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Evaluating the Healthcare Provider Interaction with Adolescents

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EVALUATING THE HEALTHCARE PROVIDER INTERACTION WITH ADOLESCENTS

CAPSTONE PROJECT

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ABSTRACT

Background: Adolescents make up the largest population of individuals infected with human immunodeficiency virus (HIV), consisting of 34% of all new infections nationwide (Centers for Disease Control [CDC], 2008). Between the ages of 13-24, the Centers for Disease Control (CDC) reports over 33,000 cumulative acquired immunodeficiency syndrome (AIDS) cases. It is estimated that half of all new HIV infections in the United States (U.S.) are in individuals under the age of 25. Therefore, it is essential that communication between adolescents and healthcare providers be open for discussions on all health-related topics, including sexuality.

Purpose: The purpose of this project is to evaluate the interaction between healthcare providers and adolescents in a clinic located in South Florida and to suggest a method to improve communication between adolescents and their healthcare providers.

Theoretical Framework: Roter & Hall Theory of the Doctor/Patient Relationship.

Methods: The project utilized a descriptive design with a convenience sample of adolescents and the Adolescent Patient Provider Interaction Scale (APPIS) in a multiethnic population in South Florida to evaluate the interaction with the adolescents' healthcare providers. The APPIS is a nine-item question scale that measures confidentiality and communication between the healthcare provider and adolescent, evaluating their interaction overall.

Results: The project recruited 60 adolescents between the ages of 18-24 from one clinical site. Findings from the project revealed that 48% felt that both the patient and provider were "in control" of the visit, and 92% "strongly agreed" or "agreed" that there was an equal "exchange of information" during the visit. The results from the project support a positive interaction between the healthcare provider and adolescent.

Conclusion: The Adolescent Patient Provider Interaction Scale (APPIS) can be useful to healthcare providers to evaluate approaches to improve health care outcomes in adolescents. Results from Clowers (2002) demonstrated that adolescents preferred communication with a provider that understood, talked to them, cared, listened, and respected them as an individual. Adolescents are at a vulnerable age where they need guidance and direction. As healthcare providers, we are able to provide vital information to adolescents through communication.

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CHAPTER ONE

INTRODUCTION TO THE PROJECT

Introduction

Adolescence is a period of transition to adulthood, as adolescents are beginning to make their own decisions. However, this is also a period of risk-taking with certain choices frequently placing the adolescent in a position for a multitude of high-risk behaviors including unsafe sexual practices. Estimates suggest that while representing 25% of the sexually experienced populations, 15-24 year olds acquire nearly 50% of all new sexually transmitted diseases(STDs)(CDC, 2008). Sexually transmitted diseases are defined as any infection, such as gonorrhea, syphilis, chlamydia, and genital herpes, which is transmitted from direct sexual contact; some of these infections may be asymptomatic (CDC, 1996).

In 15-19 year old adolescents, rates of chlamydia increased by 10.7% in 2008 (CDC, 2008). Adolescents are believed to represent at least a third of the cases of chlamydia worldwide; in some settings, almost half of the adolescents at high risk have either chlamydia or gonorrhea or both (Diehne & Reidner, 2005).

However, adolescents may not be forthcoming about their risk-taking behaviors with their parents and sometimes even with their peers. They need a place to turn to for accurate advice and answers to questions to sensitive topics. A healthcare provider appears to be the logical choice. Providers that care for adolescents should be able to provide knowledge and influence attitudes and behaviors of teens by providing them with accurate information regarding issues that they may be unable to discuss with their parents or peers (Berlan & Bravender, 2005).

A healthcare provider and patient relationship is built on the establishment of trust. When adolescents feel they can trust their healthcare provider, an open line of communication

occurs between the provider and the adolescent, an openness that the adolescent may lack in other relationships (Berlan & Bravender, 2009). If communication between the provider and adolescent is limited, possible constraints are placed on this healthcare relationship. Adolescents need to be able to ask questions about their health and lifestyle choices in an open relationship where the give and take of information is nonjudgmental (Berlan & Bravender, 2009). If this does not occur, there may be a negative impact on the adolescent's future relationships with healthcare providers.

Adolescence

Adolescence is the time of life when the individual is neither a child nor an adult. Life becomes more complex as the adolescent attempts to establish a personal identity separate from his or her family of origin and as a member of a wider society. In their attempt to separate and establish their own identity, adolescents tend to become self-centered and anxious and often behave in ways that defy the societal norm, as they try to fit both into a world of their peers as well as a new mature role (Hay, Levin, Sondheimer, & Deterding, 2007). In adolescence, peer relationships are very important, and thinking about the future is not a priority. Cognitively, the adolescent moves from concrete thought processes to abstract thinking, and with this new mental power comes a sense of omnipotence and a belief that the world can change merely by thinking about it (Hay, Levin, Sondheimer, & Deterding, 2007). In this stage of development, this type of thinking often leads adolescents to believe that they are invincible, and while things may happen to other individuals (for example, becoming ill from risk-taking behaviors), it will not happen to them.

There are a variety of health behaviors, safe and unsafe, that may be initiated during adolescence. Smoking, drug and alcohol use, and unprotected sex are frequent high-risk

behaviors that occur during adolescence. Without healthcare intervention, there is the possibility that these high-risk behaviors may transition into the adulthood years (Clowers, 2002).

Approximately 16% of the 900,000 pregnancies among adolescents in 1988 were planned, with 55% resulting in births (Lommell & Taylor, 1992). Unplanned sex, not thinking about contraception, poor knowledge of contraception methods, and lack of availability of contraception are some of the barriers to contraception use in the United States (Lommell & Taylor, 1992). If healthcare providers are able to initiate these conversations prior to the initiation of sexual activity among adolescents, thus making the adolescent more aware of contraception methods available, this can possibly increase the knowledge and decision making skills of the adolescent.

Adolescent/Healthcare Provider Relationship

A trusting relationship between the patient and his or her healthcare provider is crucial if the healthcare provider hopes to have an impact on the health of the sexually active adolescent. Adolescents may choose not to discuss their sexual behavior and history with their parents but may open up with their health care provider, knowing they are assured of an open dialogue to discuss anything with confidentiality and without judgment (Clowers, 2002). Without an open dialogue, the adolescent may have nowhere to turn for needed healthcare information.

Effective communication between the adolescent and healthcare provider is essential to high-quality health care and the overall well-being of the adolescent. Patient compliance, morbidity, mortality, and risk-taking behaviors have been linked to medical encounters, emphasizing the importance of effective communication between the patient and provider (Clowers, 2002). Healthcare providers have the capacity to supply the adolescent client with tools to assist him or her to survive a complex developmental phase in order to grow into a

healthy adult. Adolescents may lack communication skills or be reluctant to communicate their questions about sex. According to Clowers (2002), adolescents report that if given the opportunity to discuss issues about sex with the healthcare provider they would. However, most adolescents are too embarrassed to initiate this type of conversation. This suggests that conversations about safe sex and contraception should be initiated by healthcare providers with this age group more than any other.

Adolescents will seek medical care with their parent's knowledge, but less than 20% will seek care related to birth control, sexually transmitted diseases, or drug use if parental notice is required (Loxterman, 1997). A questionnaire conducted at Massachusetts General Hospital (2010) demonstrated that adolescents would be unwilling to seek medical care for sexually transmitted diseases if their clinician discussed this with their parents. The adolescent values autonomy and privacy; therefore, establishing an effective provider and patient relationship is very important.

Hall et al. (2008) found that adolescents undergoing routine physical examinations do not regularly talk to their healthcare providers about prevention of sexually transmitted diseases. The findings suggest the need for increased efforts on the part of healthcare providers to engage with adolescents about prevention of STDs. A survey among primary care providers found that adolescents who engage in conversation with the provider about STDs are more likely to use a condom (Hall et al., 2008).

