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Satisfaction of Telehealth for the 55+ Population

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Satisfaction of Telehealth for the 55+ Population

by

Cynthia K. Schweizer

A project submitted to the faculty of
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in partial fulfillment of the requirements for the degree of
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Problem Recognition

There is a primary care need for the 55+-year-old population related to the increasing aging population, physician shortages, and, more recently, Coronavirus Disease 2019 (COVID-19) to implement Telehealth care. COVID-19 was first discovered in Wuhan, China, in December 2019 (Center for Disease Control & Prevention (CDC), 2020). COVID-19 is a SARS-CoV-2 most likely related to a bat coronavirus (Fisher & Heymann, 2020). Most people have mild symptoms from the COVID-19 pandemic, and others such as senior citizens, and those with certain diseases, have severe cases and death (CDC, 2020).

Studies show that many senior citizens are interested in participating in healthcare technology, such as Telehealth (Zheng et al., 2016). The Telehealth project will include the 55+ population to provide more participants for the project at an internal medicine clinic. The American Association of Retired Persons (AARP), the American Seniors Association, and the Association of Mature American Citizens consider age 50 as the earliest that can qualify for senior-citizen status (Reed, 2021).

Telehealth is an alternative method for routine healthcare practices and management of chronic illnesses necessary for healthy, independent living among older adults (Bakas, 2018). Telehealth's contribution and interventions will affect causal factors such as moderating or mediating factors of health problems. Some of those factors include insufficient primary care coverage due to decreasing numbers of primary care providers (PCP), the increasing older population, complex health issues that come with aging, the need for frequent follow-up routine visits, and the future of pandemics. Research shows in the United States a shortage of more than 100,000 doctors by 2030.

The projected physician shortage relates to a lack of physicians from population growth, increased numbers of aging Americans, and retirements of practicing doctors (Boyle, 2020). Projected, for the first time in U.S. history, the number of older adults surpass children under 18 years old by the year 2035 (United States Census Bureau, 2018).

The continued growth of an aging population along with PCP shortages and COVID-19 has forced many clinics, hospitals, and other healthcare agencies to rely on Telehealth. The government has provided forms of payment for Telehealth for senior citizens during a pandemic. In this clinic setting, the Nurse Practitioner (NP) often provides routine follow-up visits, and typically reviews lab values, vital signs, weight, and other follow-up needs, all reviewed in the healthcare storage system Healow, visible during a Telehealth visit. Often discussions about medications, diet, or needed equipment take place. The NP telehealth visits take some of the burdens from the PCP. Many senior citizens are unable to travel to the clinic. Some live in rural areas that make travel difficult. Telehealth in rural areas has helped palliative care teams better communicate with patient families and assist with health care access (Weaver et al., 2020).

Problem Statement

A primary care need for the 55+-year-old population related to rapidly expanding aging population, immediate physician shortages due to the inability to increase physician demand at the same pace as with the rapidly rising population rate to compare Telehealth effect on primary healthcare needs during the Spring-2021.

Project Goal

Provide the 55+ patients within an internal medicine office the opportunity to participant in the Telehealth 55 Questionnaire regards to their Telehealth experience. The

questionnaire will provide qualitative and quantitative information as a quality improvement measure for future Telehealth visits concerning senior citizens within the Intracoastal Internal Medicine office.

Literature Review

The literature review included ERIC, CINAHL, and EBSCO HOST search engines from the John R. Doshier Memorial Library and the William Madison Randall Library. The following review shares information to support the future of Telehealth and process improvement within a clinic setting for the senior citizen population. There are benefits in having a Telehealth visit versus an office visit or a phone call.

Telehealth

Masoumeh et al. (2018) studied face-to-face and telenursing education and the impact on the quality of family caregivers caring for patients. A study provided caregiver training for a face-to-face group of 34 participants and a telenursing group of 34 participants. The control group was a group of 35 participants who were diagnosed with cancer. The same questionnaire was distributed to all three groups. Following the questionnaire, 12 weeks of training for caregivers in the face-to-face group and telenursing groups for caregivers to provide quality care to the cancer patient. The study found face-to-face and telenursing increased in comparison to the control group. Overall, the intervention, quality caregiver's care in face-to-face and telenursing intervention groups increased, but the control group did not. Findings indicated the effectiveness of the two training methods was similar without differences and suggested combining both training methods of face-to-face training and telenursing interventions.

