Role of in-hospital care quality in reducing anxiety and readmissions of kidney transplant recipients

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ABSTRACT

Background: A total of 17,000 patients receive kidney transplants each year in the United States. The 30-day readmission rate for kidney transplant recipients is over 30%. Our research focuses on the relationship between the quality of care delivered during the patient’s hospital stay for a kidney transplant, and the patient health outcomes and readmissions related to the transplant.

Methods: We interviewed 20 kidney transplant recipients at a major transplant center in the United States. Findings from these interviews were used to inform the data collection using structured surveys, which were administered to an additional 77 kidney transplant recipients. We used ordinary least squares regression to predict the effects of two dimensions of in-hospital care quality—information consistency and empathetic care delivery—on level of patient anxiety 1 week following discharge. Further, we estimated a logistic regression to predict the effect of anxiety, combined with the two dimensions of in-hospital care quality, on occurrence of 30-day readmissions.

Results: Patient anxiety levels 1 wk after discharge are significantly associated with information consistency and empathetic care delivery—on level of patient anxiety 1 week following discharge. Further, we estimated a logistic regression to predict the effect of anxiety, combined with the two dimensions of in-hospital care quality, on occurrence of 30-day readmissions. Results: Patient anxiety levels 1 wk after discharge are significantly associated with information consistency and empathetic care delivery of care. Patient anxiety 1 wk after discharge is associated with occurrence of 30-d readmissions. The logistic regression model indicates that the risk of getting readmitted is 110% higher for a one unit increase in patient anxiety level 1 wk after discharge. Finally, patient anxiety fully mediates the effects of consistency of information and empathetic care delivery on occurrence of 30-d readmissions (50.96% of the effect is mediated).

Conclusions: Our study suggests two ways of preventing readmissions through reduction of postdischarge anxiety: (1) standardizing in-hospital care, so that information received by patients is consistent, and (2) by training caregivers to be more empathetic toward patients during the delivery of this information.

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Introduction

In 2014, over 17,000 patients received kidney transplants in the United States. The wait list for such transplants is longer than 100,000 with >3000 patients being added to the list every month. Post-transplant, kidney recipients have high occurrence of 30-d readmissions. A study covering kidney transplants from 2001 to 2005 found the readmission rate to be 31%. Proper self-care by patients after discharge, including adherence to medication protocols, doctor visits, dietary modifications, and infection prevention, plays an important role in preventing readmissions. The instructions for such postdischarge care are given to the patients during their transplant-related stay at the hospital. However, these instructions for kidney transplant recipients are becoming more complex with the aggressive use of marginal organs and with increasingly complicated transplant cases being accepted. In addition, with early discharges stemming from added pressures for reducing patient lengths of stay, the scope of patient responsibilities for self-care is also increasing. This added complexity and content of post-transplant self-care can lead to increase in patient anxiety with respect to their conditions immediately after discharge. In this research, we seek to examine the role of reducing patient anxiety after discharge in prevention of 30-d readmissions for kidney transplant recipients.

Although several studies have directly linked quality of care within-hospital settings to patient health outcomes such as patient satisfaction and readmissions, the transition of care after discharge is also important to the well-being of the patient. Given the importance of postdischarge self-managed care for kidney transplant recipients, we reason that, for such patients, anxiety after discharge may be the “missing link” between quality of care delivered at the hospital and clinical outcomes such as occurrence of readmissions. By focusing on these relationships, our study seeks to contribute toward research on the combined effects of patient characteristics and actions of care-providing teams on outcomes of surgeries.

The relationships that we study are supported in the extant health care and service delivery literature. The transitions theory in health care emphasizes the need for understanding and reducing a patient’s vulnerabilities during milestone changes such as organ transplants so that the patient is better prepared for life, post-transition. This follows the established view on the importance of a service delivery process that, besides providing consistent delivery, also generates a good rapport between care provider and the patient. Based on these perspectives, we studied the effects of information consistency and empathetic care during hospital stay on patient’s anxiety 1 wk after the discharge and the mediating role of patient anxiety in the link between in-hospital care and occurrence of patient readmission. Figure 1 represents the model examined in this research.