Veit, Sanci, Young, and Bowes (1995) conducted a study with 57 medical practitioners and found that 52 of them had little or no training in adolescent health. Jacobsen, Wilkinson, and Owen (1994) found that physicians' consultations with teenagers were 23% shorter than those with older adults. According to the National Youth Risk Behavior Survey (NYRBS), over 33%

of teens have engaged in sexual intercourse by the ninth grade, with an increase to 60.5% by the 12th grade (Merzel et al., 2004). The Guidelines for Adolescent Preventative Services (GAPS) recommends annual screening for sexually active adolescents between the ages of 11 to 21 and testing of all sexually active adolescents (Merzel et al., 2004). These guidelines/recommendations were developed by the American Medical Association (AMA) for primary care providers to emphasize health guidance and the prevention of behavioral and emotional disorders in addition to medical conditions (CDC, 1992).

During the often tumultuous transition to adulthood, adolescents need important information regarding health and lifestyle choices. Healthcare providers should be able to import knowledge and influence behaviors of adolescents by providing non-judgmental, accurate information about issues they may be unable to discuss with their parents or peers (English & Ford, 2004). Trust is vital to maintaining an open line of communication between the provider and adolescent patients. If open communication is restricted or the adolescent perceives that confidentiality is not being maintained by the provider, termination of the relationship may occur and may negatively impact the adolescent in future relationships with healthcare providers.

Problem Statement

Healthcare providers may lack communication skills necessary to talk to adolescents.

Purpose of the Study

The purpose of this project was to evaluate the interaction between healthcare providers and adolescents in a clinic located in South Florida and to suggest a method to improve communication between adolescents and their healthcare providers.

Theoretical Framework

The theoretical framework that guided this project is the Roter and Hall theory (Roter & Hall, 1993). The theory was developed by Debra Roter and Judith Hall and consists of four types of patient-provider interactions. The first one is paternalism. This type of relationship is common when the provider is in control of the visit and is seen as a traditional form of the provider-patient interaction. The patient's role is passive and dependent, with the provider's role being dominant, professional, and autonomous; the provider maintains an emotional detachment and distance from the patient and acts in the patient's best interest (Roter & Hall, 1993). The second type is consumerism, indicating that the patient has prepared for the visit and is in control of the visit; this focuses on the patients' rights and providers obligations, rather than the rights of the provider to direct and for the patient's obligation to follow directions and comply (Roter & Hall, 1993). The third interaction consists of a default category characterized by a lack of control by the provider and the patient and shows a poor relationship between the two. Neither party has accepted responsibility for medical decisions, with no mutual middle ground. In this case, a patient may drop out of care completely secondary to failed expectations or frustrated goals, reflecting a bitterness response from the provider. The provider may not even be aware of the rationale for the loss of the patient or even realize that the patient has dropped out of care (Roter & Hall, 1993). The ideal circumstance to occur is the fourth interaction, mutuality, in which the provider shares decision making with the patient based on the patient's needs and understanding. The manner in which a provider communicates with a patient is essential in establishing trust and establishing an effective relationship (Roter & Hall, 1993). This model views the patient neither as standing alone, nor as standing aside, when a difficult task, such as a medical decision, needs to be undertaken. The provider and the patient each bring strengths and

resources to the relationship, as well as a commitment to work through any disagreements that may occur in a mutually respectful manner (Roter & Hall, 1993).

Communication is ideal in this model, providing a liberating release and the opportunity for insight and perspective (Roter & Hall, 1993). Being able for a patient to communicate his or her story is an exploration of the significance and impact of a patient's illness or medical problem. How a patient understands his or her disease and the attributions he or she may make are extremely important for understanding reactions and fears (Roter & Hall, 1993).

This theory is unique, enabling a provider to spend quality time with an adolescent in the mutuality model in order to obtain trust and respect. This may not be obtained on the first or second visit, but with time, a healthcare provider can establish a relationship with an adolescent that is worthwhile. Many adolescents will not seek information about sex, drugs, and/or alcohol from their parents. If adolescents are not able to trust their healthcare provider, adolescents may turn to peers, who may provide them with detrimental information, steering them in the wrong direction, or they may choose to never return to the healthcare system.

Project Objectives

The purpose of the project will be achieved through the following objectives:

1) Assess current interactions between adolescents and their healthcare providers**.**

2) Suggest a method to improve communication between adolescents and their healthcare providers.

Significance of the Study

The findings from this project may have significance in the areas of nursing education, practice, research, and policy.

Education

The findings from the project may demonstrate the need for increased and better communication between the healthcare provider and adolescent as they interact. This knowledge may provide a basis for teaching specific adolescent communication skills to advance practice nurses and nursing students. Evaluating how nurses and other healthcare providers communicate with the adolescent in the clinical setting will provide the evidence-based knowledge on how clinicians can better implement or improve communication skills in dealing with adolescents on sensitive health care issues as unprotected sex.

Practice

This project may provide the practitioner with an improved capability to provide quality care in a specialized area of practice through improved communication with an adolescent population that tends not to trust adults. Doctoral-prepared nurse practitioners (DNPs) should have the knowledge and expertise to collaborate with other healthcare members to improve the overall healthcare of the adolescent population. Knowledge of how best to interact with adolescents about a sensitive topic may create positive healthcare changes in adolescents.

Research

Although there is some research on adolescent and healthcare provider interaction, there is scarce research on the methods of improvement on the interaction between the healthcare provider and the adolescent during the healthcare visit. Some research does suggest there is a lack of proper communication between the two. The findings of this project may add to the literature and provide direct evidence on the quality of the interaction between adolescents and their providers, and a method to possibly improve communication will be investigated once the interaction is assessed in this project.

Healthcare Policy

The findings from this project may provide information on key areas between the patient and the healthcare provider communications. It may provide additional information on how best to meet the needs of the adolescent population. The findings may demonstrate that additional quality time may need to be allotted for the adolescent healthcare visits to discuss questions and concerns on sexually transmitted diseases. Healthcare reimbursement may recognize the importance of having a dialogue on sexually transmitted diseases, rather than simply trusting the adolescent, once an STD occurs to know the signs and symptoms and get treatment.

Healthcare providers having an influential voice in politics and becoming proactive regarding sexuality with adolescents could prove to be instrumental. Primary care providers need to have a voice with politicians and keep them informed on the number of STDs among adolescents and to hopefully collaborate together for solutions geared towards the better interest of the adolescent's future. These simple healthcare policy considerations may decrease the number of STDs in a population with the largest amount of STDs nationwide. Many in the adolescent population are misinformed on how STDs are contracted, signs and symptoms, and treatment.

Summary

If the adolescent is unable to communicate comfortably and appropriately with his or her healthcare provider and trust in the confidentiality of a professional who can provide facts and current healthcare information, then the healthcare provider has failed. This age group, more than any other, must be able to turn to an individual it can trust and who can provide information that is accurate and beneficial to their patients well-being.

The Roter and Hall theory is valuable in that it allows adolescents to communicate at their pace and not be judged, opening the door between the healthcare provider and the adolescent.

This project proposes to explore the interaction between adolescent patients and the healthcare provider.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Patient/Provider Interaction

Schaeuble, Haglund, and Vukovich (2010) suggested that primary care is an integral part of adolescence as there are numerous interventions, screenings, and educational tools that assist with risk reduction, promote current health, and help to prepare the adolescent for adulthood. Primary care should be the source of information and support regarding sexual behavior, nutrition, physical activity, and substance abuse**.** However, the adolescent can experience a variety of barriers when accessing primary care, one of which is the way the provider interacts with the adolescent. When adolescents perceive provider interactions negatively, they are deterred from returning to that specific provider and may avoid routine care all together.

In a study by Schaeuble, Haglund, and Vukovich (2010) adolescents were given a Preferences Survey that was developed to assess the healthcare preferences of adolescents. The instrument included 82 open-ended questions**.** Measuring quality of care and provider-patient communication, the results indicated that respect and trust were most important in adolescents' judgments of the quality of healthcare received. Items on the respect and trust subscale measured participants' trust in the provider and the providers' level of trust and respect of them. The adolescent felt that it took time to establish trust with the provider and preferred one consistent provider. When the teens felt comfortable, they were "more willing to talk and open up." In the meantime, if the adolescent does not want to answer any questions, then a provider should not push the client any further. The adolescents cautioned that a provider should not become angry when the teenagers do not want to talk about their problems or answer questions. For the participants, the paramount issue in the relationship was respect from the provider. They

want to feel cared about as a person and to be treated with the respect that they believe should be offered to all persons (Schaeuble, Haglund, & Vukovich, 2010). It appears from the results that adolescents believed they were not treated with respect during the health encounter.