Tasneem et al. (2019) provided a needs assessment of patient perceptions on telehealth visits and the quality of care. There were 13 patients diagnosed with end-stage cancer under palliative care. Interviews were based on the impact of patient's health management, user experience, technical issues, and the cost and time. The majority of patients favored telehealth and felt the doctor-patient relationships would not suffer. Another asset of having Telehealth as an integral part of patient care was that Telehealth promotes familiarity with nurses and providers. Patients felt confident the technical abilities of their caregiver to navigate telehealth visit, privacy concerns as with other technologies, cost not an issue, believed telehealth as an alternative to an in-person visit increase access, save time, increase comfort and safety by avoiding a trip to the office. Overall results showed potential for acceptance of telehealth by oncology patients in an urban location under palliative care.

Whitehouse et al. (2020) investigated telehealth-delivered diabetes self-management education and support (DSMES) for older adults with type 2 diabetes mellitus following hospital discharge. One in-person home visit followed with weekly virtual DSMES for 4 weeks. Diabetes knowledge was measured at baseline and completion of the program. The Telehealth Usability Questionnaire was completed after the final session. Enrollment of 20 patients, 12 completed the intervention. The most common reason for attrition was discharge to a skilled nursing facility. Hemoglobin A1C was taken at baseline and then again 3 months later post-hospital discharge. The A1C values decreased by 1.1%, no hospital readmissions for any patient who completed the program. Telehealth successfully delivered senior citizens with diabetes type 2 follow-up education post-hospital stay to increase knowledge and decreased A1C.

Older Adults

Bakas et al. (2018) discussed telehealth as an alternative method for routine healthcare practices and management of chronic illnesses necessary for healthy, independent living among older adults. A study was completed to test the Telehealth Community Health Assistance Team (t-CHAT) feasibility, a nurse-led intervention delivered via a telepresence robot to promote independent healthy living among older adults. A quasi-experimental design total of 21 older adults, 11 participants in a T-CHAT group, 10 on the waitlist/control group. T-CHAT group had three weekly health coaching sessions from a nurse practitioner student through the telepresence robot. Chronic disease self-management promotion and maintenance of regular health practices and struggle with ongoing chronic illness self-management programs have improved self-efficacy for managing chronic disease. Many older adults prefer one-on-one interactions with healthcare providers, and a mailed toolkit may not be sufficient for some older adults. A telepresence robot used in this study had a camera and a small screen on a remote-controlled base that maneuvered to enter the homes of older adults. The screen showed the clinician's face; the clinician can see the older adult and their surroundings in their home environment. When the visit is finished, the clinician remotely drives the robot back to a docking station for charging. Data analyzed for this study used covariance (ANCOVA) with baseline values as covariates, affect sizes using partial eta squared. Medium to significant improvements in unhealthy days, depressive symptoms, sleep, quality of life, and confidence/self-efficacy favored the T-CHAT group. Further study and refinement of the program to promote healthy independent living among older adults are needed.

Rural

Weaver et al. (2020) telehealth in rural areas has helped palliative care teams better communicate with patient families and assist with health care access. Telemedicine has the potential to extend care and access to home-based hospice services for children. A qualitative study to learn from experiences of rural hospice nurses caring for children at the end of life using telehealth modalities to inform palliative communication. Five themes about Telehealth noted accessible support, participant inclusion, timely communication, informed and trusted planning, and familiarity cultivated. Recommend communication and engagement in creative forms of human connection fosters therapeutic relationships across screens. Telehealth provided familiarity, which the interviewed nurses recognized as important for a professional presence. The therapeutic relationships and personal trust took longer to enter into with the screen. Taking time for a moment for relational content and thoughtful pauses may support a way to foster a relationship.

Physician

In Boyle (2020), the projected physician shortage relates to a shortage of physicians from population growth, increased numbers of aging Americans, and retirements of practicing doctors. People over 65 generally require more specialized care. A multipronged approach to physician shortages and gaps in care needs to ensue. This type of approach would include technology and training doctors and staff on using technology such as telehealth to improve care and reach underserved populations. It is essential to expand the care that doctors and other health care professionals can provide, such as expanding the roles of physician assistants and nurse practitioners as in some

states during COVID-19. COVID-19 has also highlighted the fact that there is a need for more specialists. It is projected a shortage of specialists, between 9,300 and 17,800 medical specialists alone is predicted.