Materials and methods

We examined these relationships using data collected from a sample of patients at the kidney transplant unit of the State University Wexner Medical Center (OSUWMC). This transplant unit conducts about 200 kidney transplants per year, which is the type of allograft studied in this research. Institutional Review Board (IRB) approval was obtained (IRB # 2014H0405) to collect both primary (qualitative interviews and structured survey) and secondary (hospital records) data from adult kidney transplant recipients at OSUWMC. The investigators included the chief quality and patient safety officer, the physician transplant director, and the nursing director for the kidney transplant unit at OSUWMC. The research team interacted with all the members of the transplant team, which consisted of 24 nurses (15 inpatients and nine outpatients), 12 transplant physicians, and inpatient and outpatient nurse managers.

Our interview and survey data (a subset of questions and discussion points for our interviews and the questions used in our survey are provided in Appendices A1 and A2) are related to the discharge instructions delivered during hospitalizations, interactions with the caregivers, and self-reported health status of the patients 1 week after discharge. We matched these data with secondary data about patient complexity (e.g., preexisting psychological and health conditions), length of stay, patient controls (e.g., age, gender, ethnicity), graft functioning during the time of discharge, and the occurrence of 30-d readmissions. Patients undergoing multivisceral transplants were excluded from our sample because such procedures have substantially different discharge instructions and postoperative care guidelines. All of the patients (n = 20) that we interviewed had undergone single kidney transplant surgeries within the past 6 mo (Jan 2014-June 2014). Of the patients in our subsequent survey sample, 70% had undergone single kidney transplant surgeries within the past 4 y (2011-2014).

Fig. 1 – Framework relating in-hospital care quality and readmissions for kidney transplant recipients. Patient level controls: age, gender, ethnicity, donor type, year of transplant, preexisting psycho-social and health conditions, length of stay, and graft function at the time of discharge. (A) 13% of variation in anxiety levels are explained by information consistency and empathetic care delivery (total explanation with controls = 30%). (B) Odds of getting readmitted is 110% higher for a unit increase in anxiety levels 1 wk after discharge.
As a first step, we conducted semistructured interviews with 20 kidney transplant recipients to understand the current state of the quality of care delivered during patient hospitalization. Our interviews focused on topics such as extent of interactions with the physicians and nurses, availability of information related to postdischarge care, and wellness on discharge. These interviews were recorded and later transcribed for analyses. The content of these conversations pointed to several issues related to the quality of care delivered during the patients’ stay in the hospital that could potentially impact the patients’ level of comfort with postdischarge care. For instance, when asked about receiving instructions for postdischarge care, (Q5 in Appendix A1), one patient noted:

“It was overwhelming and I certainly don’t remember any of these conversations. There were often too many people giving us different instructions. It was clearly confusing and I had to educate myself after the discharge on labs and signs and symptoms of rejection”

In general, our interviews suggested that the information delivered during patient stay varied in content across different caregivers delivering such information and was delivered in a somewhat rushed manner. To further understand the interactions among caregivers and the patients during their transplant-related stay in the hospital, we spent additional time shadowing, on multiple occasions, all 15 inpatient caregivers responsible for patient care and discharge instruction delivery. The data collected from these shadowing experiences reaffirmed the existence of variation in the content and delivery of information, particularly that pertaining to postoperative care. As an example, consider the evidence-based standard of care that requires patients to drink at least 3 L of fluid every day. In different rounds of shadowing, we found that while one nurse recommended that the patient drink “a lot of fluids” (without any specific amount mentioned), another nurse suggested “2 L of fluids”, and a third nurse suggested “100 ounces of water”. Such inconsistencies in information often appeared to confuse patients, adding to the tremendous overload that the patients were receiving in the quantity of information. Our shadowing experiences also allowed us to observe varying levels of empathy in the interactions of caregivers with patients. For instance, in some instances, we found that the caregivers were somewhat rushed in their delivery of instructions due to varied circumstances (e.g., in one instance, a nurse who was delivering postdischarge instructions was called away to assist for a biopsy and had to rush through the instructions).

