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An Evaluation of Patient Satisfaction with Telephone Follow-up in an Urgent Care

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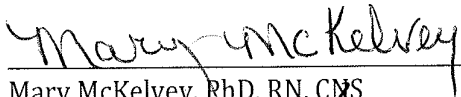
AN EVALUATION OF PATIENT SATISFACTION WITH TELEPHONE FOLLOW-UP IN AN
URGENT CARE

Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice


By

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Date: 04/19/2015

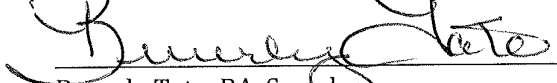
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March 30, 2015
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March 30, 2015
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March 30, 2015
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PATIENT SATISFACTION WITH TELEPHONE FOLLOW-UP

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First, the author would like to extend much gratitude to her committee and preceptor for all the guidance they provided throughout the entire process. Secondly, she would also like to express her greatest appreciation for the staff members of the urgent care under study as their enthusiasm and willingness to consistently function as team members truly led to the uneventful and uninterrupted implementation of the study. Thirdly, and lastly, she would like to acknowledge her appreciation for her mother, as without her unwavering support, insight and guidance, completion of this process would never have been possible. As her one and only child, she dedicates this manuscript to her.

ABSTRACT

The overall goal of health care is to provide high quality care that will improve the health of all individuals (World Health Organization, 2014). According to Woodring et al., (2004) and Guss, Leland and Castillo (2013), prior to a decade ago, quality of health care was primarily based on professional practice standards, preventable adverse events and mortality rates. Although evaluation in these areas is still important, over the past few years, it has been recognized that patient perception of the care they receive is a key indicator in the measurement of quality of health care.

With the variety of services offered in healthcare, in order to be knowledgeable regarding patients' perception of services and to ensure that providers are meeting patients' needs, evaluation of patient satisfaction (PS) has to occur. PS is not only dependent on the quality of care delivered, but factors such as patient demographics play a role as well (Afzal, Rizvi, Azad, Rajput, Khan & Tariq, 2014). Evaluation of PS with delivered services is imperative as highly satisfied patients are more likely to engage in health promoting behaviors (Kimman et al., 2010).

The service that was evaluated in this study is a Telephone Follow-up (TFU) protocol in a Central Ohio urgent care. There is a major paucity in the literature regarding use of TFU and its evaluation in the urgent care setting. TFU has been successfully utilized in a variety of settings such as urology, gastroenterology and pediatric ambulatory surgery (Jeffery, Doumouchsis, & Fynes, 2007; Kassmann, Docherty, Rice, Bailey, & Schweitzer,

2012; Turner, 2012; Zheng, Zhang, Qin, Jing-Fang, & Wu, 2012). In addition, high PS rates have been associated with TFU use (Davies, Vas & Oyibo, 2013; Turner, 2012).

This study utilized mixed methods methodology and employed a descriptive design. Convenience sampling was utilized and a sample of seventy-seven participants was obtained. The primary objective was to evaluate PS with the TFU protocol and the secondary objective was to assess if any personal characteristics and demographics were associated with high levels of PS. The Telemedicine Satisfaction Questionnaire was utilized to obtain PS data. Descriptive statistics were employed for data analysis of the personal characteristics and demographic data as well as PS ratings. Qualitative data was analyzed with utilization of NVivo 10 qualitative data analysis software.

This study obtained a 43% response rate and it was found that a majority of the responders were highly satisfied with the TFU protocol. A statistically significant association was found between ethnicity and high PS rates for only one of the questionnaire statements. Content analysis of the qualitative data revealed that although the majority of responders valued TFU, many preferred to be knowledgeable in regards to the timing of TFU.

Based on the study findings, key recommendations included allowing patients to select a convenient time for TFU and for the urgent care to utilize a dedicated resource for TFU performance. By evaluating PS with delivered services, patients' needs will be met through modification of existing practices.

AN EVALUATION OF PATIENT SATISFACTION WITH TELEPHONE FOLLOW-UP IN AN URGENT CARE

Introduction

The overall goal of health care is to provide high quality care that will improve the health of all individuals. One of the key components of this goal is to construct health services that will meet the needs and expectations of the individuals served (World Health Organization, 2014). Prior to a decade ago, quality of health care was primarily based on professional practice standards, rates of error, preventable adverse events and mortality rates. Although evaluation in these areas is still important, over the past few years, it has been recognized that patients' perception of the care they receive is a key indicator in the measurement of the quality of health care. It also plays a major role in the evaluation of clinical effectiveness and the need for performance improvement (Woodring et al., 2004; Guss, Leland & Castillo, 2013). According to the Hospital Compare website (2013), a consumer oriented website that provides information on how well hospitals provide recommended care to patients, Medicare reimbursements will not only be based on the actual number of services provided, but these reimbursements will also be based on the provision of high quality services. With this taken into consideration, it is clear that from a financial perspective, by linking quality of care to payment, attainment of high PS rates will become even more important than it was prior to the recognition of its role in the measurement of quality of health care. Simply put, when the delivered care meets patients' expectations, satisfaction is achieved and PS is strongly influenced by patients' experiences (Greeneich, Long & Miller, 1992).

With the variety of services offered in health care, in order to be knowledgeable regarding patients' perception of services and to ensure that patients' needs are being met,

evaluation of PS has to occur. PS is not only dependent on the quality of care delivered, but factors such as patient demographics play a role as well (Afzal et al., 2014). Evaluation of PS with delivered services is imperative as it has been recognized that highly satisfied patients are more likely to engage in health promoting behaviors which will lead to the improvement of overall health (Kimman, et al., 2010).

The service that was evaluated in this study was the TFU protocol in a Central Ohio urgent care. According to the Agency for Healthcare Research and Quality (2011), TFU should occur 48-72 hours after patients are discharged from the health care facility, with the intended purpose of evaluating patients' conditions including compliance and comprehension of prescribed medications and treatments.

For the purpose of this study, by evaluating PS with the TFU protocol, issues that may exist specifically with the telephone call and the process were identified in order to determine if there was a need for performance improvement interventions that will maximize PS, meet patients' needs and ultimately improve patient health outcomes. In addition, considering that studies by Young, Meterko and Desai (2000) and Afzal et al. (2014) have found an association between patient demographics and PS, in order for providers in the studied urgent care to effectively provide optimum care to their patient population, determining if there was an association between patient demographics and PS was very important.

According to the American Academy of Urgent Care Medicine, Urgent Care Medicine is "the provision of immediate medical services offering outpatient care for the treatment of acute and chronic illness and injury" (2014). According to Yee, Lechner and Boukus (2013), the care provided by an urgent care is on a walk-in basis. These facilities are typically open daily with extended evening and weekend operations, however, services are not provided

twenty-four hours per day. Urgent care centers are typically staffed by physicians, nurse practitioners and physician assistants. A few of the services provided include, but are not limited to treatment of upper respiratory infections, minor injuries such as lacerations and simple fractures. Utilization of an urgent care does not replace the role of a primary care provider; however, it provides a means for patients to receive care if their primary care provider is unavailable, if an ailment occurs outside of the primary care provider's practice business hours and it also provides an alternative to long emergency department wait times (AAUMC, 2014).

According to the Chief Executive Officer (personal communication, July 21, 2014) of the urgent care under study, the TFU protocol was implemented one year prior to conduction of the present study and evaluation of PS with its use has not occurred. The TFU protocol is conducted by a registered nurse or a radiographic technologist three days after patients are discharged from the urgent care and becomes a part of the patients' medical record. The TFU protocol predominantly focuses on evaluation of symptom resolution, culture results and X-Ray over-read results. One attempt is made to obtain contact with patients and this occurs at the convenience of the urgent care staff member, as the registered nurse and radiographic technologist are still responsible for the provision of direct patient care as well as the conduction of the TFU protocol for patients previously evaluated. If an attempt at direct contact is unsuccessful, patients with a voicemail box are left a message informing them that they are being contacted for follow-up. Patients are also instructed to contact the urgent care if they have any questions or concerns.

The services provided at the studied urgent care include but are not limited to laceration repairs, tuberculosis testing, treatment of upper respiratory and gastrointestinal infections, the provision of sports physicals and the performance of incision and drainage

procedures for abscesses. Approximately fifty to one hundred patients are served on a daily basis with approximately 95% of these individuals being medically insured (Chief Executive Officer, personal communication, July 20, 2014).