Senior Citizen

Reed (2021) talks about senior citizens and mentions the American Association of Retired Persons (AARP), the American Seniors Association, and the Association of Mature American Citizens, consider age 50 as the earliest that can qualify for senior-citizen status. The term senior citizen is to convey the distinction of the elders in our society. How old is a senior citizen? Some organizations call the age of 50 to be a senior, while others feel the age of a senior is at 60 or higher. The age of 65 is a milestone known for Medicare benefits. It is essential for healthcare providers to be aware and understand the healthcare benefits for their senior citizen patients. Senior citizens are living longer and more active participants in society.

Healthcare

Pioli et al. (2018) discuss various hypertension types, the causes, and physical changes within the body. A patient with “White-Coat-Effect” (WCE) may have elevated office BP levels induced by the presence of a physician or health care professional. Careful examination of the patient regarding a diagnosis with uncontrolled hypertension where medication adjustments may not be required. The diagnosis is confirmed when the office BP is significantly elevated (>20 mmHg for SBP and >10 mmHg for DBP) when compared to out-of-office measurements, Ambulatory BP Monitoring (ABPM), or Home BP Monitoring (HBPM). White Coat Hypertension (WCH) is diagnosed when a patient is without antihypertensive treatment and presents with high BP levels in the office, but

when BP is monitored at home (ABPM), or Home BP Monitoring (HBPM), BP levels are not elevated. Diagnosis must be accurate and closely monitored. Patients at home for a telehealth care appointment may minimize the “white-coat syndrome.” Further studies are recommended for the evaluation of such phenomena due to the possibility of Cardiovascular (CV) risks.

Pandemic

According to the Center for Disease Control and Prevention (CDC) (2020), most people have mild symptoms from the COVID-19 pandemic. Others, such as senior citizens, and those with certain diseases, have severe cases and death. Senior citizens in the United States had the most recorded deaths from COVID-19 with complications of influenza, pneumonia, and respiratory failure. As a result of the coronavirus pandemic, people may not get needed medical care due to canceled appointments, cutbacks in transportation options, fear of going to the emergency room, or an altruistic desire not to burden the health care system, among other reasons. Telehealth is utilized throughout the peak of COVID-19 and remains an alternative method for a healthcare option determined by the physician.

Theoretical Underpinnings

Nursing Quality Caring

The Quality-Caring Model selected is about independent and collaborative relationships necessary for successful Telehealth care. Understanding structure, process, outcomes, and components is a function of time and circumstances. The essentials include relationship-centered professional encounters, the greater part of nursing’s work (Duffy & Hoskins, 2003). The clinical caring process holds relationships on mutual

respect, faith, hope, trust, and sensitivity to creating a human connection. From observation, creating a human connection while caring for a patient via Telehealth requires less distraction and greater comfort showing more of a relaxation benefit for the patient. Being at home affects the discussion and care between the provider and patient with a positive experience. Patients at home for a healthcare appointment may likely minimize the “white-coat syndrome” (Pioli et al., 2018).

When one feels cared for, a sense of security makes it easier to learn new concepts such as Telehealth, change behaviors, take risks, and follow guidelines. While independent relationships with patients/families are primary, collaborative relationships are essential to quality care. Relationships characterized by caring contribute to positive outcomes for patients/families, health care providers, and health care systems (Duffy & Hoskins, 2003).

Technology Caring

Technology and caring must be in unison, both competencies to perform needed tasks with technology. Nurses must have the ability to perform necessary duties to provide care and seamlessly meet the needs of patients in a caring way. This is essential for all technological necessities of care, as with the Mid-range Theory, technology, and caring are harmoniously aligned (Locsin, 2013).