Next, informed by our interviews and a review of existing theories, we created a paper-based survey to collect data from other kidney transplant recipients at OSUWMC. These surveys were used to collect data between Oct 2014 and July 2015 from patients who visited the outpatient transplant clinic for postoperative care. Table 1 provides the summary statistics for respondents of our survey as well as corresponding summary statistics for the population of kidney transplant recipients at OSUWMC for 2013 and 2014. There were no statistical differences in gender, donor type, race, and length of stay between our sample and the 2013-2014 populations of kidney transplant recipients at OSUWMC (P > 0.20). After closing out our survey-data collection, we conducted focus groups with two different groups (in July and Aug 2015) of kidney transplant recipients at OSUWMC to communicate our preliminary qualitative findings and inferences and to brainstorm ideas for improving in-hospital care quality, mainly related to instructions for postdischarge care. Figure 2 provides an overview of the timeline for our completed data collection thus far.

### Measures

#### Dependent variables

**30-d readmission occurrences**

The primary dependent variable in our study is whether the patient was readmitted to the hospital within 30 d after posttransplant discharge due to kidney-related issues (especially increased creatinine levels). A binary variable (1 = yes, 0 = no) was used to measure occurrence of readmission. In our sample, 24 of 77 patients were readmitted to the hospital within 30 d of discharge after their transplant surgeries (31%). This rate is not statistically different from the 2013 and 2014 30-d readmission rates for kidney transplant recipients at OSUWMC (33%, P = 0.78 for 2013 and 36%, P = 0.43).
Patient anxiety
We measured patient anxiety using four items based on the PROMIS scale (nihpromis.org) previously used by several researchers. This scale measures the extent of patient anxiety 1 wk after discharge. The reliability of this scale (Cronbach alpha) is 0.93.

Independent variables
Information consistency
We measured the consistency of information received by a patient during his or her hospital stay for transplant using five items that measure the easiness to get information straightened out and the level of understanding of symptoms and procedures. The scale is adapted from and has a reliability (Cronbach alpha) of 0.73.

Empathetic care
We measured the extent of empathy in care delivered during the patient’s stay using a three-item scale adapted from the SF-36 questionnaire. This scale measures the extent of empathy shown by care providers during the patient’s stay at the hospital (1-5 Likert scale).

Controls
Several patient level factors can impact patient anxiety and readmissions; and hence, we include such factors in our analyses. We control for gender, ethnicity, and type of transplant (living versus cadaveric), age of the patient, and year of transplant. We also account for the patient’s length of stay, preexisting psychological condition, preexistence of diabetes, and occurrence of delayed graft function at the time of discharge in our analyses. Table 2 lists all the measures and their operationalization and presents summary statistics based on our data.

Validity and reliability
We conducted confirmatory factor analysis (CFA) to assess the convergent and discriminant validity of multi-item scales used in this study. The measurement model included 11 items representing the three constructs shown in the conceptual framework—two independent variables (information consistency and empathetic care delivery) and one dependent variable (7-d patient anxiety). The fit indices indicated that the model fit the data reasonably well ($\chi^2 = 111.21, df = 51$, comparative fit index = 0.92, standardized root mean square residual = 0.07). Convergent validity was assessed by examining the path coefficients from the constructs to their corresponding measurement items. All path coefficients were significant ($P < 0.01$) with values ranging from 0.54 to 0.95. Discriminant validity was assessed in two ways. First, we analyzed all possible pairs of constructs in a series of two-factor confirmatory factor analysis models. Each model was estimated twice—one constraining the correlation between constructs to unity and once freely estimating the correlation. The chi-square difference between the two models was statistically significant ($\chi^2 (df = 1) > 3.84, P < 0.01$) for all possible pairs of constructs implying that the unconstrained model had a better fit than the constrained model. This provided evidence for the discriminant validity of the constructs. Second, we examined the average variance extracted for the constructs, which ranged from 0.51 to 0.80. The average variance extracted

Table 2 – Variables and operationalization.

