compassion, presence, and any other act or attitude that would foster healing, and expects nothing in return" (Koloroutis & Trout, 2012, p. 27). The purpose of this relationship is to, "connect with another *as a person* in order to facilitate his or her healing" (Koloroutis & Trout, 2012, p. 28). The focus of the curriculum is not to undermine the importance of clinician's instrumental knowledge. Rather the intent is to find the intersection between instrumental and relational knowledge in order to best facilitate client healing (Koloroutis & Trout, 2012). While developed for a wide-range of individuals, the *SMAAP* curriculum can benefit OTs particularly to help them become more intentional and aware of the importance of relationships with their clients.

Components of the *See Me as a Person* curriculum. The curriculum outlines a specific way of thinking regarding clinician-patient interaction. Koloroutis and Trout (2012) outlined particular practices that are intended to guide this way of thinking. The components include *presence through attunement, wondering, following, and holding* (Koloroutis & Trout, 2012). *Presence through attunement* is described separately from *wondering*, *following,* and *holding* because unlike *wondering, following,* and *holding*, *presence through attunement*, "becomes the container in which the therapeutic relationship occurs" (Koloroutis & Trout, 2012). Therefore, *attunement* must be constant in order to create a space for *wondering, following* and *holding*. Koloroutis and Trout (2012) described *wondering, following* and *holding* as, "ways of thinking,

ways of being, and ways of acting. They facilitate an authentic, healing connection" (p. 49). Therefore, through practicing *attunement* while *wondering, following*, and *holding*, one can learn to hold his or her client at the center of his or her practice.

Presence through attunement. Koloroutis and Trout (2012) defined *attunement* as, "a feeling of harmony or oneness with another being; it is both a way of being and a way of doing. It is the experience of focusing on another person with openness and acceptance" (p. 50). It is essential to use throughout all clinician-client interactions because it helps clients feel safe because they feel the clinician is fully present (Koloroutis & Trout, 2012).

Wondering, following, and holding. These practices were created to help foster a connection between the clinician, the client and the client's family. Often, clients hold all the critical information clinicians need to know. *Wondering, following,* and *holding* all aid the clinician in obtaining that important information from the client (Koloroutis & Trout, 2012). *Wondering* is defined as, "a state of mind characterized by curiosity, openness, and acceptance—a joyful not-knowing and an intentional elimination of our own agenda" (p. 51). *Following* is considered, "a series of intentional acts that demonstrate devotion on the part of the clinician to being lead and taught by the patient and family" (Koloroutis & Trout, 2012, p. 51). The practice of *following* is cultivated by acknowledging the caregivers' responses, allowing the patient and the patient's family to determine the process of care by listening to and acknowledging their history and culture, and also being aware of body language and other non-verbals (Koloroutis & Trout, 2012). Additionally, *holding* is defined as, "a conscious decision to lift up, affirm, and dignify that which the patient or family member has taught, resulting in intense focus on the patient or family member while treasuring both the information and the person" (Koloroutis & Trout, 2012, p. 52). Ways to practice *holding* include speaking and writing about patients with

respect and only with the intention to pass on valuable information, as well as making sure the client knows the contents of his or her care plan and ensuring the healthcare provider responds to emotional situations with non-judgment (Koloroutis & Trout, 2012).

The workshop. The *SMAAP* workshop was designed to bring to life the concepts and ideas explored in the *SMAAP* book. Some topics covered in the workshop include, "the nature of the therapeutic relationship, conditions under which it can be effective, and the knowledge and skills essential for the relationship to happen" (See Me as a Person, 2017, para. 2). Any healthcare professionals including physicians, nurses, rehabilitation therapists, social workers, pastoral care workers, and other professionals can attend the *SMAAP* workshops. It is particularly helpful for healthcare teams to attend the workshops together so they can foster a RBC culture in the workplace. The main goal of the *SMAAP* workshop is to explore and cultivate a better understanding of how therapeutic relationships can be used in the, "highly technical, fast-paced, time-constrained, and frequently chaotic healthcare environment" (See Me as a Person, 2017, para. 5). The workshop is conducted through a series of interactive activities including, "interactive scenarios taken from actual practice, reflective exercises, dialogue, and group and pairs-based exercises" (See Me as a Person, 2017, para. 7). Overall, the workshop is intended to foster a renewed sense of the importance of relationships in healthcare settings.

Conclusion

TUS and client-centered care have been widely used in healthcare to encourage purposeful relationships between clients and their healthcare practitioners. The IRM was created to guide relationship-building between OTs and their clients (Taylor, 2008). Although, researchers have found that definitions of client-centered practice in OT are ambiguous and inconsistent, making it difficult to translate the concept of client-centeredness to OT practice.

Additional barriers to client-centered practice in OT include systems level, therapist level, and client level factors (D'Cruz et al., 2016; Gupta & Taff, 2015; Wilkins et al., 2001). While there are barriers to implementation of TUS and client-centered care in OT, practicing OTs believe that TUS and client-centered care are essential to their work even though practitioners feel inadequately trained in TUS upon graduation from OT programs (Cole & McLean, 2003; Taylor et al., 2009). The RBC Model was created as a guide to aid in maintaining relationships as the central focus in healthcare to improve the overall quality of the healthcare experience (Koloroutis, 2013). RBC can be found in many hospitals and has shown to improve outcomes such as increasing quality of care (Cropley, 2012; Groah, 2014; Haskard Zolnierek & DiMatteo, 2009; Jackson, et al., 2001; Lown et al., 2011; Winsett & Hauck, 2011; Weng et al., 2011; Woolley et al., 2012) and improving cost effectiveness (Burt et al., 2015; Boulding et al., 2011; Cimiotti et al., 2012; Cropley, 2012; Levinson et al., 1997; Winsek & Hauck, 2011). Due to the positive impacts of the RBC Model, the *SMAAP* curriculum and workshop were developed to be facilitated with individuals, including OTs, who are interested in building their interpersonal skills to better serve their clients in practice. The present study explored the impact of the workshop from the facilitators' perspectives. In the following methods section, research techniques for the present qualitative research study are introduced including the purpose, study design, criteria for participation, procedures, and data analysis.

Methods

Purpose

This phenomenological qualitative research study investigated the perceived impact of the *See Me as a Person* (*SMAAP*) curriculum from the facilitators' perspectives. The student researcher became involved after discussions with Dr. Haertl about collaborating on a thesis project. The student researcher conducted five interviews with facilitators of the *SMAAP* curriculum to facilitate a deeper understanding of how well the curriculum translates to practice and what strengths and barriers are present in implementing material learned through the curriculum into everyday practice.