Needs Assessment

Target-Population

The primary care needs for the 55+-year-old population often require frequent primary care physician and nurse practitioner routine visits. To observe the 55+-year-old population with various comorbidities, the Telehealth effect and healthcare satisfaction

needs over 2-3 weeks. The average Telehealth visit per day for a patient 55+-year-old is approximately five visits per day. This study takes place at an internal medicine office supporting research for an aging population's healthcare needs. For the project, the Primary Care Physician (PCP) is a partner, sponsor, and stakeholder. Primary Care Physician, Nurse Practitioners (NP), Registered Nurses (RN), Medical Assistants (M.A.), Phlebotomists, office staff including receptionists, telehealth trainers, medical records, human resources, and accounting are involved in the daily function of the internal medicine clinic, therefore, were also stakeholders. For this study, the PCP, MA, NP, Telehealth trainer, and Medical Records are vital participants. Choice of setting is at the PCP's office, and 55+-year-old patients communicate via Telehealth for routine visits.

Organizational Assessment

The Internal Medicine Clinic is busy, prosperous, with an excellent reputation, affiliated with the County Medical Center, and highly respected within the community. The ratings are 4.7 out of 5.0, with positive comments about excellent care (Healthgrades, n.d.). Often the elderly population move here from the northern states to reside once they have retired. Many of the senior citizen's families remain in the northern states. Currently, the clinic has an online system with an App called Healow. The Health Portal and Healow App is a secure tool that allows 24/7 access to your health care via computer, tablet, and smartphone. Healow is an assessable, safe, secure, convenient communication tool. It has the capability for updates on health records such as patient labs, physical assessments, vital signs, notes, appointments, consults, email, and personal information such as phone number, address, and a conduit to Telehealth (Partners in

primary care/Healow, 2020). The PCP's, NP's, RN's and adult patients of all ages use the Healow App or sign in to the Healow portal from a computer.

The staff and most clients are technology savvy. For example, when the NP is on a Telehealth visit with a patient, and the patient's internet is interrupted, the NP quickly calls the client's smartphone. The NP and client FaceTime for a couple of minutes until the internet problem is resolved. Once resolved, they return to the Telehealth screen. The NP's quick action to utilize informatics portability is the knowing, caring, and well informed of technology assets. Advantages of Telehealth care lead clients to more involvement with their health care, the potential for cost savings when staff not in the office, and relies on current knowledge and known alternatives to address a problem. Patient satisfaction occurs with the ability of Telehealth to monitor, visualize, and interact remotely with patients in rural, urban, and suburban areas (Wynn, 2020). Telehealth provides accessible support, timely communication, informed and trusted planning. Ultimately, a knowledgeable comfort level develops (Weaver et al. 2020).

Available Resources

The community has Uber, bus, taxi, and trolley public transportation, a local health department with many services such as health care, education, social services, and food pantries. Below is a link to the City of Wilmington, North Carolina Transportation (2021), <https://www.wilmingtonnc.gov/departments/public-services/sustainability/transportation>. The Patient/Physician ratio for this county is 1,070/1 (County Rankings, 2020). Centrally located within city limits are a university, a community college, and a large trauma level two medical center with 855 patient beds.

Many local businesses are supportive monetarily and volunteer for many functions within the community.

Cost Analysis

This project's costs are minimal other than an online quality secure Qualtrics questionnaire titled “Telehealth 55 Questionnaire” with one text answer question and three Likert Scale questions included in the questionnaire, security, access to results, time-consuming data collection, statistical results, and interpretation of results.

This project will take approximately 3 weeks of client participation in collecting data to obtain a substantial number of participants. During the 2-3 week time frame, each patient who provides consent to participate in the “Telehealth 55 Questionnaire” will participate in this study. The NP has Telehealth visits on Tuesdays and Thursdays. The PCP also has Telehealth visits a few times throughout the workweek. The telehealth visits are scheduled for 15-minutes. In observation of approximately half of Telehealth's workday (8:00 am to 11:00 am), visits included an average of five patients within the 55+-year-old age group. The project is to take place within a 2-3 week timeframe with approximately 30-50 patients to participate in the study.

Work Plan

It was anticipated that meetings and emails in preparation with PCP, NP or MA, and other stakeholders were to start in January/February 2021. A questionnaire was developed via the Qualtrics platform including one Free Text question – What is your previous experience and personal comfort with Telehealth system? Also included were three Likert scale questions that had five possible answers as follows: 5. Very Satisfied, 4. Satisfied, 3. Neither Satisfied nor Dissatisfied, 2. Dissatisfied, 1. Very Dissatisfied.

