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Telehealth Etiquette Education: Preparing Practitioners for Successful Patient Encounters

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Dedication

I am dedicating this page to all who have supported me on this journey. First to God, thank you for giving me life and the opportunity to work in a field that I am compassionate about. To my husband for being my hero during this journey. Your support and love were what has kept me from drowning in my ambition. To my children, Jordan and Skylar, my stride to show you that you can accomplish anything that you put your mind to, is what keeps me focused in life. To my committee chair, Dr. Coke, I can never thank you enough for your time and support. To Dr. Rutledge and Dr. Canady, thank you graciously for accepting my invitation to be my committee member and for all your contributions. Thank you all for believing in me.

Acknowledgments

Table of Contents

Abstract

Background: During the COVID 19 pandemic, access to healthcare was impacted tremendously. The utilization of electronic information and communications in healthcare is known as telehealth. Telehealth is a technology to deliver care when patients and practitioners are not at the same site. Although telehealth has been suggested as a solution to the access to care concern, a major limitation was the lack of education on delivering successful telehealth visits. Quality of care can be negatively affected if proper etiquette is not utilized to ensure an effective telehealth visit.

Objective: This DNP project aimed to increase the practitioners' comfort and competence in telehealth etiquette, by delivering an educational intervention on telehealth etiquette and allowing the practitioners the opportunity to practice the skill.

Method: A total of 13 individuals (NPs and PAs) were recruited and agreed to participate. Pre-intervention, participants completed a self-rating on telehealth etiquette comfort and competence and completed a virtual simulated telehealth visit with a trained standardized patient. Following that, the participants were delivered a virtual educational intervention focused on telehealth etiquette. Post-intervention, the participants were able to complete another simulated telehealth patient visit and re-rate themselves on telehealth etiquette comfort and competence using a Likert Scale of 1 to 10, with 1 = not comfortable/competent and 10 = very comfortable/competent.

Findings: The average reported rating by each participant before the intervention was 7.46 (SD 2.18) for telehealth comfort and 7.23 (SD 1.92) for telehealth competence. Post-intervention, the average reported rating by each participant was 9.1 (SD .64) for telehealth comfort and 9.4 (SD .77) for telehealth etiquette competence. A dependent t-test showed a statistically significant increase in participants' self-rating in telehealth comfort (M 1.61, SD 1.89) t (12) = 3.1, p< .001.

There was also a statistically significant increase of competence in the participants' self-rating in telehealth etiquette (M 2.15, SD 1.77) t (12) = 4.4, p = .001.

Conclusion: Telehealth is here to stay and is a viable avenue to improve access to healthcare. Practitioners must be adequately trained in telehealth etiquette to maintain the quality of care delivered through telehealth. The DNP project was a success in that the finings indicated a statistically significant increase in the pre-and post-intervention ratings. The telehealth etiquette education significantly increased the ratings of the practitioners' comfort in delivering patient care through telehealth and their competence in telehealth etiquette. The results of this research may be used to make informed practice recommendations and replicated, or similar studies aimed at improving the practitioner-patient telehealth experience

Keywords: "telehealth, telemedicine, telemonitoring, telehealth etiquette, COVID-19, video conferencing"

Chapter 1: Introduction and Background

Telehealth is becoming an increasingly important method of providing patients with cost-effective, high-quality care from afar (Rutledge et al., 2017). Since the SARS-CoV-2 (COVID-19) introduction in the United States in 2019, telehealth has been critical in ensuring access to medical care and assisting in virus containment. Telemedicine (TM), a subset of telehealth, refers to the delivery of medical care remotely through a virtual clinic visit (Rutledge et al., 2017). According to the World Health Services Organization (2010), telemedicine is:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information, for diagnosis, treatment and prevention of disease and injuries, research, and evaluation, and for the continuing education of health care providers, all in the interest of advancing the health of individuals and their communities.

Since the COVID-19 pandemic, telemedicine has proven to be a promising method of healthcare delivery. Telemedicine consultations, for example, can assist in recognizing acute respiratory infections (URIs) and other seasonal illnesses without requiring patients to leave their house and risk infecting others or contracting another sickness (Chiron Health, 2019). In addition, more specialized services such as pediatric neurology and cardiology are available to underserved patients in both urban and rural locations, thanks to TM.

Telehealth technology increases the likelihood of overcoming healthcare problems by helping patients obtain services and lower expenses while improving favorable outcomes (Rutledge et al., 2017). Remote care through telemedicine is expanding and presents an excellent opportunity to impact healthcare delivery. However, appropriate etiquette through an electronic device screen, unique to telehealth experiences, is seldom discussed in industry training (Gustin

et al., 2020). The correct camera placement, the avoidance of workplace sounds, the lack of personal objects visible in the camera's field of view, plus the provider's attire selection are all examples of telehealth etiquette (Rutledge et al., 2017). Therefore, educating and training practitioners on proper etiquette for telehealth sustainability and successful patient encounters.

Need Assessment

A needs assessment of the organization, Piedmont Urgent Care by Wellstreet (PUCBW), revealed that practitioners were quickly launched into performing telemedicine without formal training due to the COVID-19 pandemic. The telehealth program launched in March 2020. Patients utilized devices such as their cell phones, tablets, and computers to perform their telehealth visits. The environment of the patients was noted to be in a public place while driving and sometimes in areas that did not have the proper lighting. Practitioners performed telemedicine outside urgent care clinics, in their homes, on laptops, and mobile devices. The beginning stages of the telehealth implementation included connection issues on the patient and practitioner end. A frequent complaint by patients seemed to focus on screen side etiquette. Patients complained that the visit was too brief, and the provider's manners lacked empathy. Some complaints were related to background noise, referring to hearing a dog barking, and others mentioned the provider not being a good listener. Other complaints said that the provider was rude, not allowing them to speak, talking over them, and not making eye contact during the visit. These complaints prove telehealth etiquette training is needed to improve the telehealth process and experience for patients. Twenty-five percent of visits now are currently being performed by Telehealth (August 2021). However, no formal telehealth education to ensure successful visits has typically been offered to the practitioners.