The primary question in this study queried: What is the perceived impact of the *See Me as a Person* curriculum from the facilitators' perspectives? Sub-questions investigated: (a) how well does the curriculum translate to practice, (b) what components of the curricula are effective, (c) what learning opportunities are most effective for translation to practice, (d) what learning opportunities would enhance the curricula, (e) what facets of the relationship between CHCM staff enhance the translation to practice, (f) what are the barriers of translation to practice, and (g) how are the facilitators impacted by delivering the curriculum? These questions were developed through collaboration with Dr. Haertl, Mary Koloroutis, and Kary Gillenwaters in order to explore questions CHCM had about the curriculum, and more broadly, to determine the impact of this specific RBC model in healthcare settings.

Study Design

The present study used a phenomenological research design (See Appendix C) to explore the personal experience of facilitators of the *See Me as a Person* curriculum through narrative. A

phenomenological approach was utilized in order to investigate the meaning and interpretation of the facilitators' experience (Luborsky & Lysack, 2017).

The principal question and sub-questions in this study investigated the impact of the *SMAAP* curriculum from the facilitators' perspectives. The study employed the research design of Creswell and Miller (2000), which includes a primary research question and sub-questions developed by the principal researcher and the student researcher in collaboration with CHCM. After constructing the research questions, the student researcher and principal investigator developed an interview guide (See Appendix D). Patton's (2017) standardized open-ended interview approach guided the construction of the interview guide.

Procedures and Participants

The current project received Institutional Review Board (IRB) approval in June 2017. The project began when Kary Gillenwaters, an alumna of St. Catherine University and current employee at CHCM, felt there was potential for collaboration between St. Kate's and CHCM. She then met with the program director of OT at St. Kate's, Dr. Sames, professor of occupational therapy, Dr. Haertl, and one of the founders of the *SMAAP* curriculum, Mary Koloroutis. The meeting resulted in ideas for research. Additionally, founders, facilitators and participants have put a significant amount of effort and resources into the *SMAAP* curriculum. Therefore, it is crucial to investigate the impacts of the curriculum.

Recruitment

The principal investigator and student researcher wrote a recruitment email (See Appendix E) that an employee of CHCM in a non-leadership role sent out to all trained facilitators of the *SMAAP* curriculum across the country (11 possible participants). Interested participants then emailed the student researcher expressing their interest in the study and the

student researcher sent them additional information including the consent forms. The consent forms explained the study's procedures, risks and benefits, confidentiality, contact information and the voluntary nature of the study (See Appendix F). After reviewing the consent forms, the interested participants set up an in-person or phone interview with the student researcher. Inclusion criteria for the present study included: persons (a) must be 18 or older, and (b) must be a trained facilitator of the *SMAAP* curriculum. In-person or phone interviews were then conducted, audio-recorded, and transcribed by the student researcher. The interviews lasted between 30-60 minutes. One man and four women participated in the study. The five participants had been trained between one and five years as facilitators of the *SMAAP* curriculum.

Data Analysis

Interviews were directly transcribed and both inductive and deductive methods were utilized for data analysis. Inductive reasoning is typically used in qualitative research because it aims to draw generalizations from participants' experiences. Deductive reasoning approaches begin with a broad concept or theory that are used to organize data into the preexisting categories (Patton, 2015; Taylor, Kielhofner, Tsang, & Arbesman, 2017). The type of research design often determines whether the study uses inductive or deductive reasoning to guide analysis. Researchers also may use both inductive and deductive analyses to discover parallel themes and enhance reliability and validity (Patton, 2015; Taylor et al., 2017).

Deductive coding was employed by color-coding each line of the transcription based on the data's relevance to the study's sub-questions. Investigator triangulation was used for inductive analysis using two evaluators to analyze the transcripts for common phrasing and patterns and then comparing findings (Denzin & Lincoln, 2003). Both inductive and deductive results are discussed in the following section.

Results

Inductive and deductive methods were used to analyze results. Deductive findings included synthesis and response to the research sub-questions. The inductive section examined commonalities and themes found through analysis of participant responses. Five facilitators of the *See Me as a Person* curriculum participated in the study. There were 11 possible participants.

Deductive Findings

Translation to practice. Most of the participants explained ways in which the components (*wondering, following, holding* and *attuning*) taught in the *See Me as a Person* curriculum could effectively translate into practice. Many of the facilitators voiced that the concepts taught in the curriculum are not, "rocket science," and that "humans are hard-wired for [practicing these concepts]." One participant stated, "Human beings need oxygen like they need connection. Without it, they don't thrive." Conversely other participants highlighted that they found it could be difficult to implement some of the curriculum components to practice because they are not as "understandable and translatable." Facilitators mentioned that attunement was often most easily understood by participants while, "The other concepts [wondering, following, and holding] are a little more abstract so it takes a little more work to make them think about, what does that look like in everyday life?"

The facilitators often received feedback from workshop attendees with examples of how they saw their patients as people and engaged in TUS after attending the workshop. For example, one workshop attendee explained how she had a patient that was not cooperating and her initial reaction was to get in the patient's face and yell. However, after the workshop she took a step back and instead of getting in the patient's face and reacting with preconceived notions, she took time to *wonder* and listen to her patient's story and concerns. By doing this, the workshop

attendee interacted with her patient as a person with a story and context rather than as an illness, which can be common when treating multiple patients over time with similar diagnoses. The attendee reported that by doing this they both had a better interaction and they built trust. Workshop attendees also gave feedback to the facilitators following participation in the curriculum that their client's family members also expressed sentiments of gratitude for healthcare professionals treating their loved one as a person.

Other participants expressed uncertainty regarding the accessibility of the components of the curriculum when translating them to practice. One participant explained, "You may not notice when you're attuned or when someone is attuned to you but you definitely notice when people are misattuned and that's a concept that is understandable and translatable." However the other concepts can be more ambiguous and hard to imagine in everyday life. Another participant voiced that because the concepts are so generalizable, some people find it difficult to visualize how the particular components will look in practice because it can look so different in every organization. However, the majority of participants were firm that from their experience, the components could be effectively translated to practice because they are concepts that healthcare providers already implement. The difference after the workshop is that practitioners become intentional about it.