Woods et al. (2006) developed an adolescent patient/provider interaction scale (APPIS) to assess the interaction between the provider and the adolescent at risk for sexually transmitted diseases (STDs). In many regions of the United States, the sexually active adolescent has higher rates of sexually transmitted diseases than older individuals (Woods et al., 2006). The scale was the first scale developed for this use, as there is a lack of information on the impact of the patient and the provider regarding interaction and relationship on the reduction of sexually transmitted diseases and risk behaviors (Woods et al., 2006).

The participants in this study consisted of 192 adolescent females between the ages of 17 to 21, recruited from a control arm of a larger HIV prevention study in Atlanta, Georgia. The study was conducted in three different sites: a county STD clinic (n=51), an urban adolescent clinic (n=99), and a family planning clinic (n=42). The APPIS scale had a Cronbach alpha of 0.79 for reliability. Half of the participants in the study reported that the provider was in charge of the visit. However, 88% strongly agreed or agreed that there was an equal exchange of information during the visit. The APPIS attempts to measure the style of exchange of information and balance of power during the healthcare visit, so in the future, interventions can be planned to enhance mutual exchange of information for the adolescent at risk for STDs.

Klostermann, Slap, Nebrig, Tivorsak, and Britto (2005) explored in a qualitative study of how the adolescent perceives patient and provider trust and identified physician behaviors related to those perceptions that could be modified to promote adolescent healthcare. Fifty-four adolescents were divided into separate groups by age, gender, and health status. They were

recruited from the community and from hospital-based clinics to participate in 12 focus groups. The themes of the focus group were related to preferred physician characteristics and trusting one's provider. The adolescents held a variety of different views regarding their providers, with the younger adolescents (11 to 14 years old) expressing concerns of confidentiality with their health information. In conclusion, the importance of trust and listening to recommendations about behaviors to improve trust and listening may help providers build positive relationships with their adolescent patients.

The older adolescent (15-19 years old) felt that conversations between the health care provider and the adolescent were to be maintained confidential. The older adolescent felt that if the health care provider discussed anything they shared confidential with their parents, the adolescent would lose trust in their health care provider. Adolescents in all age groups did respond that health care providers could establish and gain trust by being honest, being friendly, being there, asking for the adolescents opinion, remaining confidential, and being upfront with health care information.

Confidentiality

Communication among the healthcare provider and the adolescent is of utmost importance to provide up-to-date information as well as overall high-quality healthcare to the patient. When sharing personal information with the healthcare provider that can be sensitive and possibly embarrassing, adolescents have an outlet for private information they may not wish to share with their parents or peers. Confidentiality is crucial and is essential to maintain with an adolescent clientele. When adolescents trust their healthcare provider, the healthcare provider is capable of promoting a positive, healthy behavior and lifestyle. However, in the beginning of the adolescent-provider relationship, the healthcare provider must consider that although

confidentiality is important, there are laws that govern confidentiality that may mandate parental notification. This is crucial to identify to both the parent and the adolescent early on in healthcare encounters (Berlan & Bravender, 2009).

Confidentiality needs to be addressed with the adolescent to help build a trusting relationship and to help facilitate open discussions regarding the adolescent's health and sexual behaviors. Therefore, confidentiality issues need to be discussed in the first visits with the adolescent and parents by addressing state laws/statutes for adolescents. It is important for both parents and adolescents to understand the legal rights of adolescents to give informed consent, without the parent's knowledge of treatment pertaining to contraception, pregnancy, sexually transmitted diseases, substance abuse, and mental health without parental consent, which has been established in most states, including Florida (ACOG, 2006). As of 2008, all states allow minors to consent to testing and treatment of STDs. Only the District of Columbia and 21 other states explicitly permit all minors to consent to contraceptive services (ACOG, 2006). In Florida, within 48 hours of a minor's abortion, parental notification in person or over the phone is required. Consent from the parents for the abortion is not required, and a minor may bypass a parent with court approval. Thus, an abortion is permitted without parental notification in a medical emergency (Florida Senate, 2010).

In Florida, the adolescent is assured of confidential STD clinical services, including a health history and risk assessment, physical exam, STD testing if indicated, treatment, and counseling (Florida Department of Health, 2010). Facilitating open communication at the first visit makes the parent and adolescent aware of the legal rights and hopefully helps to establish a confidential relationship between the adolescent, parent, and provider.

Loxterman (1997) conducted a survey with adolescents about seeking medical care if parental knowledge was mandated. Adolescents experiencing depression, STDs, suicidal thoughts, or pregnancy pose a grave danger to themselves. A healthcare provider can offer the assistance needed by encouraging screening and treatment. The study results showed that less than 20% of adolescents would seek STD treatment, birth control, or drug/alcohol treatment if parental knowledge was mandated; this could affect adolescents' decision making and may reduce the likelihood of treatment. A parent or relative may be the cause of the adolescents' emotional or physical issues. Thus, guaranteeing confidentiality to the adolescent is essential in helping the adolescent receive the care that is needed in this vulnerable population.

Berlan and Bravender (2009) reviewed healthcare-related studies relevant to adolescent consent and confidentiality in medical literature as well as the legal framework for the provision of this care. Their findings revealed that physician assurances of confidentiality increase adolescents' willingness to disclose sensitive healthcare concerns, but the assurances were rarely given. Adolescent consent varies state to state, with federal guidelines and common law concepts that are applicable throughout the United States (Berlan & Bravender, 2009). Confidentiality in this age group has significant implications for improvement in adolescent healthcare (Berlan & Bravender, 2009). Healthcare providers must be aware of these implications, federal policies, and the state the provider practices in pertaining to certain health issues, such as sexually transmitted diseases, birth control, and pregnancy.

Lehrer, Pantell, Tebb, and Shafer (2007) examined the risk characteristics associated with confidentiality concerns as a reason for forgoing health care among adolescents in the United States. The study used data from home interviews of the National Longitudinal Study of Adolescent Health. The results showed that the prevalence of risk factors was increased among

males and females who reported confidentiality concerns as compared with those who did not report those concerns. Regression analysis for males (n=1123) showed that high depressive symptoms, suicidal ideation, and suicide attempts were each associated with increased odds of reporting confidentiality concern as a reason for forgone health care (Lehrer et al., 2007). In a multivariate analysis for females (n=1315), having had sexual intercourse, no birth control with last sexual experience, prior sexually transmitted disease, prior alcohol use, high and moderate depressive symptoms, suicidal ideation, suicide attempts, and unsatisfactory parental communication were each associated with increased odds of confidentiality concern as a reason for forgone health care (Lehrer et al., 2007). Findings of this study suggest that if restrictions to confidentiality are increased, healthcare use among the adolescent population will diminish, thus increasing the likelihood for adverse health outcomes in this vulnerable population.

Communication

Communication is an essential component in any successful relationship. Effective communication between the patient and provider is essential for quality healthcare and to promote the overall well-being of the patient. The adolescent may not the best communicator or may be reluctant to say what he or she may want or need. Therefore, it is important for the healthcare provider to provide the information about STDs and contraception by initiating the conversation.

Clowers (2002) looked at the communication between 185 adolescent females between the ages of 14 and 19 and their healthcare provider. Consistent results demonstrated that the adolescent preferred communication with a provider that understood, talked to her, cared, listened, and respected her as an individual. The results of this survey indicated that young

women appreciate the importance of knowledge and an individual's medical skills, but it is the communicatively competent healthcare provider that they seek the most.