The staff members at the studied urgent care consists of medical secretaries who perform operations at the front desk, registered nurses, radiographic technologists, physicians, physician assistants and nurse practitioners (Chief Executive Officer, personal communication, July 25, 2014). Also according to the Chief Executive Officer (personal communication, September 21, 2014), on any given day, the staffing model typically consists of a medical secretary, a physician, a registered nurse, a radiographic technologist and either a physician assistant or a nurse practitioner.

Due to PS with TFU and the association between patient demographics and high PS levels never being formally evaluated since implementation of the TFU protocol in the urgent care under study, the need for improvement cannot be determined. Based on the results yielded from this study, improvement interventions were constructed and proposed.

Background/Significance of Problem

Utilization of urgent cares have dramatically increased over the past decade which is predominantly due to long emergency department wait times, the reduction in available primary care appointments and individuals' desire to receive immediate care (Yee et al., 2013). According to Schoen et al. (2009), only 29% of U.S. primary care physicians have after-hours arrangements available. Without after-hours services and long emergency department wait times, there is a heavy reliance on urgent care facilities. Approximately 60% of individuals with established primary care reported that there were not any after-hours services at their primary care provider's practices (O' Malley, 2013). As a result of the

increase in demand, urgent care facilities in the U.S. have increased from 8,000 to 9,300 since 2008 (American Academy of Urgent Care Medicine, 2014). With this surge in urgent care utilization and PS being a key indicator in the measurement of quality of health care, it is of high importance that an evaluation of PS occurs. Studies have shown high levels of PS with the TFU service, however, there is a major paucity in the research regarding its use and evaluation of PS with its use in the urgent care setting. Assessment of PS with urgent care services such as TFU bears significance not only for patients, but also for health care professionals and health care institutions as well.

In addition, although the quality of care delivered has an impact on PS, it has to be noted that other factors such as patient demographics have an impact on PS as well. In the study by Afzal et al. (2014) which assessed PS with a health care facility and the effect of demographic characteristics on PS, it was found that the elderly and less educated patients with lower income were more satisfied with the health care facility when compared to their younger, more educated counterparts who were in a higher income bracket. In a similar study by Young, Meterko & Desai (2000) that examined the relationship between PS scores and demographic characteristics, it was found that age, health status and ethnicity had a statistically significant effect on PS scores. Upon review of the literature, a major paucity regarding studies that evaluated the association between personal characteristics and demographics in the urgent care setting was revealed. With this paucity taken into account, combined with the knowledge that there is an association between patient demographics and PS, conduction of an evaluation with the aim of determining if there is an association between patient demographics and high levels of PS in the studied urgent care is important. Through this evaluation, providers were able to determine if patients' needs were being

met, as well as determine the need for interventions that will improve the services provided to their patient population.

Patients

The literature has illustrated that TFU is well accepted by patients and providers (Zheng et al., 2012). It has been widely utilized in a variety of settings such as endocrinology, gastroenterology, urology, colorectal surgery and pediatric ambulatory surgery (Anderson, 2010; Beaver et al., 2010; Jeffery et al., 2007; Kassmann et al., 2012; McVay et al., 2008; Salmon & Hussain, 2012; Turner, 2012; Zheng et al., 2012). In addition, it was found to be effective in decreasing hospital re-admission rates and is preferred by the majority of patients over face-to-face follow-up (Harrison, Hara, Pope, Young & Rula, 2011).

The study conducted by Davies, Vas and Oyibo (2013) that evaluated PS with TFU in patients with thyrotoxicosis, found that use of TFU was well accepted by 71-99% of patients. 90% of patients felt that TFU saved them time that would have been otherwise spent on traveling to the hospital if follow-up was face-to-face. This was also similar to the findings in a retrospective study that evaluated PS with a nurse-led TFU protocol in women with lower urinary tract symptoms (Jeffery et al., 2007). Specifically, Jeffery et al. (2007) found that the major advantages of TFU included the elimination of the need for patients to travel to the hospital, request time off work and to seek additional support from others if they were caretakers. Additional patient advantages included the elimination of the need for parking fees and long waits in overcrowded waiting rooms (Anderson, 2010). The study by Turner (2012), which focused on the evaluation of the PS with TFU in adult males with stable prostate cancer found that 90% of participants were 'very satisfied' or 'satisfied' with TFU and that 97% considered TFU to be a beneficial addition to the urology service. Turner

(2012) also found that not only were patients highly satisfied with TFU, but there were also high levels of satisfaction amongst staff members with its use.

Health Care Institutions

In the retrospective cohort study by Harrison et al. (2011), the impact of post-discharge telephonic follow-up on hospital re-admission rates was evaluated and it was found that timely TFU after discharge which was defined as within fourteen days after discharge, did lead to a reduction in re-admission rates. Specifically, the intervention group was 23.1% less likely to be re-admitted within thirty days of hospital discharge when compared to the control group who did not receive the TFU. Additionally, in this study, the TFU intervention was deemed effective in reducing near term hospital re-admissions and therefore served as a method to reduce cost for health plans and their members. With the initiation of the Readmissions Reduction Program, a regulation that was initiated by the Affordable Care Act effective October 2012, hospitals stand to be penalized in the form of reduced reimbursement rates if patients are re-admitted within thirty days of discharge from the same hospital (Centers for Medicare and Medicaid Services, 2014). With this in mind, it is evident that if there is a reduction in re-admission rates as a result of the TFU protocol, not only will there be an improvement in the quality of health care delivered, but institutions will avoid being penalized as well.

In the retrospective study by Jeffery et al. (2007) that evaluated PS with TFU in women with lower urinary tract symptoms, it was determined that not only were high PS scores attained, but TFU was more cost-effective when compared to standard face-to-face follow-up. Due to TFU only requiring use of one clinician, which was a clinical nurse-specialist, it left the physician ample time to perform other clinic activities and required use of fewer ancillary staff (2007). Overall, when compared to the control group, TFU was found

to be an attractive alternative for follow-up. Similar to previous studies that demonstrated cost-effectiveness with use of TFU, a randomized control trial by Wasson et al. (1992) was conducted in a primary care clinic with TFU being the intervention compared to the control group which received the standard face-to-face follow-up. This study found that TFU significantly reduced utilization of medical services with an estimated total expenditure of 28% less per patient over the two years that the study was conducted. Lastly, in a retrospective study, a strong association was found between post-discharge phone calls and high levels of PS, which was measured by high ratings of likelihood to recommend the health care facility on a Press Ganey survey (Guss et al., 2013).

Health Care Professionals

One of the main benefits of TFU is that it provides ample time for clinicians to spend with patients who have to attend face-to-face appointments (Anderson, 2010). Attaining PS is of great importance to nursing as it is predominantly nurse-led and is usually conducted by nurses or clinical nurse specialists (Anderson, 2010; Davies et al., 2013; Harrison, Hara, Pope, Young & Rula, 2011; Jeffery et al., 2007; McVay, Kelly, Mathews, Jackson, Kokoska, & Smith, 2008; Rennke, Kesh, Neeman, & Sehgal, 2012; Turner, 2012; Zheng et al., 2012).

According to the American Academy of Urgent Care Medicine (2014), urgent care is considered ambulatory care. With the large number of nurse practitioners who practice in ambulatory care, obtaining feedback pertaining to PS will be beneficial to health care institutions and facilities. Feedback will also provide a foundation for the evaluation of the need for possible performance improvement in health care that is delivered by nursing and other professionals. In rural areas, approximately 56.7% of all patients utilize urgent cares for non-urgent needs and to meet their primary care concerns (Thrasher & Purc-Stephenson, 2008). As a result of the demand for urgent care services, there has been an

increase in the utilization of nurse practitioners in urgent cares. With the shortage of health care professionals due to family physicians retiring and medical students choosing specialties over general medicine, there is a huge vacancy in these rural areas (Florence, Goodrow, Wachs, Grover & Olive, 2007). Greater than 60% of NPs are members of the ambulatory and primary care teams, which are vital to the management and prevention of disease (US Department of Health and Human Services, 2010).