Effective learning opportunities and tools in the curricula. While the participants independently identified many learning opportunities and tools they felt were used effectively throughout the curriculum, the main learning opportunities identified were interdisciplinary interaction and discussion/practice of two components of the curriculum: wondering and attunement. Through these learning opportunities, participants felt that the workshop attendees

were reminded of both the importance of working as a team in healthcare as well as how to more effectively relate to their patients.

One effective learning opportunity in the curricula was interdisciplinary interaction. While not all of the participants' organizations made the workshops interdisciplinary, those that did found extreme value in sharing the workshop experience among multiple professions. One participant explained the importance of "getting people out of their silos and seeing what affects people from one area to another. I think it's really nice that people learn from each other and there aren't just hardships in their own areas. We all have them and we all have to learn to overcome them." One participant explained that she had, "environmental service workers, recreational therapists, food service workers, physicians, nurse practitioners, and occupational therapists all together [for training] and that led to some very rich discussion and deeper understanding of one another." The participant found value in interdisciplinary healthcare teams of doctors, nurses, and therapists but also saw the benefit of involving other people throughout the organization such as the food and environmental service workers.

However, some participants highlighted that it's not always feasible to make the workshops interdisciplinary depending on the organization. Instead, the participant explained that one organization had nurses from various departments (OB, surgery, and critical care) attending the workshop together and saw favorable results. The leadership then thought it would be beneficial to send an entire department to the workshop together so they could practice the skills alongside one another so they could better translate the workshop concepts into their practice. One facilitator reported, "They liked coming as a team and they felt they had a closer bond and a better working relationship afterwards."

Exploring the concepts of *wondering* and *attuning* were also identified as important learning opportunities in the workshop. One participant was amazed by how often people realize they have not felt a sense of wonder in a while. The participants described wondering in the context of considering a patient's backstory "with no judgment or no preconceived notions" and no, "prejudice for what's going to happen to them," based on their diagnosis. One participant described that it is often eye-opening to people because of how many opportunities there are in healthcare every day to wonder. "When we think about how many people come through our door in a day, we could be in amazement all day long because everyone's story is brand new to us and yet because we think we know a diagnosis we are following a trajectory where we think that goes and so I think just discovering [the sense of wonder] again." Another participant explained that analyzing the concept of *wonder* is sometimes too "squishy" for some healthcare providers. One participant noted that, "some people need to be reminded of the scientific piece of it…especially with wondering; failure to wonder is actually anti-scientific because if you stop collecting data and only go by what you think is true, you're no longer exploring your hypothesis."

Multiple participants expressed that exploring *attunement* through a particular activity was consistently impactful for the workshop attendees. The activity includes attendees seated face to face having a discussion. Then they hold up a piece of paper in front of their face to obstruct their view of the other person. They may also begin looking away from their partner or fidgeting with their phones to simulate being misattuned to patients in healthcare. "It opens up great discussion about how when we walk in to take care of a patient but we're doing 20 other things, we say 'how are you doing today?' and then the patient starts telling me an answer and I turn my back…it opens up that whole, 'oh my gosh I didn't even realize I was doing that.'"

Participants described that workshop attendees often felt uncomfortable during the exercise when the paper was held up between themselves and their partners or when their partner was not paying attention, however it is commonly done every day in healthcare. One participant compared attunement to how humans use oxygen: "You may not notice when you're breathing oxygen but you definitely notice when it's not there and it's the same with attunement."

Ideas to enhance the curricula. The participants expounded upon various ideas they had to enhance the curriculum. While the majority of the participants explained that there is a great deal of value in the curriculum as it is now, some participants agreed that broadening the target audience and implementing movement in the form of "field trips" and guided observation would enhance the curriculum. Participants discussed how broadening the target audience would aid in distributing the components of the workshop across more people and adding movement would help participants better retain the information.

Facilitators described that broadening the target audience in multiple ways could enhance the curricula. Facilitators outlined how students as well as professionals outside the organizations holding workshops could add value to the curricula. By including students,

> "it's…a way to bridge that gap between education and healthcare because those relationships apply in school…it gives people the sense it is something they can do right now…it doesn't matter if [they] have some of the technical things [they] want to know…you can practice it from the second you start the program."

For the organizations that do not yet conduct the workshop in an interdisciplinary fashion, participants suggested including, "other staff such as therapists and respiratory therapy and housekeeping. This would be very beneficial for all." Another facilitator explained that it would be of value to train facilitators from multiple departments in a hospital to make sure that, "the information is getting disseminated" from department to department. From the facilitators'

perspectives, broadening the target audience could help spread the workshop components to many more people who could benefit from it.

Participants identified incorporating movement and real-time observation in the form of "field trips" as a way to enhance learning in the curriculum. One participant observed, "adult learners, in general…aren't used to sitting…in healthcare in particular so you have to keep it moving and keep them active for them to retain." One participant explained, "I think it would be interesting if you could have a session, then have them go back into their work environment and then get back together and ask how it's working." Another participant suggested, "incorporating some observation…everyone's going to sit and observe [people's interactions] for 30 minutes…with some specific direction about what to observe." The participant felt this would enhance the curricula so people were up and moving from their seat in the workshop while simultaneously feeling a real sense of connection to the material seeing it played out in real life.

The dynamic between CHCM staff. The participants that were also CHCM staff identified that modeling and the relationship between co-workers at CHCM were the most impactful variables that helped enhance translation of the curriculum to practice. Facilitator modeling is important because it supports the authenticity of the curriculum. The relationship between CHCM staff is an example of modeling and it shows both the benefits and challenges of implementing the curriculum to practice.

The facilitators who were also a part of the CHCM staff explained that modeling is the key component to enhancing the translation of workshop material to practice. One facilitator described a phrase they use at CHCM: "how I do anything is how I do everything." The CHCM employees are intentional about, "bringing [their] whole self and really experiencing it and feeling it…practicing what [they] say just transcends the whole experience. [The workshop

attendees] know when they're getting a textbook or a course that has no weight behind it." They explained how their interactions with one another and the workshop attendees is intentional and meant to exhibit modeling behaviors particularly through the language they use. The employees are constantly aware of what their interactions tell people about them.