Jacobsen, Richardson, Parry-Langdon, and Donovan (2001) conducted a focus group to determine how adolescents view primary care and to discover how primary care providers view adolescent patients between the ages of 14 and 18. The adolescents reported a lack of knowledge of services available for primary care, lack of respect for adolescent health concerns, poor communication skills among providers, and a poor understanding of confidentiality issues. The healthcare providers did not always share these same concerns and had different views on communication and confidentiality issues. The adolescent described an inequality of status with their provider and saw the provider as more of an authority figure that communicated rapidly. The adolescents voiced lack of sufficient time spent with the provider (Jacobsen et al., 2001). The adolescents appreciated certain healthcare providers gave them time to overcome any initial fears so they could effectively communicate their concerns. The data collected demonstrated important findings on how adolescents would like primary care services to be improved.

In a randomized, controlled study by Merzel, Vandevanter, Middlestadt, Bleakley, Ledsky, and Messeri (2003), adolescent sexual health assessments during a primary care visit were examined. A total of 313 adolescents completed a questionnaire on STDs and health care. Only 32% of the adolescents reported discussing sexual behavior, birth control, and STDs with their healthcare provider. Twenty-seven percent reported no discussion of any sexual health topics with their providers. Fifty-one percent had a history of sexual activity within the last three months and did not discuss sexual activity or STD prevention at their last healthcare visit. The attitudes and beliefs of the adolescents talking with their providers about a health issue were strongly associated with discussion of the topic by the provider¸ with 3% of the adolescents

initiating the conversation (Merzel et al., 2003). The adolescent and provider were discouraged in talking about sexual health, STDs, alcohol, and tobacco use with the presence of the parent at the visit. It is essential for primary care providers to facilitate communication when providing care to adolescents. Healthcare providers should provide accurate, up-to-date information on STDs and birth control, hopefully creating a positive environment for adolescents and positively reinforcing adolescents' attitudes regarding communication with their healthcare provider.

Effective communication among healthcare providers and adolescents is essential to provide health information and identify emerging health issues. A study by Mulvihill, Romaire, Gyaben, Telfair, and Caldwell (2005) addressed whether communication improves among adolescents and healthcare providers after enrollment in a State Children's Health Insurance Program (SCHIP). Surveys were mailed to 3,472 12- to 19-year-olds in the SCHIP, with 1,689 respondents (Mulvihill et al., 2005). The study explored the differences in communication among the provider and adolescent before and after enrollment in the SCHIP. The results showed that after enrollment in SCHIP, communication among adolescents and healthcare providers substantially increased. Females in the study were more likely than males to discuss sexual health, diet, and exercise**.** Older adolescents were more likely than younger to discuss sexual health, and white adolescents were more likely than non-white adolescents to have better overall communication with the provider after enrollment. There was a positive change in communication after enrollment in SCHIP, suggesting that encouragement of providers and adolescents to discuss risky behaviors is an achievable goal.

Primary care providers are in a position to be instrumental when providing information to adolescents about sexually transmitted diseases. Boekeloo, Schamus, Simmens, Cheng, O'Connor, and D'Angelo (1999) conducted a behavioral intervention trial to reduce sexual risks.

The adolescents were recruited from primary care offices and randomized into two study groups, the Intervention Group and the Usual Care Control Group. The adolescents that participated in the study were between the ages of 12-15. The intervention used was an audio-taped STD risk assessment and education about staying safe (condoms, abstinence). The results showed that more of the intervention group reported discussion of sexual topics with their provider than the control group, with more sexually active adolescents reporting condom use in the intervention group. There were no reported STDs at the end of the study in the intervention group and 7 out of 103 were reported in the control group. Educational tools and STD risk assessment follow-ups with the adolescents were at three months and at nine months, with no group reporting differences in sexual behavior. Although the impact of sexual activity and condom use was short lived in this particular study, further research is needed to develop brief, office based sexual risk reduction for adolescents (Boekeloo et al., 1999).

Klein and Wilson (2002) compared adolescents' report of topics that they wished to discuss with their provider with what they actually discussed and whether they talked to their provider about self-reported health risks. The study analyzed the 1997 Commonwealth Fund Survey of Health of Adolescent Girls (Schoen, Davis, & Collins, 1997). A sample of 6,728 males and females took part in the study. Reports were made about health risks, whether they believed their provider should discuss certain topics, and whether their provider did talk about health-related topics. Logistic regression was used to compare proportions and assess the association among the variables. The results demonstrated that adolescents frequently discussed dietary habits (49%), weight (43%), and exercise (41%) with their provider, but most frequently wanted to discuss drugs (65%), smoking (59%), and healthy dietary habits (57%). Approximately 70% of the sample reported at least one of eight potential health risks, including

physical and/or sexual abuse, alcohol use, eating disorder, drugs, smoking, exercise, preventing pregnancy, and stress. Only 63% of the adolescents had not discussed any of these risks with their provider (Klein & Wilson, 2002).

In conclusion of this study, adolescents want and need to discuss healthcare issues with their provider, but often adolescents are not the first to initiate the conversation. Adolescents may benefit from increased screening and preventative care from their healthcare provider.

Summary

In summary, this chapter reflects research studies based on how adolescents view their interaction with the healthcare provider and what is important to them. Confidentiality and communication are two key components in a healthcare visit between the provider and the adolescent. Many of the studies show that when an adolescent establishes trust, the adolescent is more willing to open up and communicate with their healthcare provider. Adolescents are at an age where they need guidance and direction, being able to trust and communicate with their healthcare provider who can offer them knowledgeable and honest information is of utmost importance in the development stage of an adolescent's life.

CHAPTER THREE

METHODS

This chapter focuses on the project design, the setting, the sample, ethical considerations, and the project implementation. The data collection procedures and the instruments used are discussed along with the plan for data analysis.

Purpose

The purpose of the project was to evaluate the interactions between healthcare providers and adolescents in a clinic located in South Florida and to suggest a method to improve communication between adolescents and their healthcare providers.

Project Design

The project utilized a non-probability descriptive design using a convenience sample of adolescents and the Adolescent Patient Provider Interaction Scale (APPIS) in a multiethnic population in South Florida to evaluate the interaction with the adolescents' healthcare providers. The APPIS (Appendix C) is a nine-item question scale that measures confidentiality and communication between the healthcare provider and adolescent, evaluating their interaction overall. The scale was developed in 2006 and was created using the Roter and Hall theory of doctor-patient relationships and two previously validated adolescent satisfaction and communication scales, the Kahn's Provider Communication scale and YAHCS communication and satisfaction scale for adolescents. (Woods et al., 2006).

Setting

The participants were recruited from a clinic in South Florida. The clinic provides primary care, women's health care, and dental services to a multitude of adolescents annually. Letters of support from the clinic are attached (Appendix B).

Sample

A convenience sample of older adolescents, 18 to 24 years of age, was used that met the eligibility criteria mentioned below. The older adolescent was chosen as being of age to sign for consent.

Determination of Sample

The South Florida clinic has approximately 202 adolescents between the ages of 18-24; the APPIS and demographic questionnaire were distributed to 30% (60 participants) of eligible patients. The sample size was determined using non-probability descriptive statistics with a convenience sample (Polit & Beck, 2004). The sample size chosen for this project was influenced by time period completion factor of weeks that were allotted for this project.

Inclusion Criteria

To be considered eligible for participation, an individual must be between the ages of 18 to 24 years of age, currently attend the clinic for care, able to read and speak English, and willing to participate.

Exclusion Criteria

Any adolescent attending the clinic not between the ages of 18-24, was unable to speak and read English, or declined to participate was excluded.

Ethical Considerations

Permission to conduct this study was obtained from the study site (Appendix B) and through the Barry University Internal Review Board (IRB) (Appendix A). Participation in this study was completely voluntary. A cover letter (Appendix D) accompanying the APPIS and demographic questionnaire explained the study and notified potential participants that participation was sought and was voluntary. The study was confidential, and completing and returning the APPIS into the lockbox constituted consent for participating in the study. The sample of adolescents was 18-24 years of age and each was legally able to sign consent. The APPIS is a confidential questionnaire. Participants were free to decline and answer any questions or choose not to participate without any consequences or impact on their care at the clinic. Confidentiality was maintained to the extent permitted by law. There were no participant identifiers or information that could link participants to published material. The researcher plans to keep documents for five years protected in a password-protected computer, and printed documents will be kept in a locked cabinet and locked office where only the researcher has access. The researcher's Capstone committee had access to the de-identified data. All documents and computer files will be maintained for a period of five years at which time they will be physically destroyed or erased. The results used for presentation or publication represent aggregate information or group averages only. No individual identifiable information will be released.