The only identifier was the patient's age, an email invite, provision of a formal explanation of the study, permission consent from clients interested in participating in this study, and an information sheet on Telehealth. Once approved by the IRB, the study began on May 14, 2021, to continue for 2-3 weeks to collect data, and end by June 11, 2021. The week of June 21-29, 2021 was to interpret, analyze findings, and provide results. The results were discussed with the Project Chair, Project Partner, Project Member, and stakeholders. All data was stored on a secure jump drive, a Passport (portable storage, password protection), and kept locked in a cabinet.

Internal Stakeholders

A partnership with Intracoastal Internal Medicine including practice partner, MA, and other key stakeholders the NP's, medical record department, and staff with a shared vision, goal, dedicated time, and resources developed. Included was ongoing communication and strategic planning for short-term and long-term planning. This was the first study to take place in the Intracoastal Internal Medicine practice. The cooperation, partnership, and commitment of collaborative communication are ongoing. Telehealth blossomed due to the Pandemic. The need for Telehealth and a performance improvement project implemented related to the new process of Telehealth

Implementation

The Telehealth experience questionnaire consists of four questions, one Free Text question, and three Likert Scale questions via Qualtrics. The question-answer choices for all three Likert Scale questions are as follows.

- 5. Very satisfied,
- 4. Satisfied,

- 3. Neither Satisfied nor Dissatisfied,
- 2. Dissatisfied, and
- 1. Very Dissatisfied.

The questions consisted of:

- Question 1. – What is your previous experience and personal comfort with the Telehealth system? (Free Text)
- Likert scale Question 2. – How satisfied were you with the questions and answered by staff during the visit? Select one answer. (Likert scale)
- Question 3. - How satisfied were you with the amount of effort it took to enter into the Telehealth system? Select one answer. (Likert scale)
- Question 4. – How satisfied were you with the Telehealth information sheet? Select one answer. (Likert scale)

Research of several questionnaires including The Telehealth Satisfaction Scale (TeSS) by Morgan et al. (2014) was reviewed. The three Likert scale questions developed were considered reliable for the specific needs of the Intra-coastal Internal Medicine practice. All questions reviewed by the practice partner and committee members were agreed upon. Questions were provided through Qualtrics. Instruments were appropriate for diverse ethnicities and multiple languages. Cultural sensitivity inclusive of sensitivity, characteristics, and values were included. Stakeholders participated in the questionnaire and were familiar with questions. Key points from the questions are paramount to developing a sound Telehealth program evaluation and future quality improvement.

The only identifier in this Telehealth project was the age of the patients.

Approximately 2-3 weeks was used to distribute and collect consent forms, distribute and

collect questionnaire results, interpret quantitative and qualitative data, and share results with the project chair, project members, and key stakeholders. The goal was to have approximately 30-50 participants. Due to staffing and patient low census, an additional week was extended agreed upon through 6/11/21 for an opportunity of more voluntary participants in the Telehealth 55 Questionnaire.

Dependent variables were the patients' successful participation in the Telehealth program. The patients received excellent health care via routine Telehealth visits. The support staff understood and followed the policies/procedures and guidelines for the Telehealth program. Financial revenue was provided within the budget. The independent variable was the Healthcare provided by the Telehealth care program. Stakeholders were involved in anticipating what the evaluation data would include and were part of the program development. Verified questionnaire corresponded to the program outcome objectives, patient satisfaction. The distribution of the questionnaire was critical to the data collection and the survey design. Opportunities to address rigor were to check findings against raw data and review raw data in light of the findings. Credibility increased when those who provided the data were asked to review the findings and provide feedback about the accuracy of the interpretations.

A timeline of 3-4 weeks was used to collect data, interpret data, and provide utilization and report of results, provide oral dissemination and electronic dissemination conclusion of current project report electronic to the University's Dover Library Digital Commons. Data will reside in a locked secure area. The project student had access and one key resource person, a statistician allowed access. The project student analyzed the

data. Understanding the meaning observed or read and discovery of process begins where groups of data form categories.