Another facilitator explained the importance of the relationship between staff regarding modeling behavior. "The energy and the dynamic that is created with another person certainly impacts how you're going to deliver that content." CHCM holds a high standard for how employees interact with their co-workers and the co-workers have set expectations with one another. When something goes wrong, it is the responsibility of the co-workers to work it out and maintain a healthy relationship with one another. Another facilitator highlighted that it can be tricky to uphold the standards at times because CHCM employees do not always challenge each other in constructive ways. "We're still a fairly conflict-avoidant culture. So we're still trying to find our way with how do we use the things we teach ourselves?" However, the majority of facilitators that work at CHCM felt that there is a strong sense of mission and partnership at the company.

Barriers of translation to practice. The most common barriers concerning translation to practice determined by the facilitators were variance in organizational culture, leadership transitions, and time constraints. Variance in organizational culture makes it difficult to implement a system for continuing to practice the curriculum components after the workshop. Instead, accountability for implementation is placed on the organizations and the workshop attendees, which can be challenging. It is particularly difficult for organizations to follow through with translation to practice due to time constraints as well as leadership transitions.

Facilitators reported the most common barrier of translation to practice is variance in organization cultures, which makes it difficult to embed the components into practice following the workshop. There is awareness among facilitators that not all organizations follow up with reflective sessions after the workshop is finished. One facilitator explained, "You can't attend a workshop and expect that to be the change. There has to be resources in their work where they are continuing to learn about it, continuing to apply it…just because you have the knowledge in your head does not mean that it will show in your behaviors…you need to practice it regularly." Another facilitator said, "What you practice grows so just because you have the knowledge in your head does not mean that it will show in your behaviors." Another facilitator offered that, "There has to be resources in their work where they are continuing to learn about it, continuing to apply it." Therefore, across participants they concluded that the variance in organizational culture made it difficult to implement structured practice of the workshop components following the workshop.

Some facilitators explained that certain organizations follow the workshop with holding reflective sessions, which involves reviewing the components learned during the curriculum. While seeing the necessity of reflective sessions, facilitators also acknowledged it is difficult for organizations to hold the sessions and it is also challenging for workshop attendees to attend the sessions due to time constraints and organizational culture. Therefore, time and transitions in staffing are also barriers to implementing the curriculum into practice. Time constraints are a significant barrier to practicing the components of the curriculum. Facilitators explained that it is difficult to get employees of organizations away from their day-to-day work in order to attend a workshop, "because they're engaged in so many other projects." If employees can barely find

time to attend a workshop, it is going to be challenging for them to be intentional about practicing what they learned at the workshop.

Additionally when employees are pulled out to attend the workshop, "it's just real hard staffing-wise." One facilitator explained that is why it is essential for leadership to be fully supportive of employees attending the workshop; otherwise, it gets overlooked because of time constraints. Multiple facilitators shared that changes in leadership made it difficult for workshop attendees to implement the curriculum in practice. One organization's director was invested in implementing the *SMAAP* curriculum in her organization, but when the director retired, "[the new leadership] liked it but they [weren't] as attached to it as the people who brought it in." Another facilitator explained that she is one of the few people at her organization that had been engaged with the curriculum from the beginning and she worries about how to, "keep the passion alive," among others who are not as connected to it.

Impact on the facilitators of delivering the curriculum. Delivering the curriculum has positive impacts both on the facilitators' practice and their personal lives. Additionally, some of the facilitators have always felt confident in the material taught in the curriculum while others have learned through the curriculum that one can actually teach people how to be better caregivers.

The facilitators agreed that being a facilitator of the *SMAAP* curriculum has significantly impacted both their professional and personal lives. Facilitators explained that they listen better to clients and co-workers now and they see people as a whole person rather than only viewing them in the context of the present situation. One facilitator explained the impact of facilitating on her own life: "it's such a blessing that I get reminded all the time about wondering, following and holding…it gives me more opportunity to incorporate more practices into my own life."

Another facilitator explained, "A lot of people walk away with a whole new sense of relationships with not only their patients but also their family…they can use a lot of these concepts with them." One facilitator admitted, "I was one of those folks who questioned whether some of this could be taught. So as I've gotten more into some of the evidence behind the curriculum, I'm more of a believer that the things we're talking about are things you can actually teach." While the material is teachable, a facilitator emphasized: "You'll never master this because humans are dynamic and humans have different ways of interpreting all kinds of things, so it's always a work in progress."

Inductive Findings

The student researcher and principal investigator inductively analyzed data for themes. Codes and interpretation were examined for similarities and accuracy through cross-checks. Analysis resulted in the following themes related to the impact of the *See Me as a Person* curriculum. The findings give us a deeper understanding of the strengths and barriers of teaching RBC to healthcare professionals.

Humanizing Healthcare and Culture Building to Encourage Change. Most facilitators found that after attending the workshop, attendees recognized the lack of relational competence exhibited in day-to-day interactions with patients. Facilitators acknowledged there is a gap between the emphases on technical information and relational competence that health care providers are taught. However, facilitators identified that many healthcare providers already know how to wonder, hold, follow and attune because these practices are part of being human. Additionally, the participants felt that leadership backing, organizational support and potential redefinition of cultural norms are necessary for the implementation of the workshop ideas into practice and to "keep it alive."

One facilitator explained that following the workshop, attendees "started questioning something that has been just part of the culture...because sometimes we are so task-oriented without focus on the relational piece." The facilitator continued to explain how an emphasis on technical information in the workplace is understandable because it is often the focus of healthcare providers' educational programs while relational competence is seldom taught. However, facilitators highlighted that wondering, following, holding and attuning are often skills that healthcare providers already have. They explained the goal of the workshop is not necessarily to teach healthcare providers the skills; rather it is about becoming intentional about implementing the components in every interaction with patients as well as, "getting people engaged in their work and reconnected with the purpose and passion of why they do what they do." Facilitators observed that workshop attendees had a hunger and desire for focusing more on their relationship with patients. Most facilitators explained that attendees left the workshop with a, "new idea of how they're showing up for patients." Workshop attendees became more aware of their routines and norms and recognized how they might negatively impact their relationship with patients.

Facilitators remarked that organizations must place an effort on implementing the workshop practices into their culture to encourage change. One facilitator expressed that a two-day workshop is not enough to be the change. Instead, it is meant as a catalyst for organizations to examine their current culture and ways it might be altered to support a culture shift at the organization.

Another facilitator suggested that one way to build a culture around the *SMAAP* practices is to add them to the employee orientation checklists to embed them in the company culture from the beginning of an individual's career with the company. The facilitator explained that

supervisors may, "monitor [his or her] new staff person and [he or she] can make sure they are wondering, following, attuning and holding their patients. It's an expectation that you attune to your patient when walking in the room." Humanizing healthcare and culture building can facilitate change in organizations to implement the *SMAAP* program into practice.