Data Collection

Once the project approval was obtained from the Barry University IRB (Appendix A); flyers (Appendix G) were placed at the sign-in area of the clinic. If an adolescent wished to participate, he or she was given the cover letter from the front desk member of the clinic who did

not provide direct care. After the cover letter was read, and the adolescent indicated he or she wished to participate in the project, the adolescent informed the front desk clinic team that he or she wished to participate, and he or she then was given the APPIS and demographic questionnaire to complete. After completion of the APPIS and demographic questionnaire, the participant placed both of these in a locked box located inside of the front desk of the clinic. Completion of the APPIS and demographic questionnaire were considered consent; the researcher checked the locked box weekly for completed forms. Data analysis initiation was driven by completion of 60 questionnaires, which fulfilled the project's sample size.

Budget

The budget included; the SPSS software package at $99; an editor at $20 hourly for five hours totaling $100, and copies of the APPIS and demographic questionnaire for the adolescents was $200. The total cost for this project was $399.

Instruments

The research measure used was the Adolescent Patient Provider Interaction Scale (APPIS) and a demographic questionnaire.

The Adolescent Patient Provider Interaction Scale

The Adolescent Patient Provider Interaction Scale (APPIS) was used to measure the adolescent and healthcare provider interaction. The APPIS questions were developed from the Roter and Hall Theory of the doctor/patient relationship. The Roter and Hall Theory contain four distinct relational characteristics**.** As explicated in Chapter One, the first is paternalism. In this type of relationship the provider is in control of the visit. APPIS question #1 addresses paternalism, regarding "who was in control of the visit"? The second type of relationship is consumerism, where the patient's rights are foremost and the providers are obligated to assist

them. The APPIS addresses consumerism also with question #1, asking if the client felt they were in control of the visit. The third interaction is characterized by a lack of control by the provider and the patient demonstrates a poor relationship between the two. Here, neither party has accepted responsibility for medical decisions. APPIS question #1 addresses this potential interaction**,** for if the client felt that neither was in control of the visit, they would answer the question "neither were/don't know." Ideally, mutuality, the fourth type of interaction occurs. The APPIS questions addresses support mutuality. The APPIS addresses mutuality also with question #1, if the client felt that the control of the visit was shared by both the provider and the client than they would answer "both were."

APPIS validity was compared with previously validated satisfaction scales used by the Young Adult Health Care Survey (YAHCS) and Kahn's Provider Communication Scale (Woods et al., 2006). The YAHCS assessed adolescents' communication with providers and satisfaction with care. The YAHCS was shown to have strong construct validity and internal consistency (Cronbach's alpha = .77) (Woods et al., 2006). Kahn's provider communication scale is based on adolescents' intention to return for Pap smears. Kahn's seven-question scale had a high Cronbach's alpha of 0.91 in a similar, primarily African American adolescent population and was modified by Kahn.,et al. (2001) in a previous study to describe the most recent clinic visit instead of future perceptions (Kahn, Emans, & Goodman, 2001).

The APPIS study recruited 192 African-American adolescent females between the ages of 15 to 21 from an STD, family planning, and an adolescent clinic. Upon completion of the APPIS questionnaire, of 192 participants, 49% felt that both the provider and patient were in charge of the visit**;** 27% felt that the patient was in charge of the visit**;** and 14% reported the provider was in charge. Of the 192 adolescents, 88% "strongly agreed" or "agreed" that there was an equal

exchange of information during the visit. Most of the responses on the APPIS were positive towards the provider. The APPIS showed good internal consistency (Cronbach's alpha = .75) and moderate convergence with the YAHCS scale ($r = .57$, $p < .001$) and the Kahn scale ($r = .48$, $p < .001$). Cronbach's alpha is a good measurement tool used to measure reliability or internal consistency of a test score, instrument. Cronbach's alpha will generally increase as the intercorrelations among test items increase, thus the higher the score the greater the reliability of the instrument used.The moderate convergence represents that different methods of measuring a construct yield similar results (Polit & Beck, 2004). The APPIS compared favorably with the previous scales of healthcare satisfaction and communication of the Roter and Hall (Woods et al., 2006).

Descriptive analysis was used for the data analysis for that study, including frequencies and variables. (Woods et al., 2006). The APPIS was compared with the YAHCS patient satisfaction scale and Kahn's Provider communication scale and was hypothesized to be similar to the YAHCS communication and satisfaction questions, and the Kahn communication scale, but was not completely the same because the APPIS contained additional concepts of interaction between patient and provider, including mutual exchange of information (Woods et al., 2006).

Although the APPIS was developed in 2006, it has not been used in the clinical setting to date. This Capstone Project was the first use of the APPIS since 2006. Along with the APPIS questionnaire; participant demographic information was obtained (Appendix E). Permission from the author, Dr. Woods, to use the APPIS is attached (Appendix F).

Data Analysis Plan

The statistical analysis plan, using frequencies is the same as in the original study by Woods et al., (2006). Descriptive statistics were used as in the previous study. Frequencies are one method of measurement used in descriptive statistics to group values into categories.

Summary

This study was a non-probability descriptive study with a convenience sample of adolescents to evaluate the interaction between healthcare providers and adolescents utilizing the APPIS and a demographic questionnaire. The goal of this project was to evaluate the interaction between adolescents and their healthcare provider and to suggest a methodology based on the findings of the APPIS to improve communication between adolescents and their health care provider that may create health care change in adolescents.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter will focus on the results from the project, the discussion of findings of the project, strengths and limitations of the study, implications for healthcare outcomes, healthcare delivery, healthcare policy, and future research.

Clinic Description

The waiting room is separate and locked from the clinic. The adolescents sign in at the waiting room with the front desk receptionist prior to being seen in the clinic. The clinic has two large rooms with two hospital beds per room for clients; the clinic has two exam rooms capable for routine exams, and Pap smears. The clinic has an internal lab for blood draws with a dental office located within the clinic. There is also one health care provider's office located within the clinic. The nurse's station is located at the front of the clinic near the waiting room.

Results of Questionnaires

This project recruited 60 participants consisting of 53.3% females and 46.7% males. The project population consisted of adolescents between the ages of 18-24, with the majority being 20 years of age (26.7%) and 19 years of age (23.3%) being the second highest. The mean age was 20 years. (Table 1).

Table 1

Age

	Frequency	Percent
18 years old	8	13.3
19 years old	14	23.3
20 years old	16	26.7
21 years old	6	10
22 years old	8	13.3
23 years old	7	11.7
24 years old	1	1.7
Total	60	100

Table 2 describes the relative control of health care visit by the provider and adolescent. The findings indicate that the adolescent felt that both the health care provider and the adolescent were in control of the visit.

Table 2

Who was in control of the visit?

	Frequency	Percent
I was	21	35.0
Provider	6	10.0
Both	29	48.3
Neither/ Don't know	4	6.7
Total	60	100.0

Table 3 reflects the exchange of information. The findings report that the adolescents felt the information shared during the clinical visit was equally exchanged during the visit.

Table 3

Was there an equal exchange of information with the provider?

	Frequency	Percent
Strongly agree	23	38.3
Agree	32	53.3
Disagree	5	8.3
Total	60	100.0

Table 4 reflects the confidentiality aspect of the encounter. The findings represent that the provider informed the adolescents that confidentiality would be mentioned concerning the health care visit.

Table 4

The provider let me know what we talked about was confidential.

	Frequency	Percent
Strongly agree	26	43.3
Agree	32	53.3
Disagree	2	3.3
Total	60	100.0

Table 5 presents how the adolescent felt the provider treated them during the visit. Was he or she treated respectfully? The findings represent that the adolescent felt the health care provider treated them with respect during the visit.

Table 5

The provider treated me with respect.