<table>
<thead>
<tr>
<th>Variable name</th>
<th>Definition</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-d readmission</td>
<td>Whether the transplant recipient was hospitalized within 30 d (0 = no, 1 = yes)</td>
<td>0</td>
<td>1</td>
<td>0.312</td>
</tr>
<tr>
<td>Patient anxiety</td>
<td>Extent of fear and worries experienced by the patient 7 d after discharge (1-5 Likert scale)</td>
<td>1</td>
<td>5</td>
<td>1.98</td>
</tr>
<tr>
<td>Information consistency</td>
<td>Ease of access and availability of information during the patient’s stay at the hospital (1-5 Likert scale)</td>
<td>2</td>
<td>5</td>
<td>4.072</td>
</tr>
<tr>
<td>Empathetic care</td>
<td>Extent of empathy shown by care providers during the patient’s stay at the hospital (1-5 Likert scale)</td>
<td>1</td>
<td>5</td>
<td>3.41</td>
</tr>
<tr>
<td>Delayed graft function</td>
<td>Occurrence of delayed graft function at the time of discharge (0 = no, 1 = yes)</td>
<td>0</td>
<td>1</td>
<td>0.08</td>
</tr>
<tr>
<td>Preexisting diabetes</td>
<td>Patient has existing diabetic condition (0 = no, 1 = yes)</td>
<td>0</td>
<td>1</td>
<td>0.26</td>
</tr>
<tr>
<td>Preexisting psychological condition</td>
<td>Whether the patient has a preexisting psychological problems as evidenced from their visit to a psychologist before transplant (0 = no, 1 = yes)</td>
<td>0</td>
<td>1</td>
<td>0.11</td>
</tr>
<tr>
<td>Length of stay</td>
<td>Log base 2 of the number of days of inpatient stay during transplant procedure</td>
<td>2</td>
<td>4.52</td>
<td>2.73</td>
</tr>
<tr>
<td>Donor type</td>
<td>Type of transplant (0 = cadaveric, 1 = living)</td>
<td>0</td>
<td>1</td>
<td>0.48</td>
</tr>
<tr>
<td>Year of transplant</td>
<td>Whether the transplant was conducted in the last 4 years (0 = no, 1 = yes)</td>
<td>0</td>
<td>1</td>
<td>0.70</td>
</tr>
<tr>
<td>Patient age</td>
<td>Age of the transplant recipient</td>
<td>15</td>
<td>77</td>
<td>51.02</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Ethnicity of the transplant recipient (0 = white, 1 = others)</td>
<td>0</td>
<td>1</td>
<td>0.33</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender of the transplant recipient (0 = male, 1 = female)</td>
<td>0</td>
<td>1</td>
<td>0.44</td>
</tr>
</tbody>
</table>
for each construct was greater than its squared correlation with any other construct, further indicating their discriminant validity. Overall, we found the constructs and their measurement items to be reliable and valid.