Participant Vulnerability Entering the Workshop. Several facilitators reported that some workshop attendees initially expressed shame and frustration about attending the workshop. Other workshop attendees were initially indifferent about the workshop because they felt so burnt out. However, after experiencing the workshop, facilitators reported that workshop attendees often left with an open mind and positive experience.

One facilitator explained workshop attendees' initial frustrations as one of the attendees said, "Wow, you're going to teach me how to be therapeutic? What have I been doing for the last 20 years?" Facilitators observed that many workshop attendees came to the workshop with, "crossed arms to begin with but by the time they left they were much more engaged." A facilitator explained that the workshop attendees became more open to the workshop when they understood that intention of the workshop is not to shame people. Rather, the intention is to acknowledge the fact that delivering healthcare services can become routine and that everyone should strive to always be, "excellent in [their] care." One facilitator humbly stated, "there's nothing shameful about [healthcare becoming routine] unless we acknowledge it but don't do anything about it."

Other facilitators experienced that some of the attendees were beginning to, "lose their grasp of why they came into healthcare." They explained these attendees were particularly vulnerable entering the workshop because they were thinking, "why am I wasting my time, I am getting ready to walk away from it all." However, facilitators reported that the workshop helped

remind healthcare providers about why they entered healthcare in the first place. As one facilitator described, "it's like we just saved one person within her own profession."

Personal Transformation. Overall, the *SMAAP* workshop seemed to increase people's awareness of their actions and biases leading to personal transformation. Facilitators gave examples of common ways in which healthcare professionals fail to follow, hold, wonder and attune with their patients. Many of the healthcare providers' reactions were, "I didn't even realize I was doing that!" Another facilitator reported that a workshop attendee wrote to them following the workshop and expressed, "I took the time to wonder and really listen to this patient and it changed the way I practice because of it." One facilitator explained the increased sense of purpose some workshop attendees expressed following the workshop: "[The workshop attendees] walk away with a sense of acknowledgment that [they are] not losing the fact that this is what [they] came into healthcare for.

Additionally, facilitators explained that workshop attendees' biases were challenged when considering how people feel when they are labeled. One facilitator noted, "I think it's surprising for some folks because they assume they don't carry much bias or they're not that judgmental when in fact [bias is] so subconscious or deep they don't even realize it." Facilitators explained how it can become easy to view a patient a certain way based on their diagnosis rather than taking time to see them as a person separate from their diagnosis. Participants warned that because of the routine nature of healthcare, "[Healthcare providers] don't consider how people are feeling when they're being labeled." One facilitator observed that challenging biases leads to greater compassion in healthcare. Particularly following the workshop, facilitators observed that attendees have, "better awareness…people are able to lift up their biases and values to facilitate compassion," leading to personal transformation.

Difficulty Quantifying the Qualitative Impact. Another important theme is the desire to quantitatively measure the impact of the workshop. Facilitators agreed they would like to have metrics to show leaders and organizations that participating in the *SMAAP* workshop has a significant return on investment. Facilitators confessed that it has been difficult to quantitatively measure the direct impact of the workshop because, "we're of course doing all kinds of other things at the same time so it's hard…we can't directly say, 'oh it's because of *SMAAP*.'"

Other facilitators explained a way in which they are working toward gaining specific measurable outcomes through partnering with a company that does online assessment of relational competency. They are aiming to measure the *SMAAP* practices of *attuning, wondering, following* and *holding* as they relate to both the therapeutic relationship with clients as well as relational competency with one's team. One facilitator described the vision as getting a baseline of people's behaviors for each of the practices prior to participating in the workshop and then having that data to hold one's self and peers accountable for continuing to develop the practices following the workshop. One facilitator expressed, "it's a huge dedication of resources and time and people and money and I think we need to somehow demonstrate its benefits." While facilitators and leaders have found it challenging to measure the quantitative impact, facilitators reported they are taking steps toward identifying specific measurable outcomes.

Overall, the study concluded that attending the *SMAAP* workshop and implementing *attuning*, *wondering*, *following* and *holding* intentionally in practice could positively impact one's relationship with his or her patients. Particular learning opportunities and tools helped the workshop attendees better learn and apply the workshop material. Additionally, some participants had ideas about how to enhance the curricula. The dynamic between the CHCM staff and the impact of delivering the curriculum on the facilitators were other themes identified from

the study. The current study also determined barriers to translating the components of the workshop to practice. Humanizing healthcare and culture building to encourage change also emerged as a theme as well as participant vulnerability entering the workshop. Participants identified personal transformation as a theme, as well as difficulty quantifying the qualitative impact of the *SMAAP* curriculum. Next, the discussion section will explore the results of the current study.

Discussion

The current study helps one better understand that taking time to connect with patients is beneficial for the patient and his or her family, as well as the healthcare provider. The study reaffirmed that there are significant barriers in health care that make it challenging for healthcare providers to engage in TUS and client-centered practice. However, the present study also determined that it is possible to teach or re-awaken client-centered practices in health care providers as well as reconstruct organizational culture to support client-centered practice through the *SMAAP* curriculum. Most of the ideas and themes constructed from participant reactions are supported by past literature, while some of the concepts are newly emerging in literature.

The results reinforced the idea that engaging in RBC can improve relationships with clients and their families. Previous research claimed that after RBC implementation in healthcare settings, there was an increase in patient satisfaction (Winsett & Hauck, 2011). Additionally, Boulding et al. (2011) found that patient satisfaction is directly related to interactions with healthcare professionals. The results of the present study support these claims as well; the study found that when workshop attendees were able to translate *wondering, attuning, following,* and *holding* in their practice, the healthcare providers' relationships with their patients were strengthened. Most participants explained that following completion of the *SMAAP* workshop, they were better able to take a step back and treat their patients as individuals rather than viewing the patient as their diagnosis. The participants reported that the healthcare provider and patient built trust through these types of interactions. However, the present study also found that some participants felt that some of the components were more difficult to implement into practice because they are ambiguous and more challenging to imagine in everyday life. Therefore, the present study established that the majority of workshop attendees found it easy to translate the

concepts learned at the *SMAAP* workshop to practice, while a couple felt translating the concepts to practice was more difficult. Consequently, the present study adds to past research that it is possible to teach and learn RBC components and then implement them in practice.