	Frequency	Percent
Strongly agree	36	60.0
Agree	23	38.3
Disagree	1	1.7
Total	60	100.0

Table 6 presents the findings on whether the provider was sympathetic towards the client. In the original APPIS, many of the adolescents felt sympathy represented a condescending attitude and they did not want the health care provider to feel sympathetic towards them. The current findings may be suggestive of the earlier studies results.

Table 6

The provider was sympathetic to me.

	Frequency	Percent
Strongly agree	17	28.
Agree	36	60.0
Disagree	6	10.0
Strongly disagree	1	1.7
Total	60	100.0

Table 7 reports that the majority of adolescents felt they were treated in a non-judgmental manner during the clinical visit.

Table 7

The provider was non-judgmental about me

	Frequency	Percent
Strongly agree	32	53.3
Agree	25	41.7
Disagree	1	1.7
Strongly disagree	2	2.3
Total	60	100.0

Table 8 reports the comfort level of the adolescents to ask any questions with that particular health care provider. An overwhelming majority felt comfortable with the health care provider.

Table 8

I felt comfortable enough with the health care provider to ask the questions I needed.

	Frequency	Percent
Strongly agree	32	53.3
Agree	27	45.0
Disagree	1	1.7
Total	60	100.0

Table 9 addresses thoroughness of the provider's explanations to questions. Adolescents felt the provider was thorough during the clinical visit.

Table 9

The provider explained everything I needed to know.

	Frequency	Percent
Strongly agree	33	55.0
Agree	26	43.3
Disagree	1	1.7
Total	60	100.0

Table 10 addresses whether the adolescent feels the provider cares about them overall and provides evidence that the adolescent felt the health care provider cared about them.

Table 10

The provider cares about me.

	Frequency	Percent
Strongly agree	16	26.7
Agree	42	70.0
Disagree	2	3.3
Total	60	100.0

The interactions between the healthcare provider and adolescents were analyzed and positive interactions were found. At the study site, 35% of the participants believed they were in control of the visit (Table 2). Roter and Hall's notion of mutuality is evidenced with 48.3% of participants agreeing that both were in control of the visit, as well as with equal exchange of information (Table 3), where 91.6% agreed. Two key characteristics with any adolescent provider interaction, confidentiality and respect were clearly maintained (Tables 4) with 96.6% agreeing confidentiality was maintained and (Table 5) 98.3% believing they were respected by the provider. Regarding the provider being sympathetic towards the adolescent (Table 6), 88% felt the provider was sympathetic towards them; however, 11.7% disagreed. This question was included on the original APPIS with similar results. The adolescents in the original study felt this question implied a condescending attitude and that the provider should not be sympathetic towards them. This rationale could be reflective of the 11.7% disagreement rate on this project.

Regarding the provider being non-judgmental (Table 7), 95% felt the provider was non-judgmental towards the adolescent. Regarding the adolescents feeling comfortable with the provider, the provider explaining, and caring (Tables 8-10), 98.3% felt comfortable with the provider, 98.3% felt the provider explained things discussed, and 96.7% felt the provider cared about them.

Discussion of Findings

The study (Woods et al., 2002) upon which this Capstone was replicated had three separate clinics with a total of 192 adolescents that treated diagnoses specific to STDs, adolescent pregnancy, and general adolescent healthcare. This particular project had a total of 60 adolescents from one clinic dealing only with general adolescent healthcare.

In both the previous and current studies, most of the responses to the majority of questions were positive towards the provider, either "strongly agree" or "agree." n terms of the question about provider sympathy for adolescents, the previous study demonstrated 17.6% "strongly agreed" and 44.7% "agreed." In this project, the results for the same question demonstrated 28.3% "strongly agreed" and 60% "agreed."

In the current project, the provider did receive positive, equal, and at times higher percentages of scores on the APPIS questionnaire than providers on the previous APPIS questionnaire. This finding may be due to the fact that the provider in this clinic does spend a significant amount of time with the adolescents. New clients may spend one hour with the provider and established clients can spend up to 30 minutes or more. The time spent with clients in the previous study was not reported.

The clinic in the current project has an "open door" policy, with most adolescents having an appointment, but adolescents will be seen the same day if needed without an appointment.

They are also able to speak with the provider in her office when personal issues occur, such as mental health concerns and/or possible pregnancy. Having a provider that understands adolescents and relates to adolescents needs and mentality is beneficial in maintaining a positive interaction between the healthcare provider and adolescents. Instituting a non-judgmental attitude and willingness to work with adolescents can possibly make a difference in health outcomes.

The provider during this project was a female physician and was available, respected, listened, and did not judge the adolescents, based on the current project results**.** Having these qualities as a healthcare provider can make a difference when dealing with a challenging population such as adolescents.

Potential Method to Improve Communication

Story theory, a middle range theory, was developed by Smith and Liehr (2008) to enable the patient to talk about their health in terms of a story. This approach has been shown to open a line of communication between the patient and the provider enabling the patient to share their history through stories, past and present. Story theory may be beneficial in assisting adolescents find their voice in an urban practice setting (Liehr & Smith, 2008). This theory has components that are pertinent in assisting adolescents explore themselves and may be beneficial in opening up a line of communication between their health care provider during their clinical visits.

Story theory is composed of three interrelated processes (1) intentional dialogue, (2) connecting with self-in-relation, and (3) creating ease. The intentional dialogue concept is defined as a provider intending to engage with the patient's life experience. Intentional dialogue is engagement with another to summon the story of a complicated health challenge. This action attempts to engage the client and provider in dialogue about life experiences to seek and possibly

begin a process of change (Liehr & Smith, 2008). The premise is that the health care provider gives their undivided attention during this stage, conveying a message that the individual is respected and worth listening to, thus opening the door to a trusting relationship.

There are two process of intentional dialogue: true presence and querying emergence. True presence is the providers focus on the individual's story. Querying emergence is clarification of vague story directions. The healthcare provider tries to understand the story from the individual's perspective; with nothing being assumed, the story is never finished with portions of the story that the individual may not be ready to share or not want to tell (Liehr & Smith, 2008). Intentional dialogue could be used with providers that may have challenging adolescents. Adolescents come from different cultural and ethnic backgrounds, and some adolescents have not been able to trust anyone. Intentional dialogue could be used to open the door to a trusting relationship between the adolescent and healthcare provider. Once an adolescent is encouraged to tell their story, he or she connects with himself or hers elf and reflects on the past through self-relation, thus leading to creating ease for the adolescent.

To establish trust and any kind of rapport, the health care provider should be non-judgmental, listen, respect, be upfront, and be honest with the adolescent in the beginning. The health care provider must be capable to talk to the adolescent about what is important in the adolescent's life, do not preach, but listen, and be on his or her level. It is crucial to talk to adolescents about themselves and learn their respect; once a health care provider does, trust and changes can occur.

Connecting with self-in-relation is composed of personal history and reflective awareness. Personal history is the unique narrative uncovered when individuals reflect on where they have come from, where they are now, and where they are going in life (Liehr & Smith,

2008). As the provider guides the patient through reflective awareness the patient becomes aware of their thoughts and feelings regarding what may be known or what was unknown. Reflective awareness is a stage in story theory where an adolescent can reflect on his or her past and allows self-evaluation on where he or she is headed or would like to go. This stage may be beneficial with adolescents wishing to pursue college or career choices but are unable to visualize a clear path, enabling them to reflect on where they were and which path they want to travel on in the future. Reflective awareness may invigorate an individual's connection with self-in-relation to others and the rest of the world and establishes a milieu for creating ease (Liehr & Smith, 2008). Creating ease is an energizing release experienced as the story moves towards resolution. This may occur in the context of the patients search for ease and the provider's ability to provide this ease (Liehr & Smith, 2008). Creating ease is the last step in story theory, where an adolescent actually has resolution to their story. Regarding the adolescent voice, story theory provides an approach to obtain information to better understand the adolescent (Smith & Liehr, 2008).