Turner (2012) evaluated PS with TFU in a urology practice and found that the health care professional thought that TFU was beneficial to the practice, as it not only provided him/her with ample time to see patients who needed the face-to-face follow-up, but it also freed up more appointment slots. Other providers also viewed TFU as a valuable addition to other follow-up services (2012). In a similar study conducted to explore patients' and enterostomal nurses' perceptions regarding an implemented TFU protocol, patients not only viewed TFU as a convenient and effective method to meet their needs, but these views were also shared by the nursing professionals in this setting (Zheng et al., 2013). Based on this review of the literature, it is evident that TFU is significant to health care professionals in general who desire high levels of PS with services provided and to nursing professionals specifically considering that it is predominantly nurse led.

The method utilized to obtain information pertaining to PS with TFU included face-to-face semi-structured interviews, postal surveys, electronic mail surveys and telephone questionnaires, with majority of the tools utilizing a Likert scale (Anderson, 2010; Davies et al., 2013; Jeffery et al., 2007; Turner, 2012). There were no studies found that compared modes of delivery of the PS questionnaire or survey to one another. The studies by Davies et al. (2013), Jeffery et al. (2007) and Turner (2012) utilized postal questionnaires that included the provision of a stamped envelope. The questionnaire response rates were 78%,

73% and 61%, respectively. The study by Anderson (2010) that utilized convenience sampling yielded a 100% response rate and utilized the telephone for delivery of the questionnaire. Another study that evaluated parent and provider satisfaction with TFU in pediatric ambulatory surgery, also utilized the telephone for survey conduction and there was a parent response rate of 91% and a provider response rate of 100% (Kassman et al., 2012). Lastly, the study by Zheng et al. (2013) which explored patients' and enterostomal nurses' perception of TFU utilized both telephone and email for survey conduction and the response rate was 100%. Based on this review, it was decided that the present study utilize the telephone for questionnaire delivery.

Theoretical Framework

The theoretical framework that was deemed most suitable to serve as a foundation for the present study was Pender's Health Promotion Model. This middle range theory explores the various factors and processes that motivate individuals to adopt health promoting behaviors with the goal of enhancing their overall health. It provides a holistic view of health and takes into consideration individuals' lifestyle, their strengths, resources, potentials and capabilities (Pender, Murdaugh & Parsons, 2011; Peterson & Bredow, 2013). This model is applicable to any type of health behavior that does not include threat as a motivator (Pender et al., 2011).

Two theories that serve as strong bases for the Health Promotion Model are the Social Cognitive Theory and the Expectancy-Value Theory. According to the Social Cognitive Theory, the greater an individual's self-efficacy, the more likely he/she will engage in health promoting behaviors and maintain such behaviors even when faced with obstacles (Butts & Rich, 2011; Peterson & Bredow, 2013). The Expectancy-Value Theory explains that individuals tend to engage in certain health promoting behaviors and strive for certain goals

if they feel the goals will be beneficial to them (Fishbein & Ajzen, 1975). This is consistent with the Pender's Health Promotion Model proposition which states "perceived benefits directly motivate behavior as well as indirectly motivate behavior through determining the extent of commitment to a plan of action to engage in the behaviors from which the anticipated benefits will result" (Pender, Murdaugh & Parsons, 2006, p. 53).

In the Health Promotion Model, there are three major concepts which include individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes. These three concepts are subdivided into narrower concepts which include perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity related affect, interpersonal influences and situational influences (Pender et al., 2011; Peterson & Bredow, 2013).

Specifically for the present study, testing and application of the entire model was not conducted. The component that was of key focus was situational influences, as these promote patient engagement in health promoting behavior (Peterson & Bredow, 2013). Through conduction of TFU, patients are engaged with the urgent care provider who can assess their health status and provide guidance and education that will encourage engagement in health promoting behaviors. According to Pender et al. (2011), situational influences can directly and indirectly influence health behaviors as certain situations do so by creating a setting in which cues that trigger action are available. The TFU process for the current study establishes TFU as a situational influence that is filled with cues to action.

According to the World Health Organization (2003), one of the most promising interventions that promote patient adherence along with other interventions such as patient education and social support is TFU. The literature has shown that health promotion interventions that include smoking cessation, hypertension, HIV and alcohol screening have

a positive impact on PS (Rega et al., 2012). With TFU being such a valuable intervention, evaluation of PS with its use is highly important, as patients who are satisfied with the care they receive are more likely to engage in health promoting behaviors which include but are not limited to specific follow-up strategies and treatment regimens (Kimman et al., 2010). By patients engaging in such behaviors, improvement in patients' overall health will be achieved, which is the end goal of the Health Promotion Model (Pender et al., 2011).

Problem statement

PS is a key component in the measurement of quality of health care. Lack of knowledge regarding PS with the use of TFU in an urgent care leads to providers not being able to effectively assess the quality of care delivered. Evaluation of PS with TFU provides a mechanism for identification of problems that might exist.

Purpose

The purpose of this study was to assess PS with the TFU protocol that was administered three days after discharge from an urgent care in the adult population and to determine if there were any personal characteristics and demographics that were associated with high PS rates.

Project Implementation Plan

Project Design

This study was a quantitative qualitative (mixed methods) descriptive study. The study utilized the Telemedicine Satisfaction Questionnaire that was developed by Yip, Chang, Chan and Mackenzie (2003) to evaluate PS with the TFU protocol at a Central Ohio urgent care in the adult population. (See Appendix A for the questionnaire).

Project Objectives

1. To evaluate PS with the use of a TFU protocol that was conducted three days after discharge from an urgent care in the adult population.
2. To assess if specific personal characteristics and demographics were associated with high PS rates which were defined as Likert scale ratings of four (agree) and five (strongly agree).

Sample Description

The sample consisted of adults eighteen years of age and older who presented to the urgent care. Convenience sampling was utilized with the goal of obtaining at least fifty participants over a seven week period who would be representative of the population served by this urgent care. The sample was recruited on Mondays during business hours which were between 9:00 am and 9:00 pm. There were no recruitment inducements. The Telemedicine Satisfaction Questionnaire was conducted every Friday via telephone from the urgent care after consent for contact was obtained from each participant at the time of recruitment. The questionnaires were conducted between the hours of 9:00 am and 7:00 pm based on the preferred times selected by each participant at the time of recruitment. Friday was chosen as the day for questionnaire conduction as it not only allowed for conduction of the TFU the day before, but it also minimized the risk of recall bias.

The study inclusion criteria were:

- English speaking individual
- Eighteen years of age and older
- Patients with an operating cellular or home phone

- Patients who were available for contact via telephone one day after conduction of TFU
- Patients who did not plan on changing their phone number within two weeks of leaving the urgent care

Data Collection

Patients were greeted by the author at the conclusion of their urgent care visit, after all treatments and discharge was complete. They were provided with a detailed description of the study via an oral script and invited to participate. See Appendix B for the oral script. For those who agreed to participate, written consent using the form shown in Appendix C was obtained and the Personal Characteristic and Demographic form (Appendix D) was completed, which was then collected solely by the author prior to them leaving the urgent care. Patients were informed verbally and in written format that the decision to not participate in the study would not pose a detrimental impact on services that they may seek in the future. Patients' preferred time for questionnaire conduction on each Friday was ascertained and documented on the Contact Information and Time Preference Recording form shown in Appendix E. In the case where contact was not made initially, up to three attempts were made to each study participant over the span of thirty to sixty minutes. If contact was not successful thereafter, they were considered a lost participant in this study. The information collected was not anonymous, however it was confidential. The patient's last name and first initial of their first name was utilized as their identifier for introduction when contacted for conduction of the questionnaire by the author. All documents were kept on the urgent care property in a secure automated digital lock box. In the case where documents had to be off the urgent care property, they were kept solely in the author's

possession. The only personnel that had access to the collected data was the author and the author’s committee members.

Budget

The budget for this study included the cost of fuel for travel which was \$240.00, the cost of printing necessary documents that included the Personal Characteristic and Demographic forms as well as the Consent and Time Preference Recording forms which was \$27.00. The cost of the statistician utilized was \$150.00. See Table 1 for details pertaining to the expenses necessary for study conduction. A research grant was awarded to the author from the Otterbein Student Research Fund which was utilized for study expenses.

Table 1 Budget

Expenses	Cost
DNP TRAVEL EXPENSES Fuel at \$30 per week x 8 weeks	\$240.00
STATIONARY Three packs of white printer paper Stapler Pack of paper clips 2 pack of staples	\$15.00 \$7.00 \$3.00 \$2.00
Final presentation poster	\$100.00
Statistician	\$150.00
TOTAL	\$517.00

Timeline

The present study was planned in a manner which allocated adequate time for study implementation, data analysis, final report construction and dissemination of study findings. The projected timeline was eight months which adequately allowed for smooth transition through each phase of the process. The author obtained approval from the Institutional Review Board at Otterbein University in August 2014, the study was implemented the following fall semester, and formal presentation and dissemination of study findings occurred in March and April of 2015. See Table 2 below for an illustration of the timeline.