Particular learning opportunities in the *SMAAP* workshop supported teaching and learning *SMAAP* curriculum components so they could be better translated into practice. Previous research established that teaching methods were limited concerning TUS and client-centered practice in OT education (Cole & McLean, 2003; Davidson, 2011; Seymour, 2012; Taylor et al., 2009). Notably, Davidson (2011) found that implicit methodology (i.e. instructor modeling, lecturing, and reading) was most frequently used to teach TUS in OT education. Due to this methodology, there were limited interactive opportunities to learn and practice TUS. Consistent with previous research, the present study found that the most beneficial learning opportunities employed during the workshop were interactive opportunities including interdisciplinary interaction and hands-on practice of *attunement* and *wondering*. Participants felt that interdisciplinary work led to a deeper understanding of others' roles and helped them to better model RBC between one another following the workshop. The workshop also offered concrete exercises in *wondering* and *attunement* that allowed participants to practice what it might feel like to use these components in practice. While these learning opportunities proved beneficial, participants still felt that more "field trips" to patient rooms for guided observation opportunities would be beneficial for their learning. Overall, the *SMAAP* workshop used effective strategies to teach RBC rather than predominately implicit methodology that served as ineffective for teaching TUS in OT education (Davidson, 2011).

While effective learning opportunities make it easier to learn and translate workshop components to practice, the present study affirms that there are significant barriers in healthcare

that make it challenging for healthcare providers to engage in RBC. The present study found barriers related to variance in organization culture, leadership transitions, and time constraints. Previous research also cited similar barriers to RBC. Lown et al. (2011) concluded that fewer than 55% of patients and less than 60% of physicians said that the U.S. health system generally provides compassionate care. The researchers reported physicians felt that the general healthcare system impacted their ability to spend enough time with patients as well as provide the highest quality of care. Previous research also identified cost-containment as a barrier to RBC as well as performing tests, procedures and documentation, which all shift focus away from RBC (Bauer-Wu & Fontaine, 2015). Researchers claimed, "The profession's values of client-centered practice are at odds with the values of biomedicine and the corporate culture that drives the health industry in the US" (Gupta & Taff, 2015, p. 244). Gupta and Taff (2015) noted that client-centered practice is unrealistic because of systemic pressures such as insurance plans limiting the extent of services a practitioner can provide.

Participants in the present study confirmed these ideas as they reported that implementing client-centered care requires significant time and energy on a regular basis from all levels of an organization. The present study supports previous research as the participants identified that variance in organizational culture was one of the main barriers to implementing the workshop components to practice. Therefore, the present study logically determined that culture building to encourage organizational change was an effective way to foster an environment supportive of the components of the *SMAAP* curriculum. The participants felt that workshop attendees were interested in and capable of shifting organizational culture because of the personal transformation that occurred as a result of the curriculum. The present study added that leadership transitions are also a barrier to implementing workshop components into practice.

While the present study confirmed findings of previous research, the study also yielded contrary results for workshop attendees. The participants concluded that many workshop attendees were able to practice RBC following workshop attendance despite barriers. They recounted examples about how workshop attendees are hard-wired for caring for and connecting with their patients and many of them were hungry for an opportunity to connect with their patients.

Koloroutis (2004) found that following RBC implementation in a hospital, employees were encouraged to emphasize caring behaviors with not only their clients but also their colleagues and others around the organization. Winsett and Hauck (2011) also determined that employing RBC in a hospital lead to better communication among staff members. The present study found that RBC among CHCM staff members aligns with previous research. They intend to be intentional about demonstrating RBC among their place of work, and especially when they are facilitating a workshop. They have a standard among themselves that co-workers maintain healthy relationships with one another and it is the responsibility of co-workers to address any concerns if they arise. Participants felt that their intentional interactions with one another are essential as they facilitate the *SMAAP* workshop to demonstrate the authenticity in modeling behaviors.

Koloroutis and Trout (2012) developed the *SMAAP* curriculum with the goal of finding the intersection between one's instrumental and relational knowledge to best facilitate client healing. The present study is the first formal research on the *SMAAP* curriculum. Therefore, the present study is the first to examine the impact of the *SMAAP* curriculum from the facilitators' perspectives. The present study determined that there are ways to teach or re-awaken client-

centered practices in healthcare providers through the *SMAAP* workshop. Further research should be done to expand these findings.

Implications for Occupational Therapy

Occupational therapy has long been centered on TUS and client-centered practice. The profession often prides itself on the notion that it is client-centered and that this differentiates OT from other professions. TUS is used in occupational therapy with the goal of helping clients optimize their occupational engagement (Taylor, 2008). However, research has shown there is little to no evidence that OT is truly client-centered (D'Cruz et al., 2016; Gupta & Taff, 2015; Whalley Hammell, 2013). Therefore, the present study has implications on occupational therapy because it concludes that despite barriers in healthcare, practitioners can learn or re-awaken client-centered practice. This is particularly impactful for OTs because previous research claimed that OT students often leave their programs feeling insufficiently trained in TUS suggesting that they are never adequately taught how to be client-centered despite the *Occupational Therapy Practice Framework* (AOTA, 2014) claiming TUS to be an integral aspect of OT practice (Morrison & Smith, 2013). Therefore, it is helpful for OT practitioners to know that the *SMAAP* workshop is a tool they can use to help them develop RBC as new practitioners or later in their careers. Additionally, OTs work continuously in interdisciplinary teams. In addition to OT, it is likely that other members of the team might benefit from further training in RBC. The study concluded that interdisciplinary engagement in RBC was beneficial for the clients as well as members of the interdisciplinary team. OTs should critically consider their level of preparedness and use of RBC to be sure they are engaging in one of the fundamental tenants of OT practice.

Limitations

Although this study provides new information about the impact of the *SMAAP* curriculum, limitations were present in the study. The first limitation is the small sample size (five participants). However, it is important to note that small sample sizes are often used in qualitative research. Therefore, one must be wary of generalizing the results of the present study to the larger population. Ideally, more data should be collected to increase the sample size. Due to the phenomenological design of the study, it is possible there is some internal bias due to the researchers coding the data, yet efforts were made to decrease bias via triangulation and cross comparisons of the data coding. Because this is the first study with the facilitators of the *SMAAP* curriculum, there is no other data to which one can compare results.