Story theory is unique, enabling a provider to spend quality time with an adolescent in order to obtain trust and respect. This may not be obtained on the first or second visit, but with time, a healthcare provider can establish a relationship with an adolescent that is worthwhile. Many adolescents will not seek information in regards to sex, drugs, and/or alcohol from their parents. If adolescents are not able to trust their healthcare provider, adolescents may turn to peers, who may provide them with erroneous or detrimental information, steering them in the wrong direction, or they may choose to never return to the healthcare system. Story theory may allow the adolescent to tell their story at their own pace and enable them to communicate and establish trust in their healthcare provider.

In order for a trusting relationship to be established between a healthcare provider and an adolescent, it is crucial that a trustworthy relationship develops from the beginning (Clowers, 2002). According to Clowers (2002), adolescents report that if given the opportunity to discuss issues about sex with the healthcare provider, they would. However, most adolescents are too embarrassed to initiate this type of conversation. This suggests that conversations about sex and safety issues should be initiated by healthcare providers especially with this vulnerable age group. This project demonstrated positive results, illustrating that if the healthcare provider has open communication with the adolescents, they may end up trusting the healthcare provider and be more communicative with the healthcare provider regarding their sex lives.

Strengths and Limitations of the Study

Historically, most perceptions of healthcare quality and patient-provider communication are focused on the adult population. One strength in this project was being able to provide a questionnaire for the adolescent population that has been previously validated, if only once.

A significant limitation in this project was that the clinic only had one provider. By limiting the study to one clinic, this decreases the researcher's ability to have the adolescents evaluate more than one health care provider**.** Also, by having one clinical site, the validity of the study is diminished; having more than one clinical site can give increased observations/results. The previous study was able to evaluate three clinics with a multitude of providers, thus giving the researcher more feedback on their study. Limiting the study to a clinic with one provider, limits the evaluation and how many interactions are taking place. In the future, it would be beneficial to replicate the study in multiple clinics to evaluate a multitude of healthcare providers. Regarding the limitations, possibly asking if the adolescents have discussed anything

of a sexual nature with their healthcare provider could be added to the questionnaire. Another limitation is that the APPIS questionnaire did not address STDs.

Implications

Advanced Practice

Advanced practice nursing is broadly defined as nursing interventions that influence health care outcomes, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health care organizations, and the development and implementation of health policy (O'Grady, 2008).

The findings of this project suggest that the APPIS questionnaire is of limited use in the clinical setting and suggest utilizing a methodology such as story theory in further studies. This project would yield greater evidence in developing a framework incorporating theory to enhance communication between the adolescent and healthcare provider. As advance practice nurses, we are unique and able to apply our nursing knowledge to issues that may not have solutions, but we are willing to look at options and capable of suggesting possible solutions. The use of story theory may strengthen the process of adolescent- provider interaction**.**

Healthcare Outcomes

The findings from this project demonstrate that positive interactions can occur among healthcare providers and adolescents. The healthcare provider at this clinic was female, suggesting that adolescent males can be just as forthcoming about health concerns with a provider of the opposite sex. Regarding healthcare outcomes, having a male or female provider may be a factor for adolescents being forthcoming regarding healthcare concerns. Adolescents in different ethnic backgrounds, especially ones living in poverty can be more prone to teen pregnancy, obesity, limited educational achievements, and violence. The majority of healthcare

outcomes in adolescent healthcare are preventable, as most behaviors demonstrated by adolescents stem from peer pressure, family, and society expectations (Healthy People, 2011). Adolescents who feel they can communicate with an adult may be less likely to become involved in risky behavior.

The findings from this project are an integral part of the advance practice nursing by promoting health and well-being in adolescents. This particular project can serve as a blueprint for future studies to evaluate and promote the healthcare provider and adolescent interaction by developing and implementing a communication tool for future studies. This was done by evaluating the interaction between the health care provider and adolescent interaction using the APPIS questionnaire.

Healthcare Delivery

Findings from this project could possibly change healthcare delivery by enabling adolescents to always see the same healthcare provider instead of multiple healthcare providers in one clinical setting. This is related to this particular project, by hopefully establishing and enabling trust between the adolescent and one particular health care provider with empathy. Barriers to healthcare delivery of adolescents are providing access to comprehensive medical services (dental, psych, and gynecology) and implementing strategies to overcome barriers to adolescent healthcare and providing and maintaining confidentially, which findings from the project demonstrate.

As advanced practice nurses, we play a key role in advancing "Nursing's Agenda for the Future" and participate in alliance efforts to change public policies affecting healthcare delivery priorities, work environments for nurses, the diversity and cultural sensitivity of the profession

(Kany, 2004). Nursing is valued for its specialized skill, and caring for improving healthcare to the public and ensuring safe, quality, and effective care is delivered.

Nurse Practitioners should strive for inter-professional collaboration to improve patient outcomes. This can be demonstrated by collaborating with physicians or other healthcare providers that primarily care for adolescents and educate them within the scope of nursing, such as using story theory to promote communication among their adolescent clientele. This methodology can be an educational tool for promoting communication between the healthcare provider and adolescent. This may provide evidence-based knowledge evaluating multiple clinicians' communication skills with their adolescent population using a methodology tool, such as story theory on promotion of communication skills with adolescents.

Healthcare Policy

The findings demonstrate that equal exchanges of information, adolescents perceiving they are in control of the health visit, being treated respectfully, and acknowledging confidentiality are all important aspects in a healthcare provider interaction. Health care providers that provide care for adolescents should become proactive regarding STDs with adolescents.

Adolescents between the ages of 20-24 have the largest incidence of Human Immunodeficiency Virus (CDC, 2011). These statistics alone should alert politicians to create funding for prevention and education towards sex education and STDs. Many adolescents are without healthcare insurance adolescents enrolled in state government programs for trade school are able to obtain free healthcare, and also obtain their GRE at the same time, but currently, there are no policies in place that promote general access to adolescent healthcare, thus possibly impacting adolescents nationwide preventative healthcare services.

Health care providers need to have a voice with politicians and keep them informed on the number of STDs among adolescents and to collaborate together for solutions geared towards the better interest of the adolescent's future. These simple healthcare policy considerations may decrease the number of STDs in a population with the largest amount of STDs nationwide. Many in the adolescent population are misinformed on how STDs are contracted, signs and symptoms, and treatment.

Future Research

There is limited research on adolescent and healthcare provider interaction, with studies and frameworks geared more towards the adult population. Research does suggest there is a lack of proper communication between healthcare providers and adolescents. Although the findings of this study do not support a lack of communication, engaging in further research using the APPIS questionnaire with an increased number of providers in multiple clinics may provide support in establishing a method to improve communication between the healthcare provider and adolescents. Further research studies formulating story theory as a methodology tool to improve communication may be instrumental in improving communication between the healthcare providers and adolescents.

Summary

This project was a descriptive study that utilized the APPIS questionnaire to evaluate a convenience sample of 60 adolescents at one particular clinic. In order to better suggest a methodology to improve communication between adolescents and healthcare providers, a project should be done that includes multiple clinical settings with more than one healthcare provider. In this particular project, the interactions between the healthcare provider and adolescent the majority of the time were positive, with the adolescents either "strongly agreeing" or "agreeing"

on the questionnaire. The project has implications for advanced practice, healthcare outcomes, delivery, and policy. Additional research utilizing the APPIS in multiple settings along with a methodology developed from the framework of story theory will add to the body of knowledge on adolescent interactions with healthcare providers.