Problem Statement

Education is critical to ensure that practitioners are adequately trained to use good telehealth etiquette and effectively evaluate patients for a successful visit. This scholarly project aimed to determine the practitioners' telemedicine comfort and competence in telehealth etiquette. The goal was to increase the practitioners' telemedicine comfort and competence in telehealth etiquette by delivering an educational intervention and allowing the practitioners the opportunity to practice the skill. Training practitioners in telehealth etiquette should be emphasized to enhance patient outcomes and satisfaction with telehealth (Rutledge et al., 2020). Furthermore, practitioners need to have the proper telehealth skills and sound understanding of telehealth technology in preparation for meeting the emerging humanitarian needs (Rutledge et al., 2017).

Specific Aims:

1. To assess the practitioners' telemedicine comfort and competence of telehealth etiquette.

2. To determine the needed interventions to increase practitioner comfort and competence with telehealth etiquette.

Clinical Questions:

1. Prior to the intervention for the urgent care practitioners, where did they self-rate their telehealth comfort and competence in telehealth etiquette?

2. After the educative intervention on telehealth etiquette, was there a statistically significant improvement in the practitioners' self-rating of their telehealth comfort and competence in telehealth etiquette?

3. Prior to the intervention, what were the practitioners' actual telehealth etiquette scores as rated by the researcher based on the TIPS-TC tool and as rated by the trained standardized patient based on the G-PACER tool?

4. Post-intervention, what were the practitioners' actual telehealth etiquette competence ratings as rated by the researcher based on the TIPS-TC tool and the trained standardized patient based on the G-PACER tool?

5. Was the intervention successful in improving the practitioners' telehealth etiquette from pre-intervention to post-intervention based on the pre and post scores on the TIPS-TC and G-PACER?

6. After the educative intervention on telehealth etiquette, how did the practitioners feel they should have self-rated themselves pre-intervention based on the newly obtained knowledge?

7. What suggestions did participants have for further developing the training?

Telehealth Etiquette

Telehealth etiquette and an adequate physical exam are essential for successful telehealth patient visits. In addition, 12 critical behavior competencies have been identified on the Teaching Interpersonal Skills in Telehealth Checklist, which include: Orientation, Verbal Clarity, Active Listening, Patient-Focused, Tone of Voice, Eye Contact, Other Body Language, Empathy, Rapport, Respect, Therapeutic Alliance, and Environment (Rutledge et al., 2020).

- Orientation helps the patient understand what will happen during the visit.

- Verbal Clarity means the patient can easily understand what you are saying through the telehealth system. Therefore, it is essential to ask the patient if they can hear you well.

- Active Listening is the process of getting a clear understanding of what the patient is saying by allowing them to speak without interruption.

- Patient-Focused is using open-ended questions to allow the patient to control the pace of the visit to get a complete understanding of their problem.

- The Tone of Voice uses an appropriate vocal volume and speed when communicating with the patient.

- Eye Contact means looking at the camera during the telehealth visit to show you are being attentive.

- Other Body Language is maintaining an upright posture with arms uncrossed, limiting distracting movements such as frequent note-taking, and using engaging facial expressions such as smiling and nodding your head.

- Empathy means selecting the best words to show you accept and share the patient's feelings.

- Rapport encourages patients to express themselves and show interest in what they are saying.

- Respect is being non-judgmental when communicating with the patient during the telehealth visit.

- Therapeutic Alliance allows the patient to partner in the plan of care development.

- Environment means limiting background noises and other distractions to ensure patient privacy during their visit.

Conceptual Framework

The educational intervention that was applied in this study was a conceptual approach designed by Carolyn M. Rutledge, Ph.D., FNP-BC, Academic Directors: Center of Telehealth Innovation, Education, and Research (C-TIER) Professor & Associate Chair, School of Nursing. Dr. Carolyn Rutledge and other nursing professors throughout the US came together and developed a telehealth toolkit available at telehealth education-ctier.com (Appendix J). In addition, Carolyn Rutledge developed a telehealth competency framework (Appendix K), named the Four P's. The Competencies based on the Four P's (planning, preparing, providing, and performance evaluation) were developed using a modified Delphi technique (Rutledge et al., 2021). Learners will be able to undertake leadership positions in all aspects of telehealth deployment, execution, and development if education is provided with competencies corresponding to the Four P's Telehealth structure (Rutledge et al., 2021). These four areas of the framework were utilized to implement and deliver an educational simulation to improve the practitioners' knowledge on the 12 critical behaviors of telehealth etiquette.

The Four Ps

Planning

During the planning phase, the expected outcome for learners was to discuss the needs and requirements for delivering telehealth services. This step is essential to identify suitable patient populations/conditions for telehealth, reimbursement problems, technology, telehealth modalities, services/professions required, and benefits/barriers to efficient performance (Rutledge et al., 2021). This stage is important when implementing a telehealth program and being a part of an established program. Planning creates the overall picture and goals looking to be attained.

Preparing

Once the plan is created and approved, the next phase is preparing. All required components for telehealth delivery, including developing protocols, workflow, and training personnel, must occur during this phase. Introducing required equipment, policy creation, and implementation, consents, security, HIPAA compliance, telehealth etiquette, clinical evaluations, and technical skills are all covered throughout the planning process (Rutledge et al., 2021). It is important during this phase to ensure staff understands how to handle emergencies, the flow of visits, the roles, and responsibilities of each professional, and the skillset to conduct a telehealth visit. Therefore, the education intervention is implemented in this phase.