Suggestions for Future Research

It is essential for future research to be conducted on the impact of the *SMAAP* curriculum to strengthen and expand the current findings. Further research will help prove the necessity of the *SMAAP* curriculum regarding benefits for clients and practitioners. Mainly, research from the workshop attendees' perspective would be valuable in adding another viewpoint. Ideally, research from the clients' perspectives would create a more complete picture of the impact of RBC on the clients. Additionally, multiple variables could be considered when inspecting the clients' perspectives. For example, one might examine how practicing RBC impacts reported levels of pain or chronic condition management. One might also conduct research from the client's family's perspectives in terms of satisfaction. Quantitative studies or mixed-methods designs could be beneficial in addition to future qualitative studies. Future research could help deconstruct the idea that healthcare practitioners are unable to conduct RBC due to systemic barriers. Rather, future research could further explore how RBC can be implemented in

healthcare practice to benefit both clients and healthcare providers. Furthermore, future research might examine the sustainability of the components of the *SMAAP* curriculum once they are embedded in practice.

Conclusion

Connection with others is at the basis of what it means to be human. Healing has been the result of one caring for another throughout history. Healthcare professionals need to maintain an understanding of instrumental knowledge combined with compassion to best treat their patients. OT particularly claims that the therapist-client connection is at the center of OT practice. Therefore, it is critical that healthcare professionals, especially OTs, engage in RBC to optimize patient outcomes.

The study added phenomenological data to lay the foundation for examining the impact of the *SMAAP* curriculum from the facilitators' perspectives. Some of the impacts include translation of the curriculum to practice, barriers of translation to practice and the impact of the curriculum on the facilitators. The participants also identified effective learning opportunities and tools in the curriculum as well as ideas to enhance the curriculum. Among participants, there was a sense of vulnerability entering the workshop because some healthcare professionals felt that RBC could not be taught, while others were upset that people questioned their ability to care. Participating in the *SMAAP* curriculum helped participants understand that caring for clients can be taught. Participants felt that workshop attendees underwent personal transformation and they identified ways to implement caring behaviors (*wondering, attuning, following and holding*) into their everyday practice through humanizing healthcare and culture building in their organizations. These benefits are qualitative in nature, as they were all the lived experiences and perspectives of the facilitators. Therefore, the facilitators identified that they have difficulty

quantifying the qualitative impact so they are working on gaining measurable outcomes to further justify the necessity of the *SMAAP* curriculum. OTs and other healthcare professionals should consider attending the *SMAAP* workshop to enhance their skills in client-centered care in order to provide optimal and holistic outcomes for clients.

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Appendix A: Creative Health Care Management

Inspired by the basic principles of therapeutic use of self, and fueled by a passion for client-centered nursing practice, Marie Manthey founded Creative Health Care Management (CHCM) in 1979. The mission statement includes the idea that, "every patient and family will experience healing and caring as a result of organizational transformation" (Creative Health Care Management [CHCM], 2017, para. 3). CHCM provides their services based on the Relationship-Based Care (RBC) delivery model including consultation services, learning programs, and products to all people within health care organizations and academic settings (CHCM, 2017). The goal of consulting is to use the power of different relationships within the organization to facilitate client-centered care at the core of their practice (CHCM, 2017). CHCM has expanded to a highly successful consulting business that has produced a quarterly *Creative Nursing Journal*, and multiple books including *Relationship-Based Care: A Model for Transforming Practice, I2E2: Leading Lasting Change, The practice of Primary Nursing,* and *See Me as a Person* (CHCM, 2017).

Appendix B: Explanation of Relationship-Based Care

There are twelve basic assumptions that inform the foundation of RBC as well as three critical relationships including: relationship with self, relationship with colleagues, and relationship with patients and families (Koloroutis, 2013). The RBC Model is designed to create "organization-wide transformation in the way care and services are provided to patients and their families" (Koloroutis, 2013, p. 19).

The RBC Model explores the impact of what it means to know and take care of oneself. From the RBC Model perspective, self-care is defined as the ability for individuals to, "manage their own stress, articulate personal needs and values, and balance the demands of the job with their physical and emotional health and well-being" (Koloroutis, 2013, p. 18). According to the theory behind the RBC Model, if practitioners do not practice self-care, it is more likely to impact their practice compared to practitioners who engage in self-care (Koloroutis, 2013). Therefore, one must engage in self-care before they are able to engage in healthy relationships with colleagues and clients.

Additionally, the RBC Model highlights the importance of relationships between interdisciplinary team members. In order to effectively deliver quality care, all members of the health care team must prioritize healthy relationships with one another (Koloroutis, 2013). The main way this might occur is through valuing and validating each individual's role within their scope of practice, as well as remembering the team is working together to achieve a shared goal (Koloroutis, 2013).

Finally, the RBC Model notes that the third relationship of importance is the relationship practitioners have with patients and their families (Koloroutis, 2013). In organizations with relationship-based cultures, practitioners communicate, behave, and make decisions with the

client and his/her family at the center of their practice. Clients have reported feeling most cared for when they are a part of the conversation for their care (Koloroutis, 2013).

Appendix C: Phenomenology

Qualitative methodology is used to investigate the subjective reality of study participants and focuses particularly on authenticity and groundedness (Taylor, Fossey, & Kielhofner, 2017). Qualitative research typically derives from theoretical concepts and broad questions that are then narrowed to guide data collection (Taylor et al., 2017). Common methods used in qualitative inquiry are interviews, observations, and data analysis (Mapp, 2008; Taylor et al., 2017)

Phenomenological research is a qualitative research method and philosophy used to explore individuals' lived-experience from his or her lens. Therefore, "this approach relies on personal knowledge and subjective experience." (Taylor et al., 2017, p. 131). Edmund Husserl founded phenomenology by incorporating the disciplines of psychology and logic (Luborsky & Lysack, 2017). Phenomenology is based on the idea that personal experience can be conveyed to others through narratives (Taylor et al., 2017). The most common forms of data collection are, "interactive interviewing, focus groups, and the analysis of the personal writing of participants" (Taylor et al., 2017, p. 131).

Conducting lengthy interviews about individuals' lived experiences is one of the main means of collecting data because one of the central understandings of phenomenological philosophy is that the only valid source of information about a given topic is an individual who has lived that experience. The main goal of the discussion is for the researcher to understand the experience (Taylor et al., 2017). Analysis is constant in phenomenological research, beginning when the initial data are collected. Data is then transcribed and inductively or deductively coded for themes. The goal of analysis is to produce a theoretical statement that answers the research question. The data are reported in a narrative format using direct quotes from the data to highlight the participants' experience.