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APPENDIX A

BARRY UNIVERSITY IRB APPROVAL LETTER

BARRY UNIVERSITY

11300 NE Second Avenue
Miami Shores, FL 33161-6695
phone 305-899-3020
800-756-6000, ext. 3020
fax 305-899-3026
www.barry.edu

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD Research with Human Subjects
Protocol Review

Date:	June 8, 2011
Protocol Number:	110512
Title:	Evaluating the Healthcare Provider Interaction with Adolescents at Risk for Sexually Transmitted Diseases
Approval Date:	6/8/11
Name:	Maureen Greenwood
Address:	4300 SW 6th Street Plantation, FL 33317
Sponsor:	Dr. Andra Hanlon N.A. Nursing

Dear Ms. Greenwood:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the IRB have been made. Therefore, I have granted final approval for this study as exempt from further review.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on June 1, 2012. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with IRB Application for Continuing Review (Progress Report) summarizing study results to date.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at (305)899-3020 or send an e-mail to

dparkhurst@mail.barry.edu . Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

Doreen C. Parkhurst, M.D., FACEP
Chair, Institutional Review Board
Associate Dean, SGMS
Program Director, PA Program
Barry University
Box SGMS
11300 NE 2nd Avenue
Miami Shores, FL 33161

Cc: Dr. Andra Hanlon

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

APPENDIX B

LETTER OF SUPPORT

Miami Jobs Corps

3050 NW 183rd Street

Miami, Fl 33056

March 1st, 2011

Barry University Institutional Review Board

Miami Shores, Fl.

Please note that Ms. Maureen Greenwood, ARNP has the permission of Julia Torres, MD to conduct research at Miami Job Corps for her study, "Evaluating the Healthcare Provider Interaction with Adolescents at risk for Sexually Transmitted Diseases."

Ms. Greenwood will post a flyer with information regarding the research in the office waiting room. One employee will be given cover letters and the questionnaire to distribute to the adolescents. The cover letter will describe the project, including risks and benefits. Should the adolescent choose to participate, they will drop the completed questionnaire in a locked box. Only Ms. Greenwood will have access to the completed questionnaires.

Ms. Greenwood has agreed to provide my office documentation of Barry University IRB approval before participants are recruited. She will also provide a copy of the aggregate results.

If there are any questions, please contact my office.

Julia Torres, MD

Miami Job Corps

APPENDIX C

ADOLESCENT PATIENT-PROVIDER INTERACTION SCALE (APPIS)

The questions are in regard to your interaction with your healthcare provider. There are a total of 9 questions, circle one answer that applies to your interaction.

1) Who was in control of the visit?
    a. I was
    b. The provider was
    c. Both of us were
    d. Neither/Don't know
2) Was there an equal exchange of information during your visit with your healthcare provider?
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
3) The healthcare provider let me know that what we talked about was confidential?
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
4) The healthcare provider treated me with respect
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
5) The healthcare provider was sympathetic to me
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
6) The healthcare provider was non-judgmental towards me
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
7) I felt comfortable enough to ask the healthcare provider the questions I needed to ask
    a) Strongly agree
    b) Agree
    c) Strongly disagree
    d) Disagree
8) The healthcare provider explained everything I needed to know
    a) Strongly agree
    b) Agree
    c) Disagree
    d) Strongly disagree

9) The healthcare provider cares about me
   a) Strongly agree
   b) Agree
   c) Disagree
   d) Strongly disagree

Thank you for your participation with filling out the questionnaire.

APPENDIX D

COVER LETTER

March 1, 2011

Your participation in a research project is requested on the interaction between the healthcare provider and adolescents. The project is being conducted by Maureen Greenwood, a nurse practitioner and a student at Barry University Division of Nursing. Although there are no direct benefits to you, your participation in this project may give healthcare providers information that will be useful in improving the interaction and communication among adolescents and their healthcare provider.

To participate, you must be an adolescent between the ages of 18-24, and be able to read English. You will be asked to complete a questionnaire about how you feel about your interaction with your healthcare provider. It will take you approximately 10 minutes to complete the questionnaire. The researcher hopes to obtain approximately 60 completed questionnaires. If you experience anxiety or any emotional discomfort during this questionnaire, you will be evaluated by a member of the healthcare team.

All information you provide will be kept anonymous. You will not put your name on the questionnaire and no one will be able trace the information back to you after you have completed the questionnaire. You will place the questionnaire in a locked box where the questionnaire will remain until the researcher empties the box. No one from the clinic will have access to your answered questions. Findings from this study will be reported in group form only, and you cannot be identified. All information will be kept in a locked file in my office for five years, accessible only to me. After five years, the information will be destroyed.

By completing the questionnaire you are giving consent to be a research participant and it is strictly voluntary. You may stop finishing the questionnaire at any time without penalty. If you decide not to participate, the care provided to you will not change. There are no known risks to you should you choose not to participate.

If you have any questions about this project, please feel free to email me at Maureen.greenwood@mymail.barry.edu or call me at 954-882-7519. You may contact my faculty sponsor, Dr. Andra Hanlon at 305-899-3800. You may also contact Barbara Cook at Barry University Institutional Review Board at 305-899-3020 for any questions you may have.

At the conclusion of this project, you may request a copy of the results by contacting me at the above phone number or email address. Your help is very much appreciated.

Maureen Greenwood, MSN, ARNP

APPENDIX E

DEMOGRAPHICS

Listed below are 2 questions in regards to yourself, either circle or write in the answer to the question. Thank you.

1) How old are you?

2) What is your gender?
   A) Male
   B) Female

APPENDIX F

PERMISSION LETTER TO USE THE APPIS QUESTIONNAIRE

Greenwood, Maureen

From: Woods, Elizabeth [Elizabeth.Woods@childrens.harvard.edu]
Sent: Thursday, July 08, 2010 9:20 PM
To: Greenwood, Maureen
Subject: RE: [From Children's Hospital Boston website] Adolescent scale

Yes, as long as you cite the JAH article. The questions are in the article as well as the response levels.

Elizabeth R. Woods, MD, MPH

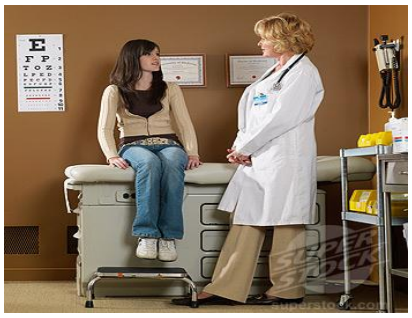
From: maureen greenwood [mailto:mgreenwood@browardhealth.org]
Sent: Thursday, July 08, 2010 7:16 PM
To: Woods, Elizabeth
Subject: [From Children's Hospital Boston website] Adolescent scale

Hello Dr. Woods,
I am an ARNP in Fort Lauderdale working on my doctorate degree in nursing. I would like to know if I could have permission to use the Adolscent Patient-Provider Interaction Scale (APPIS)? I look forward to hearing from you. Thank you.
Maureen

maureen greenwood
mgreenwood@browardhealth.org

APPENDIX G

ADOLESCENT PATIENT PROVIDER INTERACTION FLYER



A nurse at Barry University wants to learn how adolescents feel about their interaction and communication with their healthcare provider. You can help by filling out an anonymous questionnaire which will take approximately 10 minutes to complete. Your participation is completely voluntary and will not affect the care you receive here.

Please consider filling out the questionnaire if:

You are between the ages of 18-24 and are willing to participate.

To take part in this project, let a person at the front desk know you are willing to participate and they will give you a letter explaining more about the study and the questionnaires. When the questionnaires are completed, they can be placed in the special locked box at the front desk.

The principal researcher for this study is Maureen Greenwood, ARNP.

For more information contact

Maureen Greenwood, ARNP, Barry University Division of Nursing

954-882-7519

Or

Dr Andra Hanlon, Barry University

305-899-3000

Or

Barbara Cook, Barry University Institutional Review Board 305-899-3020

APPENDIX H

VITA

VITA

Maureen Greenwood
Born in 1969, Fort Lauderdale, Florida

Education

Doctorate of Nursing Practice, Barry University	2011
Master of Science in Nursing, Barry University	2007
Baccalaureate in Nursing, University of Phoenix	2004
Associate of Science in Nursing, Miami/Dade College/Jackson Memorial Hospital School of Nursing	1991

Certifications

Family Nurse Practitioner, American Academy of Nurse Practitioners (2007)

American Academy of HIV Specialists (AAHIVS) (2011)

Professional Experience

Nurse Practitioner, Care Resource	2011-Present
Nurse Practitioner, Minute Clinic	2010-2011
Nurse Practitioner, Children's Diagnostic & Treatment Center, Inc.	2007-2010

Professional Memberships

American Academy of Nurse Practitioners

Sigma Theta Tau, Nursing Honor Society