Providing

Providing/conducting telehealth services is part of the providing phase. There are three parts to this phase: 1. Beginning (getting ready for the visit), 2. Middle (performing the visit), and 3. End (wrapping up the visit including charting, referral, and follow-up). The goal of this phase is that learners will effectively perform telehealth visits/encounters (Rutledge et al., 2021). Setting the tone for the appointment, introductions to all parties involved, provider-patient consensus on the cause for the visit, telehealth visit expectations, reconfirmation of consent, and instructions on how to treat emergencies and technical problems are included in the first section. The next segment includes taking a history and doing a medical exam, which may or may not require the use of peripherals. The final piece includes diagnosis development and formulating a plan of care.

Performance Evaluation

Understanding the telehealth program's influence is part of the evaluation process. (Rutledge et al., 2021). In this final phase, learners can assess the telehealth delivery program by

reflecting on the assessments, experiences, and system analysis. In addition, outcome measures need to be considered and tracked to evaluate provider and patient experience and program effectiveness (Rutledge et al., 2021). Finally, evaluating services and improving in areas of need is the key to growing and sustaining.

<center>**Chapter 2: Review of Literature**</center>

Few studies on telemedicine etiquette have been conducted. Due to such limitations, the current literature review will address the increase in demand for telehealth and the value of telehealth training and education for practitioners. Research-based articles published in the English language from 2015 or later were searched in the CINAHL and MEDLINE databases. The following keywords were used: "nurse practitioner OR advanced practice nurse OR aprn OR np" AND "telehealth OR telemedicine OR telemonitoring OR telepractice OR telenursing OR telecare" AND "etiquette."

Telehealth Demand

In 2020, the transmission of the COVID-19 virus in humans had proclaimed a pandemic by The World Health Organization (WHO). Countless Americans perceived the virus as terrifying, and it changed many facets of their daily lives. Shelter in place orders and other restrictions on travel stopped patient care delivery by the providers as a solution was sought. The option to use telehealth for care to tackle the spread of public COVID, permitted by the Centers for Medicare & Medicaid Services (CMS), allowed beneficiaries to receive a greater selection of assistance from their providers and eliminated the necessity to present as an in-person visit (CMS, 2020). In response, video consultations, for example, were rapidly introduced to provide safe healthcare and reduce the risk of the virus spreading (Jimenez-Rodriguez et al., 2020). TM provided a new avenue for patients during this increasing need. As video consultations became more common, it was prudent for measures and processes throughout the health field to aid this mode of medical treatment, supporting its development and assuring its functionality, equality of opportunity, and effectiveness (Jimenez-Rodriguez et al., 2020). As a result, the demand and need for telehealth services have substantially increased and are expected to grow. According to

recent estimates, 30 percent of all healthcare visits will be provided through telemedicine after the pandemic, and up to 65 percent of healthcare customers expect to use telehealth after COVID-19 (Drees, 2020). Areas of focus to address this demand include expanding practitioner training, understanding telehealth regulations, and ensuring patient/provider satisfaction with TM for successful visits through proper telehealth etiquette.

Practitioner Training

Telehealth is in high demand, and fundamental training is essential in sustaining this healthcare modality. Secondary to the COVID-19 pandemic, telehealth expansion has taken place quickly without careful consideration of providers' preparation. The necessity for telehealth educational services is well acknowledged in the literature; however, only a few publications describe the information that should outline the practitioner instructional approach (Rutledge et al., 2017). A cross-sectional survey of 120 various members of the healthcare team at Puducherry's teaching hospitals in India, revealed 19 percent of respondents were extremely qualified or specialists in telemedicine, 25 percent were moderately skilled, which involves apprentices or beginners, and 56 percent were unskilled in conducting telemedicine and operating its related devices (Zayapragassarazan and Kumar 2016). The overall aim of this study was to determine the level of telemedicine understanding, expertise, perception, and competence among the members. These findings assist in highlighting the gap in practitioners' capability in the delivery and implementation of telehealth technology. Knowledge of telehealth deliverance is critically important for providers (Guise and Wiig, 2017).

The literature review regarding telemedicine has supported it as a viable model of healthcare deliverance. For telehealth encounters to be effective, the technology must perform correctly, and clinicians must be equipped to treat patients seen via TM (Nguyen et al., 2020).

For a successful deployment, sufficient training is required, and it must include confidence and trust to encourage the user to gain interest in learning how to utilize the technology (Guise & Wiig, 2017). Important changes in the dynamics of patients' health, such as the rise in individuals living with multiple chronic illnesses, are essential reasons why embracing telehealth is vital for providers. Telemedicine's capacity to enhance access to otherwise inaccessible treatment and connections is part of the solution to address such changes. As a result, nurse practitioners, who are often the primary caregivers in rural and disadvantaged populations, must have the knowledge, skills, and practices necessary to properly utilize telehealth technology (Rutledge et al., 2017). Training suggestions involve an emphasis on the technology's utility, the user's comfort, patient-centered management, and strong communication skills that establish a therapeutic connection given the apparent barrier of distance between the individual and provider (Guise & Wiig, 2017).

Regulations

Government legislation and rules regulating clinician operating, as well as healthcare payment requirements for telehealth, differ greatly and can obstruct the use of telehealth in certain practice contexts. Because of the rapid introduction of telemedicine during the pandemic, many practitioners are not knowledgeable of mandated telehealth regulations that existed before the pandemic. In part, this lack of knowledge can be attributed to many of the telehealth regulations being waived secondary to the COVID-19 pandemic to help expand access to care. The blanket of regulation waivers will expire once the public emergency is over (CMS, 2020). Each state has its own set of regulations for providing telehealth, and therefore, practitioners need to understand the laws that impact their setting of practice (Rutledge et al., 2017). Expectations post-pandemic will be compliance with regulations and laws once the waivers

expire. Therefore, practitioners need to be aware of and understand the telehealth regulations in place. Necessary telehealth regulations to consider are licensure, HIPPA (The Health Insurance Portability and Accountability Act of 1996), and reimbursement.