Appendix D: Interview Guide Questions

Background

1. Tell me a little about your background, your work position any professional degrees and how you became a facilitator for CHCM.

2. Can you tell me about the work you do beyond your work as a *See Me as a Person facilitator*?

3. How long have you been a facilitator of the *See Me as a Person* curriculum?

Facilitation

4. How were you trained to become a facilitator in the *See Me as a Person* curriculum?

<Follow up> Did you perceive the training was adequate for your skills as a facilitator?
<why or why not>

5. With whom and for whom do you facilitate the *See Me as a Person* curriculum (e.g., types of organizations, other facilitators, etc.)?

6. How frequently do you facilitate the curriculum?

Perceived Impact

7. What are healthcare providers' general reactions to the *See Me as a Person* curriculum?

8. What are the perceived effects or impact you have observed as a result of the *See Me as a Person* curriculum?

<Follow up> Explore positive areas and potential areas of need.

9. For whom do you find the curriculum most helpful and why?

10. Have you noticed any components of the curriculum to be more impactful than others? If so, which one(s)?

Teaching Methods

11. What teaching methods do you use when facilitating the *See Me as a Person* curriculum?
<Follow up> Which methods are most helpful and why; are there some you would change?

12. Do you feel that any other teaching methods would enhance the curricula? If so, which one(s)?

Translation to Practice:

13. How do you assess and/or monitor the impact of translation of the curriculum to practice?

14. What could enhance how you measure translation of the curriculum to practice?

15. What is the dynamic between CHCM staff, their relationship, and the relationships with the clients who you work with?

16. How does the relationship between CHCM staff impact translation of the curriculum to practice?

17. What are the strengths and barriers in implementing the curriculum in practice?

Other:

18. What impact has facilitation of *See Me as a Person* had on you and your own work?

19. How do you keep current to continue and grow the program?

20. Is there anything else of interest you believe is important for me to know in relation to your participation in facilitating the *See Me as a Person* curriculum?

Appendix E: Recruitment Email

You are invited to participate in a study exploring the perceived impact of the *See Me as a Person* curriculum. The study will involve in person and/or phone based interviews of CHCM *See Me as Person* facilitators. If you are willing to participate you will be asked to partake in an interview with Masters of Occupational Therapy student Alex Hein. It is anticipated the interview will last 60-80 minutes. You will be asked to participate in one interview; follow up contact will only occur if there is a question about clarity of recording or response. It is hoped this study will help inform CHCM of the facilitators' perception of the impact of the *See Me as a Person* program and will guide future directions. If you have questions you may contact Alex Hein, OTS at alhein@stkate.edu or the Faculty Advisor, Professor Kristine Haertl, Ph.D., OTR/L, FAOTA, klhaertl@stkate.edu.
For those interested in participating in the study, please contact Alex Hein at 651-357-3479 or alhein@stkate.edu.

Thank you.

Appendix F: Information and Consent Form

Study Title: The Perceived Impact of the *See Me as A Person* Curriculum from the Facilitators' Perspectives

Researcher(s): Alexandra Hein, OTS, Kristine Haertl, Ph.D., OTR/L, FAOTA

You are invited to participate in a research study entitled **The Perceived Impact of the *See Me as A Person* Curriculum from the Facilitators' Perspectives.** The study will be conducted by Alexandra Hein, OTS, a Masters of Arts in Occupational Therapy (MAOT) student at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Kristine Haertl, Ph.D., OTR/L, FAOTA, Professor in the OT Department at St. Catherine University.

The purpose of this study is to determine the perceived impact of the *See Me as a Person* curriculum. This study is important because it will explore positive aspects and potential areas for improvement of a client-centered practice curriculum implemented in healthcare settings throughout the nation. Approximately 10 people (facilitators of the *See Me as a Person* with Creative Healthcare Management) are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?
You were selected as a possible participant in this research because you are a current or past facilitator of the *See Me as a Person* curriculum.

If I decide to participate, what will I be asked to do?
If you meet the criteria and agree to be in this study you will be asked to participate in an interview exploring the impact of the *See Me as a Person* curriculum. The interview will consist of open-ended questions regarding your personal experience administering the *See Me as a Person* curriculum. In total this interview will take approximately 60-80 minutes over one session. Interviews will be in person at a mutually agreed upon location or via speaker phone and will be audio-recorded. In the unlikely chance there is a follow up question to clarify responses, you may be contacted to verify content of the interview.

What if I decide I don't want to be in this study?
Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you decide to participate in this study, but later change your mind and want to withdraw, simply notify me and you will be removed immediately. Your decision of whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?
The study has minimal risks. Some questions may be perceived as personal and/or sensitive in nature. You may choose not to answer any question that you wish without affecting your participation in the study.

What are the benefits (good things) that may happen if I am in this study?
The benefit to you for participation is an opportunity to share your unique opinions and perspectives on facilitating the *See Me as a Person* curriculum. This is an opportunity to give personal insights on the benefits and challenges of the curriculum. It is hoped that information from this study will lead to academic and practical knowledge of client-centered care in healthcare settings. In addition, the study has potential benefits for Creative Health Care Management (the owners and trainers of the *See Me As a Person* Curriculum) as they hope to learn from the data and consider future directions for the program.

Will I receive any compensation for participating in this study?
You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?
The information that you provide in this interview will be tape-recorded, and later transcribed and coded. Pseudonyms will be used in the coding, transcribing, and reporting of the information. I will keep the research results in a password protected folder within a password protected computer and only myself and the research advisor will have access to the records while we work on this project. I will finish analyzing the data by fall of 2017. I will then destroy all original reports and identifying information that can be linked back to you. You will be asked to sign a consent form at the time of the interview. You may discontinue the study at any time. Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in the any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released. The only individuals with access to the original data are me and my faculty advisor Kristine Haertl, Ph.D., OTR/L, FAOTA.

Are there possible changes to the study once it gets started?
If during course of this research study if I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.
How can I get more information?
If you have any questions, please ask them before you sign this form. You can also feel free to contact me at (651) 357-3479 or alhein@stkate.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Dr. Kristine Haertl at (651) 690-6952 or klhaertl@stkate.edu. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:
I consent to participate in the study and agree to be audiotaped.
My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher(s).

_____

Signature of Participant Date

_____

Signature of Parent, Legal Guardian, or Witness Date
(if applicable, otherwise delete this line)

_____

Signature of Researcher Date