Table 2 Timeline

Otterbein IRB application	August 2014
Project Implementation	September- December 2014
Data Analysis	January 2015
Construction of final project report	February 2015
Submission and presentation of the final report	March 2015
Dissemination of study findings	April 2015

Protection of human subjects

An application to the Institutional Review Board at Otterbein University for an expedited review was submitted and approved. See Appendix F for approval letter. Patients were notified verbally and in written format that their information would be kept

confidential and secure and that they were free to withdraw from the study at any time without penalty.

Outcome/Evaluation

Instruments

The data collection form utilized to obtain information pertaining to personal characteristics and demographics was developed by the author. A panel of experts which consisted of the author's committee members and an additional faculty member evaluated the form for readability and content validity.

The Telemedicine Satisfaction Questionnaire that was developed by Yip et al. (2003) was utilized to assess PS. The questionnaire utilizes a five-point Likert scale to measure satisfaction with 5 for 'strongly agree', 4 for 'agree', 3 for 'undecided', 2 for 'disagree' and 1 for 'strongly disagree'. For the purpose of the present study, high PS rates were defined as Likert scale ratings of four and five. Percentage distribution for each of the questionnaire statements, the mode and standard deviation were used to analyze PS rates.

The original study by Yip et al. (2003) that developed the Telemedicine Satisfaction Questionnaire involved testing of the questionnaire on newly referred patients in a diabetic center who had no experience with telemedicine videoconferencing. Internal consistency and the intraclass correlation coefficient were utilized to assess the instrument's reliability. According to the developers of the original questionnaire, internal consistency was 0.93 which indicated strong correlations between the questionnaire items. In addition, the intraclass coefficient which was also used to determine internal consistency was 0.43 (2003). According to Yip et al. (2003), at the time of development of this questionnaire, telemedicine was relatively new in medical research. A low reliability level such as 0.43 is

considered adequate in the early stages of research (Nunnally, 1978). Content validity was confirmed through examination of the questionnaire by a panel which consisted of fourteen experts which included doctors, a nurse and experts in telemedicine.

Permission to use the questionnaire was obtained from the primary developer of the original questionnaire via email. For the purpose of the present study, the questionnaire was adapted by the author as videoconferencing was not included. See appendix C for the adapted questionnaire. Eleven out of the original fifteen questions were utilized and the author added one open-ended question which pertained to comments and suggestions for TFU improvement from study participants. The Telemedicine Satisfaction Questionnaire was utilized similarly to how it was utilized in the study by Davies et al. (2013) that evaluated PS with TFU in patients with thyrotoxicosis. Davies et al. (2013) also adapted the questionnaire for the purpose of their study and postal mail was employed as the mode of delivery. For the present study, the author assessed reliability of the adapted questionnaire with use of internal consistency reliability and the Cronbach alpha as a measure. Internal consistency reliability was deemed most appropriate for a questionnaire such as this, as it evaluates the consistency of results among the various items such as statements on a given test (Trochim, 2006). According to Salkind (2014), the higher the alpha level or value “the more confidence you can have that the test is internally consistent or measures one thing” (p. 114). The Cronbach alpha level calculated for the adapted questionnaire was 1, which is indicative of good reliability. According to Zaiontz (2014), the range for Cronbach alpha is zero to one, with an alpha level above 0.7 being indicative of acceptable reliability and greater than 0.8 indicating good reliability.

Data Analysis

Descriptive statistics. Descriptive statistics were used to analyze and summarize the data with employment of Microsoft Excel 2013. Percentage distributions of the variables were used to measure distribution and central tendency was measured by use of the mode. The range was used to measure dispersion for the personal characteristics and demographics and standard deviation was used to measure dispersion for the PS ratings.

A total of seventy-seven participants were recruited and agreed to participate in the study, with no participants withdrawing from the study. Of the seventy-seven solicited, thirty-three completed the questionnaire, yielding a 43% response rate. Of the thirty-three responders, thirty (91%) were successfully contacted on the first attempt with the remaining three (9%) being successfully contacted on the second attempt. Of the seventy-seven participants recruited, thirty six participants (47%) did not complete the questionnaire as they did not directly receive the TFU call. Thirty (83%) of the thirty-six participants shared with the author when contacted for completion of the questionnaire, that they did not receive a phone call or voicemail from the urgent care. The remaining six (17%) shared that they missed the TFU call and were left a voicemail and all six did not return the call. Lastly, eight participants (10%) received the TFU call directly from the urgent care, but did not answer the telephone for conduction of the questionnaire. For these eight participants, the phone numbers provided to the author and what was recorded in their medical records were compared and all were found to be the same. Three attempts for each of these participants were made; all of which were unsuccessful.

Of the seventy-seven participants recruited, the sample consisted of 32% male and 68% female, with 90% being Caucasian, with the majority having a Bachelor degree (36%) and a yearly income between \$50,000 and \$75,000 (25%). The mode for age range,

ethnicity, education level and yearly income range for both responders and all solicited was 30-39 years, Caucasian, Bachelor degree and \$50,000-\$75,000 respectively. There was a greater number of females solicited when compared to males and interestingly, there was a greater number of male responders compared to female responders. Due to utilization of age and income ranges on the Personal Characteristic and Demographic form, the range for age and income had to be approximated, resulting in values of fifty-two and \$80,000 respectively for both the responders and all participants solicited. Detailed information pertaining to the study sample is shown in Table 3 below.

Table 3 Patient demographics and characteristics

Personal characteristics and demographics	Responders: 33 N (%)	Responders: 33 Mode (Range)	All Solicited: 77 N (%)	All Solicited: 77 Mode (Range)
<i>Gender</i> Male Female	20 (61) 13 (39)	Male	25 (32) 52 (68)	Female
<i>Age</i> 18-20 years 21-29 years 30-39 years 40-49 years 50-59 years 60-69 years 70 years+	1 (3) 5 (15) 8 (24) 4 (12) 5 (15) 5 (15) 5 (15)	30-39 years (70 and older - 18 years= approx. 52)	8 (10) 14 (18) 20 (26) 11 (14) 8 (10) 7 (9) 9 (12)	30-39 years (70 and older - 18 years= approx. 52)
<i>Education level</i> Less than high school degree High school degree or GED Some college, but no degree Associate degree Bachelor degree Graduate degree	0 (0) 1 (3) 7 (21) 6 (18) 12 (36) 7 (21)	Bachelor Degree	2 (3) 5 (6) 18 (23) 7 (9) 28 (36) 17 (22)	Bachelor Degree
<i>Yearly income</i> Less than \$20,000 \$20,000-\$34,999 \$35,000- \$49,999 \$50,000- \$75,000 \$75,000- \$99,999 \$100,000 or more No information provided	6 (18) 3 (9) 4 (12) 8 (24) 5 (15) 4 (12) 3 (10)	\$50-\$75,000 (\$100,000 or greater - less than \$20,000= approx. \$80,000	15 (19) 12 (16) 7 (9) 19 (25) 8 (10) 12 (16) 4 (5)	\$50-\$75,000 (\$100,000 or greater - less than \$20,000= approx. \$80,000)
<i>Ethnicity</i> White or Caucasian Black or African American AI or AN Asian NH or other PI Multi- or bi-racial	29 (88) 0 (0) 0 (0) 2 (6) 0 (0) 2 (6)	Caucasian	69 (90) 0 (0) 2 (3) 2 (3) 0 (0) 4 (5)	Caucasian