Licensure

One of the most critical obstacles to the widespread adoption of telehealth is licensure. Medical licensure is now governed by each state, necessitating the acquisition of separate state licenses for multi-state operations. Before COVID, nine states (Tennessee, Minnesota, Nevada, Oregon, Maine, Ohio, Texas, New Mexico, Louisiana) had legislation that allowed specific telehealth systems licenses to deliver care in different states they are not licensed in (Rutledge et al., 2017). While telehealth may help increase access to treatment, most providers are only allowed to practice in the state(s) where they are licensed (CCHP, 2021). Because of the COVID-19 public health emergency, several states have granted license exemptions to increase access to care (CCHP, 2021). The Public Readiness and Emergency Preparedness Act (PREP Act) published by the US Department of Health and Human Services (HHS) in 2020, enables healthcare professionals who are authorized to prescribe medications, deliver care via telehealth to patients in other states if they follow the legal requirements of the state in which they are licensed or allowed to practice (CCHP, 2021). The medical boards of each state monitor telehealth license exemptions. These exemptions are set to expire once the pandemic has resolved. For example, in Georgia, nurse practitioners or physician assistants doing telemedicine must have their delegating physician provide documentation to the medical board that they have shown competence to provide care by telemedicine and it is within their scope of practice (CCHP, 2021). Practitioners need to know the laws of practicing telemedicine in their state.

HIPAA

In addition to Protected Health Information (PHI) safety and confidentiality, practitioners that practice telehealth must ensure that both the originating and remote locations, the "room" or setting where the interaction takes place is safe, as well as the communication between the two locations is secure (Rutledge et al., 2017). Safe environments include an area where the patient does not feel threatened such as a local medical office. Therefore, this requires adequate HIPAA agreements with all technical workers and proper encryption of sensitive patient data (Rutledge et al., 2017). During the COVID-19 pandemic, health care practitioners are waived from HIPAA technology violations that use telehealth to interact with patients. However, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing specific regulations issued under HIPAA (HHS, 2020). During the COVID-19 nationwide crisis, according to the good faith stipulation of telehealth, the Office for Civil Rights (OCR) exercised its regulatory authority. It authorized that there would be no penalties against protected medical professionals for failure to comply with HIPAA rules and legal requirements (HHS, 2020). After the pandemic is over, many of the systems being used for telehealth, such as a mobile device facetime, may not be compliant with HIPAA rules leading to penalties on businesses. Fines of up to $50,000 per violation, as well as criminal and civil penalties, may be imposed for HIPAA breaches (Rutledge et al., 2017).

Reimbursement

As part of telehealth education, practitioners need to be made aware of how the expense of telehealth is governed. Federal and state legislations set regulations. States have the most significant influence on telehealth reimbursement and insurance coverage rules and regulations since they have the power to create legislation that allows or disallows coverage (Rutledge et al.,

2020). Reimbursement is a significant healthcare issue for many healthcare facilities. Almost every state Medicaid program reimburses for telehealth services somehow, with 48 states covering livestream, twelve states covering store-and-forward, nineteen states covering distance patient monitoring, and seven states covering all three areas (Rutledge et al., 2020).

On the other hand, Medicare considers three criteria for determining reimbursement: the patient's location, the practitioners' credentials at the patient's location, and the kind of telehealth service given (Rutledge et al., 2020). Before COVID-19, Medicare only allowed telemedicine visits if you lived in a rural area and the patient had to travel to a local healthcare facility to do the visit (Streifel and Sikka, 2020). In addition, the approved payout for telehealth services is dependent on the patient insurance coverage. Twenty-one states have passed legislation governing telehealth services by commercial insurers (Rutledge et al., 2020). Reimbursement for telehealth services may be a stumbling block; therefore, practitioners should know the regulations governing service coverage.

Patient Satisfaction

Patients and healthcare practitioners must be satisfied with TM taking the place of an onsite visit for its' use to grow (Nguyen et al., 2020). One of the advantages of TM is that it decreases the chance of exposure to pathogens on both sides, which is especially important in conditions when one or both participants are immunocompromised (such as cancer patients and patients taking immunosuppressive medications) during the Covid-19 pandemic. Among a review of adult patients who received care via telemedicine at a MinuteClinic, Polinski et al. (2016) found that 95 percent of 1734 subjects were highly pleased with the care they received, ranking telehealth as better than or equal to a traditional visit. Consistent with this, according to a recent report, of the 177 respondents to the satisfaction survey, TM was as successful as or better

than in-person evaluations with 97 percent of patients treated by an allergy provider for primary diagnoses of asthma, urticaria, chronic rhinitis, and sinusitis during COVID-19 (Mustafa et al., 2020). A successful and satisfying patient encounter is ensured by the practitioners being adequately prepared to deliver care using good telehealth etiquette.

Telehealth etiquette refers to the specific acts required for an effective telehealth encounter (Rutledge et al., 2017). Many human factors can influence patient satisfaction during a TM visit that is not as apparent during a traditional visit, such as body language, eye contact, posture, etc. With a TM experience, nonmedical behaviors play a major role in patient perception of a good visit. For example, instead of gazing at the client's face on the screen, make eye contact with them by staring at the camera (Rutledge et al., 2017). Eye contact was disrupted in one study when practitioners looked down at the EMR during TM visits (Nguyen et al., 2020). Disinterest or distraction may be seen as looking down or taking notes (Rutledge et al., 2017). Patients can sometimes not understand what the practitioner is looking at; therefore, the perceived quality of the visit can suffer. This perception implies that if four dimensions of the interaction are considered: verbal (tone), nonverbal (eye contact, body language, posture), emotional (empathy), and actions/transactional (attentiveness, listening), communication can be strengthened and improved relationships formed during a telemedicine experience (Nguyen et al., 2020). Practitioners must be taught to lean toward the camera and keep their eyes focused on the lens (Rutledge et al., 2020). Nodding is a nonverbal gesture to show the patient support and active Listening. Although practitioners cannot touch the patient during a telehealth visit, they can be taught the words that can display empathy (Nhuyen et al., 2020). The proper behaviors of telehealth etiquette ensure a compelling encounter.