Analyses and results

Main results

Our analyses of the relationships shown in Figure 1 were done using STATA 11 by estimating two regression models, the results of which are shown in Table 3. Seven cases were dropped due to missing values on preexisting conditions or graft functioning, leaving a sample size of 70 for these two analyses. First, we estimated an ordinary least squares (OLS) regression to identify the effects of information consistency and empathetic care on patient anxiety on discharge after controlling for other factors. The results from this analysis are shown under model 1 of Table 3. Both information consistency (β = −0.347, P < 0.05) and empathetic care delivery (β = −0.187, P < 0.10) were negatively associated with anxiety level on discharge. That is, increase in these dimensions of care delivered during hospitalization was associated with decrease in patient anxiety levels after discharge. Comparing these coefficients suggests that information consistency has a stronger association with anxiety levels when compared to empathetic care delivery. In terms of control variables, patients who had undergone transplants in the last 4 y had experienced higher levels of anxiety (β = −0.763, P < 0.05). None of the other control variables were significant. The overall model explained 29.7% variation in patient anxiety levels.

Next, we estimated a logistic regression to identify how patient anxiety levels, along with other variables used in model 1, affected occurrence of 30-d patient readmissions. Results are shown in model 2 of Table 3. As seen from this model, the level of patient anxiety on discharge has a strong association with the likelihood of readmission (P = 0.055). Interpreting the odds ratio for this predictor suggests that a unit increase in patient anxiety levels is associated with 110% higher likelihood of the patient getting readmitted within 30 d. The 95% confidence interval for this variable is 0.985 to 4.481. Among the control variables related to patient characteristics, we find that transplants conducted in the last 4 y (odds ratio = 0.097, P < 0.05) and length of stay (odds ratio = 136.617, P < 0.01) are associated with occurrence of 30-d readmission. Interpreting these results suggest that the patients who had undergone transplants in the last 4 y had 9.7% lower likelihood of 30-d readmission when compared to patients who had undergone transplants more than 4 y. As the length of stay was log base 2 transformed, the interpretation of its odds ratio is that with a doubling of the length of stay for a given patient, the odds of getting readmitted within 30 d increases by 36.62 times. It is also interesting to note that, in this regression (model 2), information inconsistency and empathetic care delivery are not associated with occurrence of 30-d readmission. This indicates that the effects of these two factors on 30-d readmission are fully mediated through level of patient anxiety after transplant. Furthermore, we conducted a binary mediation test using the binary mediation command in STATA. Results from the analyses suggest that 50.96% of the total effect of information consistency and empathetic care delivery on occurrence of readmission is mediated through post-surgery anxiety.

Robustness checks

We conducted three additional analyses to account for other factors that may impact patient outcomes after kidney transplants and to assess the robustness of our results. First, as a measure of intermediate outcomes, we collected information on the change in creatine levels on discharge, which is shown to have association to compliance with water intake requirements—an important discharge instruction for kidney transplant recipients. Specifically, we collected data...
on creatinine levels for patients at the time of admission and again at the time of first labs after discharge and included percentage change in creatinine as an independent variable in our two regression models. This variable was highly correlated with the variable for occurrence of delayed graft function (P < 0.01) and so, the delayed graft function variable was deleted for estimating the two regressions that included creatinine level change. Results from the regressions indicated that while the effects of change in creatinine level on anxiety and on occurrence of readmission were not significant, effects of information consistency and empathetic care delivery on patient anxiety as well as the effect of patient anxiety on occurrence of readmission were similar to the original results. These results provide further support for the relationships among the variables of interest as they account for the effect of creatinine level change, an adverse occurrence of which is frequently associated with increase in occurrence of readmissions.

Next, we obtained data on body mass index (data was available for 44 patients) and reran the two main regression models including this variable. For the model predicting anxiety, body mass index did not have a significant effect, and the effects of information consistency and empathetic care delivery remained significant and similar to original results. For the model predicting readmission, the model was nonsignificant (P = 0.13), which can be attributed to the smaller sample size. However, the effect of anxiety on readmission remained similar to our original result. The results of these analyses support our results after accounting for another preexisting characteristic of patients, obesity, which can adversely impact readmissions.

Third, to check for surgeons or practitioners impacting patient outcomes, we estimated fixed effect regressions to account for the seven surgeons who had performed transplants in our sample. This was done using "areg" command in STATA 14 for the analysis for anxiety and "clogit" command for the analysis predicting occurrence of readmissions. We found that the identity of surgeons conducting the transplants did not significantly impact patient outcomes, and the remaining results were similar to the results obtained in the original analyses.