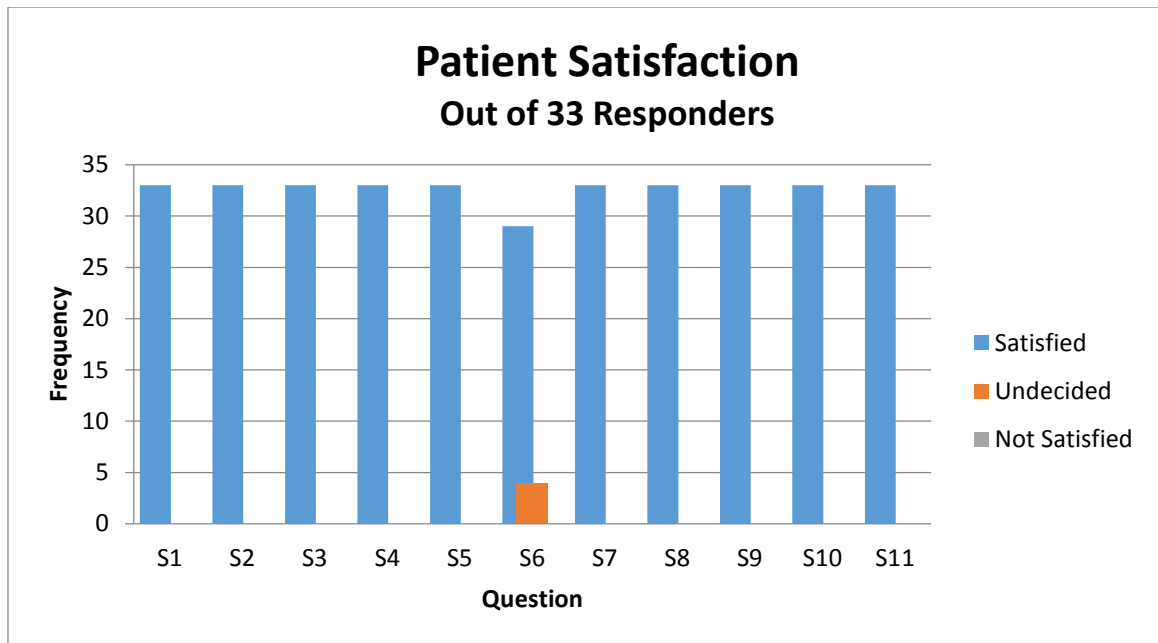
Responses to questionnaire statements. With all questions taken into account, as illustrated in Figure 1, a majority of the responders were satisfied with the TFU protocol. Specifically, responses ranged from 88-100% of responders either selecting 'strongly agree' or 'agree' across all of the questionnaire statements. This level of PS is similar to previous studies conducted by Davies et al. (2013) and Turner (2012). As shown in Table 4, a majority of responders selected a Likert scale rating of five on all statements with the exception of statements two, five, six and eight, which were related to how clearly they were able to hear their health care provider during the TFU call, with feeling that TFU saved time because they didn't have to travel, with feeling that they obtained better access to follow-up services with use of TFU when compared to face to face follow up and feeling that TFU provided for their healthcare need.

As shown in Table 4, for statement six which pertained to patients feeling that they obtained better access to follow-up care with use of TFU when compared to face to face follow-up, it was found to be the only statement that a few responders selected a Likert scale rating of three for 'undecided'. As depicted in table 4, twenty-one responders (64%) strongly agreed and eight (24%) agreed with this statement. The remaining four responders (12%) were undecided. Also as depicted in Table 4, there were no responders that disagreed or strongly disagreed with any of the questionnaire statements. The mode for all statements was a Likert scale rating of five. The standard deviation for all statements was zero with the exception of statements two, five, six and eight which had standard deviations of 0.242, 0.174, 0.712 and 0.174 respectively. As depicted and illustrated in Table 4 and Figure 1, statement six had the greatest variability as evidenced by a standard deviation of 0.712, which was higher than that of statements two, five and six.

Table 4 Responses to questionnaire (n=33)

	Strongly agree 5 N (%)	Agree 4 N (%)	Undecided 3 N (%)	Disagree 2 N (%)	Strongly disagree 1 N (%)
1. I could easily talk to my healthcare provider during the telephone follow-up	33(100)	0	0	0	0
2. I could hear my healthcare provider clearly during the telephone follow-up	31 (94)	2(6)	0	0	0
3. My healthcare provider who called for the telephone follow-up was able to understand my healthcare condition	33(100)	0	0	0	0
4. I was comfortable communicating with my healthcare provider during the telephone follow-up	33(100)	0	0	0	0
5. Telephone follow-up saved me time because I did not have to travel	32 (97)	1 (3)	0	0	0
6. I obtained better access to healthcare follow-up services by use of telephone follow-up when compared to face-to-face follow-up	21 (64)	8(24)	4(12)	0	0
7. I did receive enough attention during my telephone follow-up session	33(100)	0	0	0	0
8. Telephone follow-up provided for my healthcare need	32 (97)	1 (3)	0	0	0
9. I found telephone follow-up an acceptable way to receive follow-up care	33 (100)	0	0	0	0
10. I will use telephone follow-up services again	33 (100)	0	0	0	0
11. Overall, I am satisfied with the quality of services being provided by the telephone follow-up	33 (100)	0	0	0	0

Figure 1 Responder satisfaction frequencies. (n=33)



Patient comments and suggestions. For the qualitative data, NVivo 10 qualitative data analysis software (QSR International, 2013) was utilized. Twenty-six responders (79%) provided comments and suggestions that pertained to the improvement of the TFU protocol. See Appendix G for all comments and suggestions. The responses were entered into an Excel spreadsheet which was then imported into the NVivo 10 software. The transcribed responses were thoroughly reviewed and four themes emerged. They included *timing of the TFU call*, *patient perception of the care provided*, *face to face follow-up* and *patient perception of the staff who conducted the TFU call*. The data was then coded under each identified theme, which was then followed by content analysis.

The analysis showed that the most frequently used words amongst all responders were *call*, *time* and *nice* which were used twenty-seven (8%), seventeen (5%) and fourteen (4%) times respectively. This is illustrated in Figure 2, with the larger the size of the word

meaning the more frequently the word was used and the smaller the size of the word, the less frequently it was used.

Timing of the tfu call. For the timing of the TFU call, of twenty-six responders, there were twelve responders (46%) whose comments and suggestions pertained to this theme. Analysis showed that these patients would prefer to know when they would be receiving the TFU call and to have the option of choosing a convenient time for the call as some responders shared that the call occurred at a time that was inconvenient for them. This was supported by statements such as “being able to pick a time for the call would be nice because when they called, I was getting ready to go into a work meeting”, “would be better if they tell you what time they plan on calling or ask you which time is best to call” and “is there any way that I can pick a time for them to call? That would make it easier”.

Patient perception of the care provided. For this theme, there were fourteen responders (54%) who provided comments. Overall, based on the analysis, it is evident that responders valued and appreciated the TFU service. Support of this perspective was derived from statements such as “it is very nice of them because I can ask questions when they call”, “they really care and that is great”, “it was nice to be checked on after being sick” and “it was very nice. I was feeling better and it was nice to be checked on”.

Face to face follow-up. In regards to this theme, there were two responders (7%) who provided comments. Although this is a very small number, it was still pertinent information as it showed that TFU was seen as a valuable service when compared to face to face follow-up. Supportive statements included “I have had other follow-up in the past that had to be face to face and this was better to do over the phone”. This may have been due to its convenience, however cost may also play a key factor given the statement, “It was definitely better than previous face to face experiences in the past, as in some cases I was

feeling better and didn't need anything, but I still had to follow-up because they said I was supposed to and I still had to pay another copay”.

Patient perception of staff who conducted the TFU call. Lastly, five responders (19%) shared comments regarding the theme *patient perception of staff who conducted the tfu call*. Based on the analysis, responders were satisfied with the staff who conducted the TFU service. Comments made pertained to the attitude of the caller which was positive and supported by comments such as “the nurse that called was very nice and listened to me”, “keep doing it the way that it is done as the nurse that called is very nice” and “they were nice and the staff was able to answer all the questions I had”. There was one comment made regarding the volume of the caller’s voice in regards to the need for it be louder. There were no other comments that raised any concerns for the need of improvement.

Figure 2 Word cloud



For the second objective in the present study, utilization of the Chi-square test of independence was conducted. The alpha level used was 0.05 and the null and alternative hypotheses are as follows:

- Null hypothesis:

There is no association between the personal characteristics and demographics and high PS rates for the questionnaire statements.

- Alternative hypothesis:

There is an association between the personal characteristics and demographics and high PS ratings for the questionnaire statements.

For all the variables relating to the questionnaire statements with the exception of statement six, there was no association between the patient specific variables and high PS rates, as all responders had high PS satisfaction ratings, which for the purpose of this study were defined as Likert scale ratings of 5 for 'strongly agree' and 4 for 'agree'. Specifically, with all responders selecting 'strongly agreed' or 'agreed' for the questionnaire statements excluding statement six, a lack of variation in responses was displayed which resulted in the lack of evidence that indicated an association. Thus, the null hypothesis was not rejected.