Synthesis of Evidence

Before the coronavirus (COVID-19) pandemic, it was predicted that telehealthcare would rise at a 16.8% annual rate (Arizton, 2020). The role of human factors (communication, empathy, and telehealth etiquette) in telehealth research is a significant gap in the literature (Haney et al., 2015; Papanagno et al., 2015). Therefore, it is critical to educate healthcare providers regarding telemedicine use and potential challenges (Rutledge et al., 2017; Nguyen et al., 2020; Zayapragassarazan and Kumar, 2016; Jimenez-Rodriguez et al., 2020). Telemedicine provides significant convenience for the patient and the practitioner and increases healthcare opportunities. This scholarly project provided practitioners in an Urgent Care setting with telehealth etiquette education to feel comfortable and prepared to deliver care via telemedicine.

Conclusion

The literature search provided evidence of the demand for remote health care access (telehealth), the lack of telehealth etiquette training for practitioners, and that patient perception and satisfaction with telehealth encounters depend on the provider's performance of proper telehealth etiquette. This avenue of access to care can positively impact patient outcomes if delivered appropriately. Telehealth is not a new concept. It has grown this past year substantially, secondary to the COVID-19 pandemic. Telehealth is here to stay post-pandemic. Literature has supported that telehealth etiquette education for clinicians is needed. When practitioners are prepared and adequately trained to connect using proper telehealth etiquette, they have a significantly better chance of positive patient interaction (Rutledge et al., 2017).

<div align="center">**Chapter 3: Methodology**</div>

This project used a process improvement approach to see how a single session of educational instruction influences the practitioners' telehealth deliverance comfort and their telehealth etiquette competence. A scenario-based simulation that included a trained standardized patient was conducted before and after the educational intervention. Observation was completed by the researcher of each practitioner performing a telehealth visit with a standardized patient through Zoom. The pre-intervention assessment included the practitioners' self-rating of their comfort level delivering telehealth and their perceived competence level in telehealth etiquette. Once the educational intervention was completed, the practitioners were then be asked to re-rate themselves with the driving question of "now that you know what you know, where were you actually before, and where are you now?". The practitioners then perform their post-intervention telehealth encounters. Using the Telehealth Etiquette Checklist, the researcher and the standardized patient re-rated the practitioner on telehealth etiquette performance. Each practitioner, post-intervention, also re-rated their comfort level in delivering telehealth with proper etiquette. A satisfaction survey of the education intervention was offered to each participant after completion of the training. This translational project focused on improving the comfort and competence of delivering telehealth visits with proper etiquette to ensure successful patient encounters.

Project Design

This transitional project was considered an initiative aimed at process improvement. The Doctorate of Nursing Practice (DNP) projects utilize different methods to improve clinical practice, such as program and policy evaluation, quality improvement, and evidence-based guidelines (Moran, Burson, and Conrad, 2017). The education intervention was conducted from a 30-minute PowerPoint presentation, including videos, through the Zoom virtual platform. The

domain of the Four P's that was focused on during this educational intervention is the Preparing

phase.

Preparing

For this project, the preparing phase included public videos available on YouTube,

published by Old Dominion University, to demonstrate improper and proper telehealth etiquette.

In addition, there was PowerPoint content that covered the importance of telehealth etiquette, the

12 identified telehealth etiquette behaviors, and the appropriate way to achieve each behavior.

Each behavior has a subset of actions listed beneath it that the practitioner can be ranked on how

well they performed. During this phase, the patient scenarios were introduced to discuss how the

simulated telehealth visit would be conducted using a trained standardized patient. The outcome

goals for this phase are that the practitioners will have the knowledge and skills to deliver care

effectively through telehealth (Rutledge et al., 2021).

Setting

The project took place through Zoom, a virtual platform. Piedmont Urgent Care by

Wellstreet currently has 27 clinics in Georgia. Approximately 200 or more practitioners work at

different urgent care sites. Each clinic routinely has 1-2 practitioners working during a 12-hour

shift, and each is required to provide telemedicine services while also doing clinic visits when

feasible. When COVID-19 became prevalent (March 2020), PUCBW averaged 300-400 patients

per day through telemedicine. Currently, in June 2021, the average is 50-100 patients per day

being seen through telemedicine. Therefore, permission was granted to carry out this study by

the Regional Medical Director (Appendix L).

Population/Sample

The participants for this project were a convenience sample of physicians, nurse

practitioners, and physician assistants who currently work in the PUCBW centers. The

participants were emailed a survey requesting volunteer participation in the study. The

participants were notified that participation is not mandatory, and they can leave the study at any

time. The sample size was sought to include a minimum of 10 participants that would receive the

educational intervention. Inclusion criteria was Physicians and advanced practice providers

(APPs) working in the PUCBW walk-in clinics. Exclusion criteria included physicians and APPs

who do not work in the PUCBW walk-in clinics. Licensed practical nurses, medical assistants,

and registered nurses were also excluded from the study since they do not perform patient

evaluations. No compensation was given for participation. Once the sample was recruited, they

were educated on their human rights regarding the study, and consents were signed prior to

participation.

Tools and/or Instrument

> **Demographics**

> Three measurement tools were utilized for this translational project. The first tool was to

measure the participants' demographics (Appendix D). The Qualtrics survey was structured to

collect consent from practitioners, after which demographic information was obtained. The

demographic section was a self-made tool by the primary investigator. For confidentiality,

subjects only acknowledged their assigned participant number, credentials/profession, the

number of years they have practiced as a physician or an APP, if they have received any formal

telehealth education or training, and the number of years they had practiced telehealth.