Results

Interpretation of Data

This was a quality improvement project in a clinic setting regarding Telehealth experience. An information sheet on Telehealth was provided to all patients participating in Telehealth. Following the consent to participate, patients were asked to answer four questions regarding their Telehealth experience. Twenty-five patients showed interest when asked if they would participate in the Telehealth project by answering a questionnaire. Seven patients consented to participate in the Telehealth project. The questionnaire included one qualitative question and three quantitative questions. There were six patient participants in the Telehealth Questionnaire under qualitative question number one. One participant did not answer the qualitative question. There were seven participants in the Telehealth Questionnaire under quantitative questions two, three, and four.

Question 1 Text Responses

Findings were four out of six participants had a satisfactory or good experience with the Telehealth system, with one comment “I am also a good provider.” One out of 6 participants stated the Telehealth system was effective and thorough. One other comment 1 of 6 participants stated: “None” (Table 1).

Table 1*Previous Experience and Personal Comfort with Telehealth Results***Q1 - What is your previous experience and personal comfort with Telehealth system?**

Satisfactory

Good...I am also a provider

Good

None

I felt it was effective and thorough.

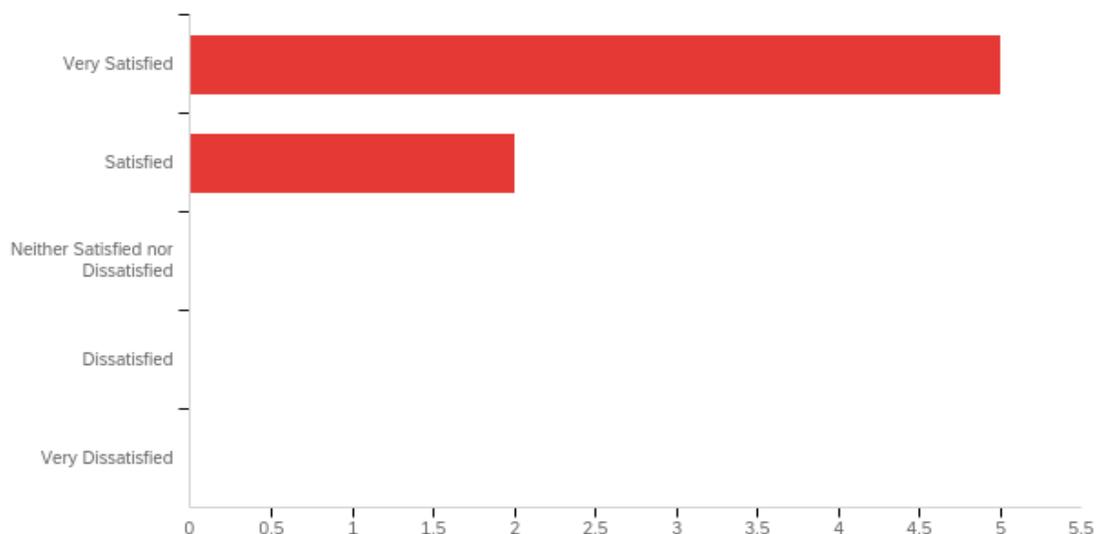
Good

Question 2 Responses

The average value from the answers from Q2 is a mean of 1.29. The standard deviation is 0.45 shows that the data are reliable from this small group. The variance is a positive number of 0.20. The majority of participants were satisfied with the questions answered by staff during a Telehealth visit (Figure 1 and Table 2).