Specifically for statement six which pertained to patients feeling that they obtained better access to follow-up services with use of TFU compared to face to face follow-up, it was found that there was no association between the variables gender, age, income level and education level and high PS rates. Interestingly however, there was a statistically significant association found between ethnicity and high PS ratings for this statement, as the p-value for ethnicity was 0.047. A majority of the responders were Caucasian/White. When ethnicity was then divided into groups labeled as Caucasian/White and Non-Caucasian/Non-white, with comparison of these binary values, the p-value result was 0.013,

which further supported the decision to reject the null hypothesis and accept the alternative hypothesis. For this statement, the p-value for the remaining variables gender, age, education level and income level was 0.66, 0.814, 0.305 and 0.606 respectively.

Unintended Consequences

As a result of the Personal Characteristic and Demographic form being originally structured in a manner that utilized age and income ranges, this led to the author facing the unintended consequence of not being able to utilize the Pearson correlation coefficient test for the secondary objective as originally planned. Although the mode was successfully utilized for a measure of central tendency, for the aforementioned reason, precise calculation of the range was not feasible.

Recommendations

Recommended Interventions for the urgent care under study

Despite a majority of the responders being highly satisfied with the TFU protocol, there are a few warranted recommendations for the urgent care under study. The first recommendation is that the medical secretary consistently confirms the accuracy of each patient's contact information upon arrival and initiates updates as necessary. This should be conducted at the beginning of each visit and not after, as patients do not always interact with the medical secretary at the conclusion of their visit. Considering that thirty (83%) of the thirty-six participants were not successfully contacted for conduction of TFU by the urgent care staff, this prompted the author to investigate the possible reasons for this finding. When the telephone numbers on patients' medical records were compared to the telephone numbers provided to the author on the day of study recruitment, ten (33%) of the thirty telephone numbers were not identical. Although it may be assumed that it is

common practice for patients' contact information to be updated at each visit, with this finding, it raises the concern that this may not be occurring on a consistent basis and may have played a major role in the urgent care staff's inability to successfully obtain direct contact with patients. For the remaining twenty participants that were not successfully contacted, possible reasons include patients not having a voicemail box, patients having a full voicemail box that was unable to store new messages and the urgent care staff being preoccupied with direct patient care and lacking available time for TFU protocol conduction.

Secondly, based on responders' comments and suggestions, it is recommended that patients' preferred time for contact for TFU be ascertained and adhered to by the urgent care staff member who is conducting TFU. Not only would this further increase PS with the protocol and the needs of the patients, but it would also increase the likelihood that successful direct patient contact would occur. In the present study, the author adhered to the participants' pre-selected time that was convenient for them. Thirty-three (80%) of the forty-one participants who received the TFU protocol were successfully contacted by the author on either the first or second attempt. It is likely that by allowing patients to select a convenient time for TFU and adhering to this time, there would be an increase in the patient contact rate. Similarly to the study conducted by Jeffrey et al. (2007), which evaluated PS with a nurse-led TFU protocol in women with lower urinary tract symptoms, TFU was conducted at a time pre-selected by the patient and a 78% response rate was yielded, which is similar to the rate of contact for conduction of the questionnaire by the author of the present study. In order for this intervention to be successfully implemented in the urgent care under study that has a high daily patient volume, while still maintaining optimum provision of direct patient care, use of a dedicated resource needs to be considered.

Thirdly, the author recommends utilization of a dedicated resource such as a medical assistant or licensed practical nurse for TFU conduction. Currently at the urgent care under study, a medical secretary is utilized as the front desk staff. According to the United States Department of Labor Bureau of Labor Statistics (2015), medical secretaries conduct secretarial duties which require specific knowledge pertaining to medical terminology and clinic laboratory procedures. Their duties include scheduling of appointments and medical record compilation and billing. The national estimate for this occupation is an hourly wage of \$16.12 with an annual salary of \$33,530.00 (2015).

Pertaining to medical assistants, 96% of urgent care centers utilize medical assistants (American Academy of Urgent Care Medicine, 2015). According to the American Association of Medical Assistants (2015), medical assistants work alongside care providers in a variety of settings, predominantly in ambulatory settings. A medical assistant's responsibility includes both administrative and clinical duties, with clinical duties consisting of but not being limited to obtaining patient histories, teaching patients about treatment procedures and regimens, authorizing prescription refills and assisting health care providers during examinations. Administrative duties include coding patients' medical information, scheduling of appointments, answering telephones and the monitoring of, as well as, the ordering of needed office equipment (2015).

The educational background of a medical assistant typically consists of graduation from a post-secondary education program which takes approximately one year and a certificate is obtained. Medical assistants may enter directly from high school and enroll in on the job training as well (U. S. Department of Labor Bureau of Labor Statistics, 2014b). Unlike the licensed practical nurse, certification is not mandatory for medical assistants, but is preferred by most employers and can be obtained through a variety of organizations,

such as American Association of Medical Assistants (American Association of Medical Assistants, 2015).

Lastly, in regards to cost, according to the U. S. Department of Labor Bureau of Labor Statistics (2014b), the median salary for a medical assistant is \$29,370.00 with a median hourly rate of \$14.21, which is more cost effective when compared to the cost of an Ohio based licensed practical nurse, whose median hourly rate is \$17.66 (Payscale.com, 2015b). Based on what the TFU service entails in this urgent care and what is required of the staff member, use of a medical assistant should suffice. In addition, health care providers are always in close proximity, so if there is ever a concern that the medical assistant is unable to or uncomfortable with addressing, the nurse, nurse practitioner or physician assistant and a physician are available for assistance.

When the role of the medical assistant is compared to the role of the medical secretary, it is evident that utilization of a full time medical assistant instead of a medical secretary is the more cost effective option. By replacing the full time medical secretary with a full time medical assistant, the medical assistant will not only be able to perform the administrative tasks that are currently being performed by the medical secretary in the studied urgent care, but they are equipped with the medical knowledge and background that is required to effectively conduct the TFU protocol. Performance of TFU could occur in between the performance of administrative tasks if the medical assistant were to replace the medical secretary. If this option is deemed insufficient for the needs of the urgent care by upper management, another option for a dedicated resource is a licensed practical nurse.

According to the American Academy of Urgent Care Medicine (2015), four percent of urgent care centers utilize licensed practical nurses. According to the Ohio Board of Nursing (2003), a licensed practical nurse is an individual who holds a valid license and

provides nursing care to individuals under the direction of a licensed health care provider such as a licensed physician or a registered nurse. Specifically, the definition of the scope of practical nursing for the licensed practical nurse regarding care provided consists of the “application of basic knowledge of the biological, physical, behavioral, social and nursing sciences” (Ohio Board of Nursing, 2011, p. 2).

The educational background consists of completion of approximately one year’s worth of nursing education, which is dependent on the type of nursing program and if attendance is full time or part time. This education is from an approved nursing education program, with courses focusing on nursing, biology and pharmacology, with licensing being acquired after successful passing of the National Council Licensure Examination; also known as the NCLEX-PN (NursingLicensure.org, 2013; U.S. Department of Labor Bureau of Labor Statistics, 2014a).

In the urgent care under study, if a licensed practical nurse were to be utilized, he/she would be able to provide nursing care which includes but is not limited to patient teaching when warranted via TFU. Similarly to the medical assistant, in this practice setting, other health care professionals such as the physician, nurse and nurse practitioner are in very close proximity, so if there is ever a concern that needs to be addressed, assistance and direction can easily be sought.

When taking cost-effectiveness into account, according to Payscale.com (2015b), the median hourly rate for a licensed practical nurse in the state of Ohio is \$17.66. This is slightly lower than what is reported by the U.S. Department of Labor Bureau of Labor Statistics (2014a) which reports a median hourly rate of \$19.97. When compared to the median hourly rate of a registered nurse which is \$25.11 (Payscale.com, 2015a), and what is required of the staff conducting the TFU, a licensed practical nurse should more than suffice

in the case that a medical assistant is deemed insufficient for the needs of the practice. It is not recommended that an additional registered nurse serve as the dedicated resource for TFU conduction, as it is not a cost-effective or labor-effective intervention.