> **Teaching Interpersonal Skills in Telehealth checklist**

> The second tool that was used was the Teaching Interpersonal Skills in Telehealth

checklist (TIPS-TC) (Appendix A). This tool was developed by Beverly Henry and Colleagues

(Henry et al. 2021). This tool consists of 12 critical behaviors of telehealth competencies. The

publisher has granted utilization of the instrument, provided credit is given to the authors

(Appendix M). A study was conducted by Beverly et al. 20121 in which the validity and

reliability were evaluated utilizing a multi-stage iterative process of the TIPS-TC. The

researchers used response patterns of SME (Subject Matter Experts) to confirm content validity.

Internal consistency of SME ratings was reliable with the Cronbach's Alpha value of .818, 172

total items, (Henry et al., 2021). Interrater intraclass correlation coefficient (ICC) and test-retest

reliability ICC were also substantial, both $p<.001$, (Henry et al. 2021). The TIPS-TC is a proven

data tool for measuring interpersonal skills in telehealth, which may be used to measure clinician

competency and personalize learning activities. The ratings on the tool range from 1-5, with 1

being very poor performance, 2 being poor performance, 3 being fair performance, 4 being good

performance, and 5 being very good performance. Overall total scores could range from 12 to 60.

Georgetown PAtient-CEnteredness Rating Scale (G-PACER)

The third tool was a standardized patient (SP) checklist that assessed the interaction

between the SP and the practitioner. A successful telehealth visit must be patient focused.

Therefore, effective communication is an important interpersonal skill that needs to be mastered.

Studies have linked better health outcomes when the interaction between the patient and

practitioner is patient centered (Tailsman et al., 2018). The long version, the original G-PACER,

had 23 Likert questions. Concurrent validity of the long version revealed that the total G-PACER

score was significantly correlated with the RIAS Patient-Centeredness score ($r=.58$, $p<.001$)

(Tailsman et al., 2018). Therefore, a shortened 12-item version (Appendix H) was established

during a study completed by Tailsman et al., 2018. This shortened version, which was used, had

a high internal consistency of .954 compared to the full scale of .950 (Tailsman et al., 2018). In

addition, the authors did a Guttman Split-Half Coefficient for reliability, and it yielded a .913

(Tailsman et al., 2018). The shortened version of the G-PACER shows to be a reliable and valid tool for assessing healthcare provider-patient interactions from the perspective of the SP. This tool is scored on a 5-point Likert scale with 1=not done, 2= poor, 3= acceptable, 4= very good, and 5=Outstanding. Overall total scores could range from 12 to 60.

Project Plans

The primary investigator met with the recruited physicians and APPs in Fall 2021 to begin the educational intervention on telehealth etiquette. The participants were able to ask questions at any time during the training session and after. The participants performed a simulated telehealth visit with the standardized patient before the intervention. After the intervention, the participants performed their post-intervention simulation telehealth visit. The researcher observed both encounters. No recording was done. The participants were able to complete the satisfaction survey afterwards through a Qualtrics developed survey. The satisfaction survey (Appendix I) allowed the participants to comment on what worked, what didn't work, and recommendations to improve the educational program.

Date Analysis

Data analysis was completed using Statistical Package for the Social Sciences (SPSS). In addition, the demographics of the research sample was analyzed using descriptive statistics.

Clinical Question 1

Prior to the intervention for the urgent care practitioners, where did they self-rate their telehealth comfort and competence in telehealth etiquette? The collection of data to answer this question was obtained from the use of two Likert scales (Appendix B). The first scale for telemedicine comfort rating includes: 1 = very uncomfortable and 10 = very comfortable. The second scale (Appendix C) for telehealth etiquette competence, when delivering patient care via telehealth, the rating includes 10 = High level of competence and 1 = No level of competence.

Both surveys were completed prior to the telehealth etiquette educational intervention. Descriptive statistics was used to describe these findings.

Clinical Question 2

After the educative intervention on telehealth etiquette, was there a statistically significant improvement in the practitioners' self-rating of their telehealth comfort and competence in telehealth etiquette? Descriptive statistics was used to analyze the practitioners' self-rating on telemedicine comfort and telehealth etiquette competence after the educational intervention. In addition, a dependent t-test was completed to show if there was a statistically significant increase in the participants' self-rating in telehealth comfort and competence in telehealth etiquette.

Clinical Question 3

Prior to the intervention, what were the practitioners' actual telehealth etiquette scores as rated by the researcher based on the TIPS-TC tool and as rated by the trained standardized patient based on the G-PACER tool? After the pre-intervention telehealth simulation visit was completed, the standardized patient rated his experience utilizing the Georgetown PAtient-CEnteredness Rating Scale (G-PACER) standardized patient (SP). The researcher rated the practitioner's actual telehealth etiquette competence using the Telehealth Etiquette Checklist. Descriptive statistics was used to describe these findings.

Clinical Question 4

Post-intervention, what were the practitioners' actual telehealth etiquette competence ratings as rated by the researcher based on the TIPS-TC tool and the trained standardized patient based on the G-PACER tool? The practitioners completed another observed, simulated telehealth visit with the standardized patient. This time they were able to apply what they had learned

during this new visit. After the post-intervention telehealth simulation visit was completed, the standardized patient re-rated their experience utilizing the (G-PACER) standardized patient checklist. Using the Telehealth Etiquette Checklist, the researcher re-rated the practitioner's actual telehealth etiquette competence. Descriptive statistics was used to describe these findings.

Clinical Question 5

Was the intervention successful in improving the practitioners' telehealth etiquette from pre-intervention to post-intervention based on the pre and post scores on the TIPS-TC and G-PACER? Total scores, pre-, and post, from the Telehealth Etiquette Checklist and the 12-item G-PACER was compared. A paired sample, T-test, was used to describe these findings.