Finally, we also verified the criteria for readmissions with the surgical team. Patients were readmitted if they had electrolyte abnormalities and/or renal dysfunctions. These criteria remained the same throughout our study period minimizing the concerns of administrative changes.

Discussion

The purpose of this study was to understand the relationship between the quality of care delivered during a kidney transplant recipient’s hospital stay and health outcomes, including occurrence of readmissions, related to the transplant. Our interviews with recent kidney transplant recipients revealed that transplant recipients value the consistency of instructions (i.e., standardized care) and empathy in care delivery (i.e., patient-centric care) as critical dimensions of care quality experienced during their hospital stay. Furthermore, our conversations with patients revealed that they are concerned about their immediate well-being after discharge due to significant lifestyle changes after transplantation. Based on the insights from these interviews, and supported by the dual theoretical perspectives of the transitions theory in health care and service operations, we proceeded to collect survey data from patients using established scales. Combining this survey data with patient clinical and demographic data, we conducted analyses to test the suggested relationships.

Our results indicated that patient anxiety 1 wk after discharge is strongly associated with the occurrence of 30-d readmissions after accounting for other factors. Specifically, the odds of getting readmitted increase by 110% for a one unit increase in anxiety levels of the patient after discharge after transplant. We also found that although the consistency and empathy dimensions of patient care in the hospital do not have a direct effect on occurrence of readmissions, both consistency of discharge instruction and empathy shown during their hospital stay are significantly related to patient anxiety levels after accounting for additional factors. In the OLS regression, these two variables explained about 13% of the variation in patient anxiety scores.

Conclusions

There are a number of studies that have supported the direct relationship between quality of care delivered during patients’ hospital stays and outcomes such as readmissions. Our study adds specificity to this relationship, particularly in the context of transplant patients needing ongoing and often chronic care. First, our study supports the notion that the quality of care for transplant patients has two distinct dimensions—consistency of information and empathy while delivering information. We find that both these dimensions are associated with patient anxiety after discharge. Second, our study finds that the relationship between quality of care delivered during hospital stay and clinical outcomes is not direct but rather is mediated by patient anxiety levels on discharge.

Furthermore, most past studies on the topic of process quality and outcomes in health care have either been conducted at the hospital level as opposed to the patient level or have studied the general population of patient discharges as opposed to transplant patients. In the context of conditions requiring chronic care such as transplants, postdischarge instructions are often numerous and complicated, including varying individualized and strict schedules for taking medication. Therefore, adhering to these instructions can be a daunting task for recovering patients. By focusing on the patient level of analysis and by studying transplant patients exclusively, our research sheds light on process quality aspects that are critical for transplant patients as well as the

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3 We did an OLS regression with just the patient controls alone (R² = 16.58%) and compared it with the regression results from Table 3 to obtain the difference in R².
intermediate patient specific anxiety aspect that plays a role in the outcomes for such patients.

Our results should be interpreted with the caveat that they do not imply causality as we did not conduct an intervention-based study but rather relied on analyzing correlations based on observational data. However, the relationships that we tested are derived from well-established theories—namely transition theory in health care and service delivery theory from operations management. Furthermore, our approach of using other forms of data for triangulation such as interviews with 20 patients, and observations of provider-patient interactions through shadowing of providers in-hospital rounds hopefully strengthens our conclusions. Moreover, accounting for the different control variables that can potentially impact our dependent variables provides additional confidence in the existence of relationships. The associations that we do find support for can serve as the basis for future intervention-based research for establishing causal relationships.