Although options have been provided regarding the utilization of a dedicated resource, it has to be recognized that potential barriers exist. Despite the most cost and labor effective option being the replacement of the full time medical secretary with a full time medical assistant, there is a risk that the medical assistant may encounter a similar issue that is possibly currently with the registered nurses and radiographic technologists who currently conduct the TFU protocol. Specifically, the full time medical assistant may experience preoccupation with administrative tasks that leads to inadequate time to consistently conduct TFU at patients' preferred time. If upper management foresees this as a potential issue and/or the urgent care is unable to allocate funds for an additional full time employee who would require the provision of an annual salary as well as benefits to serve as the dedicated resource while keeping the medical secretary, the other option is to hire a medical assistant or licensed practical nurse on a part time basis. This would be a feasible alternative as the part time employee can be utilized specifically for TFU from 5:00 pm to 9:00 pm five days a week, which would be a total of twenty hours a week. This would likely be more convenient for patients who are full time workers, considering that it would lead to less interruption and distraction during their work day. In addition, patients will still have the opportunity select a convenient time within these hours for TFU. Not only would this be beneficial to patients, but it would also be beneficial for the urgent care from a financial standpoint as they would only have to allocate funds for the hourly rate of this part time employee without the provision of a benefits package, while still optimizing care delivered as well as meeting their patients' needs.

The fourth recommendation is for up to a maximum of three attempts be made in order to obtain direct patient contact for TFU. Currently, staff members make only one attempt to contact patients for TFU and this is based on the staff member's available time. A specific reason for the remaining twenty (67%) of the thirty participants not receiving a telephone call or voicemail for TFU conduction is unknown, but staff preoccupation with the provision of direct patient care is a high possibility. Further investigation in this area should be considered. In addition, similarly to the conduction of the present study, with use of dedicated resource to conduct TFU, this will permit time for up to three telephone call attempts to be made over the span of one hour. Specifically for the purpose of TFU conduction, a monitoring form could be utilized with intervals for calls occurring every ten to fifteen minutes for patients on the list. Utilization of this form would provide the calling staff member ten to fifteen minutes to conduct TFU for each patient prior to calling the next patient. See form in Appendix H.

The last recommendation pertains to the secondary objective. Based on the analysis, the only patient specific variable that was found to have a statistically significant association with high PS scores was ethnicity, specifically pertaining to patients feeling that they obtained better access to follow-up services with TFU when compared to face to face follow-up. Considering that this is an association with positive PS ratings, the only recommendation in regards to this is for the urgent care to continue conducting the TFU protocol in the manner that it is currently being done. For the other questionnaire statements, no recommendations were warranted as there were no statistically significant associations found. When considering clinical significance, knowing that majority of responders were highly satisfied with the TFU protocol regardless of their personal

characteristics and demographics, reassured the author that the service provided by the urgent care was meeting the needs of the patients served.

Overall, these recommendations are appropriate for the urgent care under study and may possibly be effective if applied in a similar health care setting. However, this would be strongly dependent on the PS rates with an established TFU service in another setting and suggested areas of improvements. Despite this possibility, the author does not support the application of the discussed recommendations in other settings, as the results of the present study which led to the formulation of the aforementioned improvement interventions were not intended to be generalizable and were tailored specifically to the studied practice. In addition, application of these recommendations in another setting would be grossly inappropriate without the evaluation of PS with an established TFU protocol occurring first. Without evaluation of PS being conducted prior to the implementation of the recommended interventions in another practice setting, the author would be unable to determine if these recommendations are even warranted.

Limitations

Utilization of convenience sampling and lack of a control group posed a limitation. According to Terry (2012), this type of non-random sampling has the greatest risk of bias of any sampling strategy. Secondly, due to this sampling method, generalizability of the study findings were limited. Despite this limitation, it must be noted that it was not the author's intent to generalize the study findings as they were specifically intended for the urgent care under study.

The use of patients' last name and the first initial of their first name as identifiers posed a limitation as a few of the responders and the total solicited participants did not

provide information pertaining to their yearly income. The participants from both these groups were seventy years of age or older. The decision to keep data confidential instead of anonymous was chosen as patients' names were necessary for an introduction when contact was made for questionnaire conduction.

The low response rate posed a limitation in this study. The response rate was 43%, which was lower than similar studies which utilized similar modes of delivery for the PS questionnaire. Previously conducted studies yielded response rates between 91% and 100% (Anderson, 2010; Kassman et al., 2012; Zheng et al., 2013). The presence of incorrect phone numbers, the urgent care staff being preoccupied with direct patient care and patients being called at times that were inconvenient for them likely played a major role in the occurrence of this low response rate.

The utilization of age and income ranges on the Personal Characteristic and Demographic form limited the author's ability to obtain a precise calculation of dispersion which was measured by the range. Use of these ranges also limited the type of testing used to evaluate the secondary objective.

Future Directions of the Project

This study was successful in evaluating PS with the TFU protocol in the studied urgent care. It demonstrated that by evaluating PS, not only can appropriate practice specific interventions be constructed and proposed with the ultimate goal of practice improvement and maintenance of optimum PS ratings, but patients' needs will be met and the overall efficacy of the urgent care can be improved.

Replication of this study in another urgent care or other healthcare setting is recommended, however, the structure of the questions on the Personal Characteristic and

Demographic form will need to be modified. Specifically, instead of utilizing age and income ranges, exact numerical data for both age and income should be solicited. By obtaining precise data, limitations pertaining to the type of tests that can be utilized to determine if there is an association between high PS ratings and patient specific variables will be eliminated.

Replication of this study should also include the utilization of patient anonymity instead of confidentiality. This will likely encourage participants to be more forthcoming and eliminate possible discomfort regarding the provision of their personal information. Specifically, assignment of serialized numbers for each participant may be utilized, however, it is imperative to make note that the author will need to explicitly identify who they are and the purpose of the call prior to identifying the participant by the assigned serialized number in order to minimize confusion. For instance, when study participants are contacted for questionnaire conduction, the introduction could state: "Hello, my name is _____ and I am calling from _____ in regards to the study named Telephone Follow-up. May I please speak to the individual who was assigned the number 'eight' for conduction of the PS questionnaire?"

In addition, it is recommended that this study be replicated in the same urgent care with the target population being pediatric patients and their parents. Considering that the urgent care does serve both a pediatric and adult population, obtaining feedback from parents regarding their satisfaction with the protocol would be beneficial to the practice as it would determine the status of satisfaction in the pediatric population. If this were to be successfully replicated, in order to eliminate any possible confusion, it would have to be confirmed that the parent or guardian who received the TFU service would be the same individual available to complete the questionnaire three days later.

Lastly for the future direction of this study, if the current author or any other researcher wishes to replicate this study, statement six should either be eliminated from the questionnaire or confirmation that all study participants have had prior experience with face to face follow-up should occur. In the present study, there were a few responders who selected a Likert scale rating of three for 'undecided' for this statement. The author is unable to ascertain why these responders chose this rating. This could be due to responders genuinely being indifferent and it could also be due to responders never experiencing face to face follow-up and having no basis for comparison. Due to the ambiguity, it is best to eliminate the statement completely as a small sample size may result if prior experience with face to face follow-up is part of the inclusion criteria.

Implications

The benefits of the evaluation of PS with the TFU cannot be stressed enough, as it primarily enabled the author to determine PS levels with the provided TFU service and to assess if there was a need for improvement. As a result, the author was able to formulate ideas and propose recommendations specific to the urgent care under study. These ideas and recommendations were patient centered with the goal of increasing PS with the service provided and meeting patients' needs. Through the provision of these patient centered recommendations, this will increase the likelihood that patients will comply with prescribed treatment regimens and engage in health promoting behaviors as they are highly satisfied, which will ultimately improve their health outcomes.

Overall, this study illustrated the importance of the evaluation of services provided in health care. Although the study findings are not generalizable and the recommendations made are not intended for application in other health care settings, it will encourage other health care providers and professionals to conduct initial as well as ongoing evaluation of

provided services. By evaluating PS with provided services, consistent maintenance of high PS levels and the implementation of warranted interventions can occur.

Summary and Conclusion

Patient perception and satisfaction with the care they receive is of high importance. Not only has it become a key indicator in the measurement of quality of care over the last few years, but maintenance of optimum levels of PS in any health care institution is associated with an increase in patient compliance with prescribed treatment regimens and health promoting behaviors. The service evaluated in this study was a TFU protocol in an urgent care that had been in effect for the past year. The response rate was lower than what was expected when compared to similar previously conducted studies, however, it was found that majority of the responders were highly satisfied with the protocol. Secondly, the study found that the only statistically significant association present was between high PS ratings and ethnicity and this was in regards to patients feeling that they obtained better access to follow-up services via TFU when compared to face to face follow-up.