Clinical Question 6

After the educative intervention on telehealth etiquette, how did the practitioners feel they should have self-rated themselves pre-intervention based on the newly obtained knowledge? After the education content was delivered to the practitioners, they were asked to re-rate themselves based on the newly acquired knowledge. Each practitioner was asked, "Although you rated yourself previously at the chosen rating, what was your actual rating when you now apply what you have learned to your choice?". Descriptive statistics was used to describe these findings.

Clinical Question 7

What suggestions did participants have for further developing the training? The satisfaction survey was an open-ended questionnaire to allow comments that can help improve the telehealth etiquette training. Compilation of the participants' responses into a table was completed.

Institutional Review Board/ Ethical Issues

This project was submitted to Georgia College and State University Institutional Review Board (IRB) for permission. This translational project had no foreseen physical or psychological harm that could result from the project. Participants were allowed to enter the study voluntarily and were able to decline further participation at any time. Participation was confidential. Prior to the start of the study, informed consent was obtained (Appendix E).

Conclusion

Telehealth has been proven to be helpful in terms of increasing access to care. During the present COVID-19 epidemic, telehealth has proved to be a critical mode of patient care delivery. The primary objective of this scholarly project was to improve the patient encounter process and improve the practitioner's telehealth etiquette competence to produce successful telehealth visits. The data was collected and analyzed. The data was utilized to see whether the practitioners' comfort level with telemedicine and telehealth etiquette had changed. These results were also used to identify whether there was a difference in pre-and post-intervention instrument total scoring. Overall, this data was used to evaluate if the scholarly project's aim was achieved.

Chapter IV

Results

The results of this telehealth quality improvement project are reported here. Findings include descriptive information concerning the participants and their telehealth etiquette abilities as rated by the researcher and a formally trained standardized patient. These ratings were done before and after an intervention to increase the provider's knowledge of telehealth etiquette.

Initial data screening was performed prior to conducting the statistical analysis. Data were initially collected using Qualtrics and exported to SPSS version 27. No discrepancies occurred during the transfer of the data into SPSS. Therefore, the study's instrument had no missing data. Table 1 shows the variables, the instruments used to measure the variables, and the generated measurements.

Table 1

Variable, Instrument, and Generated Measurements

Variable	Instrument	Generated Measurement
Telehealth Etiquette	Teaching Interpersonal Skills in Telehealth Checklist (TIPS-TC)	This instrument used interval/ratio levels of measurements for 12 questions rated by the researcher as 1 (Very poor performance) – 5 (Very good performance) for a total score of 12-60.
Telehealth Comfort	Researcher Developed Visual Analog	This instrument used interval/ratio levels of measurements rated by the participant as 1 (Not comfortable) – 10 (Very comfortable).
Telehealth Competence	Researcher Developed Visual Analog	This instrument used interval/ratio levels of measurements rated by the participant as 1 (Not competent) – 10 (Very competent).

Provider-Patient Interaction	Georgetown PAtient-CEnteredness Rating Scale (G-PACER)	This instrument used interval/ratio levels of measurements for 12 questions rated by the standardized patient as 1 (Not done) – 5 (Outstanding) for a total score of 12-60.

After reviewing all interval and ratio level data for central tendencies, it was found that

the Georgetown Patient Centeredness Rating Scale (G-PACER) and Teaching Interpersonal

Skills on Telehealth Checklist (TIPS-TC) were both normally distributed. The Fisher's Exact

score for the skewness of the G-PACER pre-intervention was 0.15 with kurtosis of 0.65, and the

G-PACER post-intervention skewness was 0.52 with kurtosis of 0.66 (Munro, 2012). The

Fisher's Exact score for the skewness of the TIPS-TC pre-intervention was 0.52 with kurtosis of

0.17, and the TIPS-TC post-intervention skewness was 1.34 with kurtosis of 0.48 (Munro, 2012).

There were no outliers identified. All data were normally distributed and met the assumptions of

all the parametric statistical analyses used to answer the clinical research questions.

Description of Study Sample

A total of 13 participants volunteered for the research study. Of these participants, 12

were female (92%), and one was male (8%). In addition, there were 11 Advanced Practice

Nurses (83%) and two Physician Assistants (17%). None of the participants had previous formal

telehealth training (certification) but 6 of the 13 participants reported they had attended a brief

20-minute telehealth etiquette training prior to the beginning of the study provided by Wellstreet.

Years of experience as a medical provider ranged from 3-28 years, and telehealth experience

ranged from 0-2 years.

Description of the Instruments

This section describes the study instruments, reliability in this sample, the mean scores and standard deviations, the percentage of the study participants above the normal ranges (Table 2). Instruments used as continuous variables were normally distributed.

Table 2

Descriptive of Research Instruments

Variable	M (SD)	Observed Range	Possible Range	Outcome	α
TIPS-TC PreTotal	32.0 (4.5)	24 - 40	12 - 60	Higher scores indicated better telehealth etiquette.	.80
TIPS-TC PostTotal	52.5 (4.3)	43 - 58	12 - 60	Higher scores indicated better telehealth etiquette.	.84
G-PACER-PreTotal	26.7 (6.3)	16 - 38	12 - 60	Higher scores indicated better patient-provider interaction.	.88
G-PACER-PostTotal	43.1 (5.4)	34 - 52	12 - 60	Higher scores indicated better patient-provider interaction.	.82

Georgetown Patient Centeredness Rating Scale. The interaction between the standardized patient (SP) and the practitioner was measured using the G-PACER, a 12-item visual analog with scores for each item from 1-5 (Tailsman et al., 2018). The sum value of these responses was calculated for the total score that ranged from 12-60. The SP was asked to rate each item based on their perspective on practitioner-patient interaction using five responses, ranging from 1 being not done and 5 being outstanding. Pre-intervention Cronbach's alpha for the sample was acceptable at .88 and post-intervention at .88 (Tabachnick and Fidell, 2013).