Figure 1

Satisfaction with Questions Answered by Staff during Telehealth Visit

**Table 2**

Q2 Statistical Data

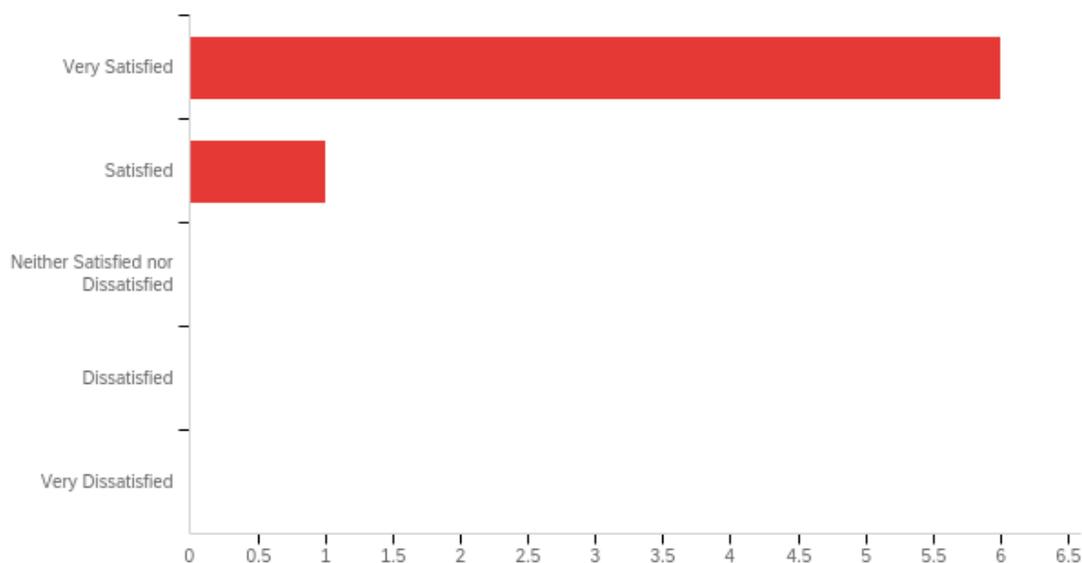
#	Field	Minimum	Maximum	Mean	Std. Deviation	Variance	Count
2	How satisfied were you with the questions answered by staff during the visit? Select one answer.	1.00	2.00	1.29	0.45	0.20	7

Question 3 Responses

The average value from the answers from Q3 is the mean of 1.14. The standard deviation of 0.35 shows that the data are reliable from this small group. The variance is a positive number of 0.12. Most participants were very satisfied with the amount of effort it took to enter into the Telehealth system (Figure 2 and Table 3).

Figure 2

Satisfaction with the Amount of Effort to Enter into the Telehealth System

**Table 3**

Q3 Statistical Data

#	Field	Minimum	Maximum	Mean	Std. Deviation	Variance	Count
3	How satisfied were you with the amount of effort it took to enter into the Telehealth system? Select one answer.	1.00	2.00	1.14	0.35	0.12	7

Question 4 Responses

The average value from the answers Q4 was a mean of 1.71. The standard deviation was 0.88 and shows that the data are reliable from this small group. The variance was a positive number of 0.78. Over half of the participants were satisfied with the Telehealth information sheet (Tables 4-6 and Figure 3).

Table 4*Q4 Statistical Data*

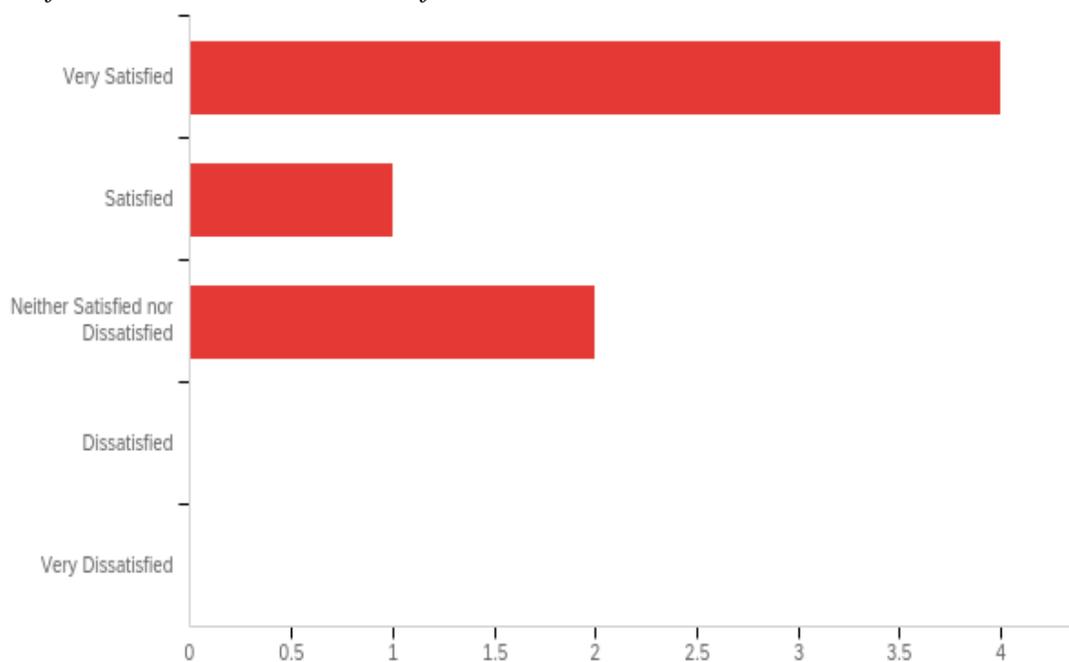
#	Field	Minimum	Maximum	Mean	Std. Deviation	Variance	Count
1	How satisfied were you with the Telehealth information sheet? Select one answer.	1.00	3.00	1.71	0.88	0.78	7