Based on the study findings, recommendations were made that were specifically tailored to this practice. The key recommendations included the utilization of a dedicated resource for the conduction of TFU and to establish a time for the conduction of the TFU protocol that was individualized and personalized for each patient. Despite the author's lack of intent for generalizability of the study findings, there is a possibility that the recommendations may be applicable to other settings if evaluation of PS with an established TFU protocol were to yield similar findings.

In conclusion, evaluation of PS with the TFU protocol demonstrated that patients found the service to be a very desirable. As a result of the information obtained, practice

improvement interventions were constructed and proposed. It also has demonstrated the importance of not only evaluating TFU specifically, but also other provided health care services. Evaluation was imperative as lack of knowledge regarding PS with services creates barriers to the provision of care that meets the needs of the clientele served and the implementation of improvement ideas and strategies.

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APPENDIX A: Telemedicine Satisfaction Questionnaire (TSQ)

Participant _____

Date: _____

Likert Scale: 5- strongly agree, 4- agree, 3- undecided, 2- disagree, 1- strongly disagree

Likert Scale	5- strongly agree	4- agree	3- undecided	2- disagree	1- strongly disagree
1. I could easily talk to my health care provider during the telephone follow-up					
2. I could hear my health care provider clearly during the telephone follow-up					
3. My health care provider who called for the telephone follow-up was able to understand my healthcare condition					
4. I was comfortable communicating with my health care provider during the telephone follow-up					
5. Telephone follow-up saved me time because I did not have to travel					
6. I obtained better access to health care follow-up services by use of telephone follow-up when compared to face to face follow-up					
7. I did receive enough attention during my telephone follow-up session					
8. Telephone follow-up provided for my healthcare need					
9. I found telephone follow-up an acceptable way to receive follow-up care					
10. I will use telephone follow-up services again					
11. Overall, I am satisfied with the quality of services being provided by the telephone follow-up					

If you could make one comment regarding the improvement of the telephone follow-up protocol, what would it be?

APPENDIX B: Oral Script

Hello, my name is Audia Ellis and I am an Otterbein University Doctor of Nursing Practice student. As part of my studies, I am conducting a project to evaluate patient satisfaction with the current telephone follow-up protocol that is conducted with each patient seen in this urgent care three days after they are discharged.

If you decide to participate in this study, prior to leaving the urgent care today you will be given a consent form to sign, you will request a time that is most convenient for you to complete the questionnaire via telephone 4 days from today and then you will complete a demographic form which will ask you five simple questions about your ethnicity, age, gender, highest level of education and annual income. This entire process should not take any more than 15 minutes of your time. When you are contacted in 4 days, you will be asked 11 questions about your satisfaction with the telephone follow-up protocol that you received and this will not take any more than 7-10 minutes of your time. The information collected will be evaluated by the urgent care and will be used to evaluate and improve the quality of care that is delivered.

Your participation is entirely voluntary. Any personally identifiable information collected during the study will be kept strictly confidential. If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits.

Do you have any questions about the study?

Thank you for your participation. If you have any questions later on you may reach me by email at audia.ellis@otterbein.edu or by phone at _____

APPENDIX C: Informed Consent

The Department of Nursing at Otterbein University supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

We are interested in gathering information pertaining to patient satisfaction with the telephone follow-up protocol that is conducted three days after discharge from the urgent care. The total time required from the time of recruitment into the study to completion of the questionnaire which will be conducted via telephone 4 days after your urgent care visit is 25 minutes. The information gathered will be beneficial to the urgent care as it will be used to evaluate the telephone follow-up protocol and determine if changes are warranted.

Your participation is solicited although strictly voluntary. We assure you that your full name will not be associated in any way with the research findings.

If you would like additional information concerning this study before or after it is completed, please feel free to contact me by phone or mail.

Sincerely,

Mary McKelvey, PhD, RN
Principal Investigator
Science Building, room 439B
614-823-1433

Signature of subject agreeing to participate
With my signature I affirm that I am at least 18 years of age.

APPENDIX D: Personal Characteristic and Demographic Form

1. Are you male or female? (Circle one)

- Male
- Female

2. How old are you? (Circle one)

- 18- 20 years old
- 21-29 years old
- 30-39 years old
- 40-49 years old
- 50-59 years old

3. What is the highest level of education that you have completed? (Circle one)

- Less than a high school degree
- High school degree or GED
- Some college, but no degree
- Associate degree
- Bachelor degree
- Graduate degree

4. What is your yearly income? (Circle one)

- Less than \$20,000
- \$20,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000 or more

5. What is your ethnicity? (Circle one)

- White or Caucasian
- Black or African American
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- Multi- or bi-racial

APPENDIX F: Institutional Review Board Approval Letter

INSTITUTIONAL REVIEW BOARD
Review
RESEARCH INVOLVING HUMAN SUBJECTS _____
Review
OTTERBEIN UNIVERSITY _____
Review

X Original
Continuing
Five-Year
Amendmen
t

ACTION OF THE INSTITUTIONAL REVIEW BOARD With

regard to the employment of human subjects in the proposed research: HS# 14/15-11
McKelvey, Hummer & Ellis: An Evaluation of Patient Satisfaction with Telephone ...

THE INSTITUTIONAL REVIEW BOARD HAS TAKEN THE FOLLOWING
ACTION:

✓

Approved _____ Disapproved

Approved with Stipulations* _____ Waiver of Written

Consent Granted

Deferred

◆Stipulations stated by the IRB have been met by the investigator and, therefore, the protocol is APPROVED.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the principal investigator leave the college, signed consent forms are to be transferred to



Chairperson

the Institutional Review Board for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the IRB, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date: 30 August 2014 Signed:

OC HS Form AF

APPENDIX G: Responders' Comments and Suggestions for Improvement

1	It is convenient. Knowing the time that they were going to call would be nice.
2	Being able to pick a time for the call would be nice because when they called, I was getting ready to go into a work meeting.
3	It is very nice, but it would be better if I knew the time that they were going to call ahead of time.
4	It was great. It would have been nice to know what time the call was coming, as I typically don't pick up unidentified calls.
5	Is there any way that I can pick a time for them to call? That would make it easier.
6	It is very nice for them because I can ask questions when they call.
7	It is great. The nurse that called was very nice and listened to me.
8	Keep doing it the way that it is done as the nurse that called is very nice.
9	The person who called was very pleasant. Keep the staff that they have.
10	I have had other follow-up in the past that had to be face to face and this was better to do over the phone.
11	It was very nice. I was feeling better and it was nice to be checked on.
12	It was good. I like it.
13	It was definitely better than previous face to face experiences in the past as in some cases, I was feeling better and didn't need anything in the past and I still had to pay a co-pay to have follow-up.
14	It was nice to be checked on after being sick.
15	Just knowing when they were going to be calling would be great.
16	Keep it the way it is. Just let patients know what time they will be calling.
17	Everything was great. I really love that they check on people.
18	They really care and that is great. It would be much better if they told me when they were going to call.
19	It was nice. The only thing is that the time that they called was inconvenient as I had just got to work, so I had to call back. Knowing ahead of time when they were going to call would have been better.
20	They were nice and the staff was able to answer all the questions I had.
21	Would be better if they tell you what time they plan on calling or ask you which time is the best time to call.
21	I would prefer for them to call me at a time that I was off work, like in the early morning or evening after work.
22	Call was great. They just need to make sure that they called at a time that was more convenient or ask what time is best to call would make it better.
23	I would prefer for them to call me at a time that I was off work, like in the early morning or evening after work.
24	Call was great. They just need to make sure that they called at a time that was more convenient or ask what time is best to call would make it better.
25	It was nice to be checked on.
26	The person on the phone needs to talk louder.

APPENDIX H: Telephone Follow-up contact form

TFU call Time	Patient name	Patient phone number	Attempt #1	Attempt #2	Attempt #3
9:30am			X		
9:45am				X	
10:00am			X		
10:15am			X		
10:30am					X
10:45am			X		
11:00am			X		
11:15am			X		
11:30am				X	
11:45am				X	
12:00pm			X		
12:15am			X		
12:30am			X		