Our findings also inform the recent health care policy debates related to readmission reduction programs. The Centers for Medicare and Medicaid incentivize hospitals to reduce 30-d readmissions through improved quality of care delivered during the hospital stay. Joyn and Jha (2013) argue that the current emphasis on 30-d readmission rates is misguided as there are several factors at the patient levels that are outside the hospital settings and that can affect the likelihood of readmissions. Along these lines, our results that show patient anxiety levels immediately after discharge as the missing link between the quality of care delivered and readmissions, suggest the importance of measuring anxiety levels as a part of patient experience surveys (e.g., HCAHPS survey). Our results should also encourage hospital administrators to develop standardized and patient-centric approaches to delivering postrecovery instructions, especially in the context of interventions for chronic illnesses.

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Author contributions: This article has been revised and approved by all authors. A.C., G.A., S.M.B., and P.W. drafted this article and developed the study concept. L.S. did the analysis and patient survey data collection. T.P., M.H., and M.L.H. assisted in getting patient and nurses’ participation in the study, and M.N. assisted in matching patient survey data with their medical records data for the revision, whereas M.G. assisted in getting inputs from the nurses through shadowing practices. Finally, A.C., L.S., and S.M.B. were responsible for obtaining the IRB approval for the study.

Disclosure

The authors of this manuscript have no conflict of interest to disclose as described by the Journal of Surgical Research.

REFERENCES


Appendix A1 – Subset of discussion points and questions used for interviews of kidney transplant recipients

(Target: Transplant Recipients who have undergone a kidney transplant during Jan 2014-June 2014)

1. Introduce the team and ask about the patient’s condition before admission
2. What made you choose OSUWMC for your transplant?
3. Tell us more about the care rendered after the transplant.
4. Tell us more about the extent of communications with the physicians and nurses post-transplant.
5. How was the discharge instruction delivered? Were you able to understand these instructions?
6. Were there any important issues not addressed regarding the discharge planning?
7. What are some suggestions for improvement in the discharge process?
8. How did you feel after discharge?
9. What was the most important thing do you remember from your discharge process?

Appendix A2 – Measurement items in the survey questionnaire.

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measurement items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient anxiety</td>
<td>During the week following your discharge, please rate the intensity of the following items related to anxiety</td>
</tr>
<tr>
<td>Cronbach α = 0.93</td>
<td>1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Often; 5 = Always</td>
</tr>
<tr>
<td></td>
<td>I felt fearful</td>
</tr>
<tr>
<td></td>
<td>I found it hard to focus on anything other than my anxiety</td>
</tr>
<tr>
<td></td>
<td>My worries overwhelmed me</td>
</tr>
<tr>
<td></td>
<td>I felt uneasy</td>
</tr>
<tr>
<td>Information consistency</td>
<td>The following items relate to the ease of access to information when required during your stay.</td>
</tr>
<tr>
<td>Cronbach α = 0.73</td>
<td>1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree</td>
</tr>
<tr>
<td></td>
<td>It was difficult to get conflicting information straightened out (reverse).</td>
</tr>
<tr>
<td></td>
<td>I felt uncomfortable asking about something related to discharge I don’t understand (reverse).</td>
</tr>
<tr>
<td></td>
<td>It was hard for me to tell about new symptoms (reverse).</td>
</tr>
<tr>
<td></td>
<td>I felt uncomfortable asking about the treatment procedures (reverse).</td>
</tr>
<tr>
<td></td>
<td>The caregivers’ team was easily approachable</td>
</tr>
<tr>
<td>Empathetic care delivery</td>
<td>The following items relate to the caregiver interactions during your stay.</td>
</tr>
<tr>
<td>Cronbach α = 0.94</td>
<td>1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree</td>
</tr>
<tr>
<td></td>
<td>The manner in which my caregiving team receives me is polite, kind and sets me at ease</td>
</tr>
<tr>
<td></td>
<td>The caregiving team members have a reassuring attitude.</td>
</tr>
<tr>
<td></td>
<td>The caregiving team members respected my privacy during the physical examination.</td>
</tr>
</tbody>
</table>