Table 5*Satisfaction with Telehealth Information Pre-Test Results*

#	Answer	%	Count
1	Very Satisfied	85.71%	6
2	Satisfied	14.29%	1
3	Neither Satisfied nor Dissatisfied	0.00%	0
4	Dissatisfied	0.00%	0
5	Very Dissatisfied	0.00%	0
	Total	100%	7

Table 6*Satisfaction with Telehealth Information Post-Test Results*

#	Answer	%	Count
1	Very Satisfied	57.14%	4
2	Satisfied	14.29%	1
3	Neither Satisfied nor Dissatisfied	28.57%	2
4	Dissatisfied	0.00%	0
5	Very Dissatisfied	0.00%	0
	Total	100%	7

Figure 3*Satisfaction with the Telehealth Information Sheet*

Overall, there was satisfaction with the Telehealth experience. The majority of participants were very satisfied or satisfied. There were two participants not satisfied or dissatisfied with the Telehealth information sheet.

Limitations

In the Telehealth Performance Improvement Project Spring of 2021, patient Telehealth visits had declined as the numbers of COVID-19 cases declined and COVID-19 vaccines were administered. Fewer patients participated in Telehealth visits at the Intracoastal Internal Medicine Office. Most patient visits took place in the office setting. There were fewer office visits in the Fall of 2020 and more Telehealth visits in the Fall of 2020.

In addition to fewer COVID-19 cases, the staff's ability to participate less in assisting with the implementation of the Telehealth questionnaire process in Spring 2021. There were initially two staff and one PCP available for the Telehealth project. One staff member early on was not able to assist any longer. Later, the other staff person was able to participate occasionally. The one PCP assisted in obtaining consent from patients to participate in the Telehealth project. There were fewer Telehealth visits. The PCP stated most patients wanted to have office visits rather than Telehealth.

When the PCP asked patients if they were interested in participating in a Telehealth questionnaire, they had more success receiving patient consent to participate. The MA did not have as many positive reactions or responses to participate in the Telehealth questionnaire. Perhaps having only the PCP asking patients if they were interested in the participation of the Telehealth project would have been more successful in obtaining participants.

The busy Intracoastal Internal Medicine Office is not a part of a large organization. An internal medicine office part of a large organization has more opportunities that provide many resources and is likely to have more personal available to

assist. The office dynamics, staff availability, need for Telehealth declined, and overall patient preferences for an office visit, affected the ability to collect more data for the Telehealth process improvement project.

Overall, the Telehealth questionnaire provided a snapshot of the patient opinions of the Telehealth experience. A finding showed patients were satisfied with the ease of logging in to the Telehealth system. Patients were required to use the Healow application or online enter Healow to participate in the Telehealth system. The utilization of Healow was thought to have been a distractor in patient participation in Telehealth. To log into Healow first before Telehealth was not an issue. Most all participants felt logging into Telehealth was without any difficulty.

The majority of the patient population in the Intracoastal Internal Medicine Office during Fall-2020 visits were often via the Telehealth system. During Spring-2021 from the PCP, the majority of patients wanted to have their office visit in person. The Intracoastal Internal Medicine Office is within the city limits. Most patients live within the city limits. If more patients live out in the county countryside with a longer distance to travel, more patients may have been interested in Telehealth.

Lastly, the stress and detrimental care required for all patients during Fall-2020 due to the COVID-19 Pandemic may have fatigued many patients and healthcare workers. Fatigue and burnout may have caused a disregard for any extra activity such as participation in a Telehealth questionnaire.

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