Teaching Interpersonal Skills on Telehealth Checklist. Telehealth Etiquette was measured using the TIPS-TC. The TIPS-TC consists of 12 critical behaviors of telehealth competencies. This scale was a 12-item visual analog with each item scores from 1-5 (Tailsman et al., 2018). The sum value of these responses was calculated for the total score that ranged from 12-60. The 12 competencies consisted of verbal Clarity, active Listening, patient-focused, tone of voice, eye contact, other body languages, empathy, rapport, respect, therapeutic alliance, and environment. The researcher was asked to rate each item on how well each item was performed using five response choices, ranging from 1 being very poor performance and 5 being very good performance. Pre-intervention Cronbach's alpha for the sample was acceptable at .82 and post-intervention at .84 (Tabachnick and Fidell, 2013).

Telehealth Comfort Scale. Pre and post-intervention telehealth comfort was measured using the researcher's scale developed in Qualtrics. This is a one-item visual analog with a possible rating of 1-10, with 1 being very uncomfortable and 10 being very comfortable.

Telehealth Etiquette Competency Scale. Pre and post-intervention telehealth etiquette competency was measured using the researcher's scale developed in Qualtrics. This was a one-item visual analog with a possible rating of 1-10, with 1 not competent and 10 very competent.

Analysis of the Research Questions

Clinical Question 1 Results: Before the intervention of the urgent care practitioners, where do they self-rate their telehealth comfort and competence in telehealth etiquette?

Descriptive statistics were used to analyze the practitioners' self-rating on telemedicine comfort and telehealth etiquette competence prior to the educational intervention. The average reported rating by each participant prior to the intervention was 7.46 (*SD* 2.18) for telehealth comfort and 7.23 (*SD* 1.92) for telehealth competence. Table 3 reports the findings.

Table 3

Descriptive of Practitioners' Self-Rating Pre-Intervention

Variable	N	M (SD)	Minimum	Maximum	Possible Rating
Pre-Comfort	13	7.46 (2.18)	3	10	1-10
Pre-Competence	13	7.23 (1.92)	3	10	1-10

Clinical Question 2 Results: **After the educative intervention on telehealth etiquette, was there a statistically significant improvement in the practitioners' self-rating of their telehealth comfort and competence in telehealth etiquette?**

Descriptive statistics were used to analyze the practitioners' self-rating on telemedicine comfort and telehealth etiquette competence after the educational intervention. The average reported rating by each participant, post-intervention, was 9.1 (*SD* .64) for telehealth comfort and 9.4 (*SD* .77) for telehealth etiquette competence (Table 4).

Table 4

Descriptive of Practitioners' Self-Rating Post-Intervention

Variable	N	M (SD)	Minimum	Maximum	Possible Rating
Post-Comfort	13	9.1 (.64)	8	10	1-10
Post-Competence	13	9.4 (.77)	8	10	1-10

A dependent t-test showed a statistically significant increase in participants' self-rating in telehealth comfort (M 1.61, *SD* 1.89) t (12) = 3.1, p< .001. There was also a statistically significant increase of competence in the participants' self-rating in telehealth etiquette (M 2.15, *SD* 1.77) t (12) = 4.4, p = .001.

Clinical Question 3 Results: Prior to the intervention, what were the practitioners' actual telehealth etiquette scores as rated by the researcher based on the TIPS-TC tool and as rated by the trained standardized patient based on the G-PACER tool?

Descriptive statistics were used to analyze the practitioners' actual telehealth etiquette competence rated by the trained standardized patient (using the G-PACER tool) and the researcher (using the TIPS-TC tool) before the educational intervention. The average reported rating for telehealth etiquette competence was 32 (*SD* 4.45) by the researcher and 26.69 (*SD* 6.34) by the standardized patient. Table 5 reports the findings.

Table 5

Descriptive of Practitioners' Actual Total Rating for Telehealth Etiquette Pre-Intervention

Variable	N	M (SD)	Minimum	Maximum	Possible Range
TIPSTC-PreTotal	13	32 (4.45)	24	40	12-60
G-PACER-PreTotal	13	26.69 (6.34)	16	38	12-60

Clinical Question 4 Results: Post-intervention, what were the practitioners' actual telehealth etiquette competence ratings as rated by the researcher based on the TIPS-TC tool and the trained standardized patient based on the G-PACER tool?

Descriptive statistics were used to analyze the practitioners' actual telehealth etiquette competence as rated by the trained standardized patient (using the G-PACER tool) and the researcher (using the TIPS-TC tool) after the educational intervention. The average reported rating post-intervention by the researcher for telehealth etiquette competence was 52.46 (*SD* 4.29) and 43.08 (*SD* 5.36) by the standardized patient. Table 6 reports the findings.

Table 6

Descriptive of Practitioners' Actual Total Rating for Telehealth Etiquette Competence Post-Intervention

Variable	N	M (SD)	Minimum	Maximum	Possible Range
TIPSTC-PostTotal	13	52.46 (4.29)	43	58	12-60
GPACER-PostTotal	13	43.08 (5.36)	34	52	12-60

Clinical Question 5 Results: Was the intervention successful in improving the practitioners' telehealth etiquette from pre-intervention to post-intervention based on the pre and post scores on the TIPS-TC and G-PACER?

A dependent samples t-test was conducted to test the hypothesis that the educational intervention will significantly increase the practitioner's telehealth etiquette. This hypothesis was supported. The findings showed a statistically significant increase in the participants' telehealth etiquette from pre-intervention (M 32, *SD* 4.45) to post-intervention (M 52.56, *SD* 4.29) t (12)=

15.69, p = <.001 using the TIPS-TC tool. There was also a statistically significant increase in the participants' telehealth etiquette pre-intervention (M 26.69, *SD* 6.34) to post-intervention (M 43.08, *SD* 5.36) t (12)= 12.25, p= <.001 using the G-PACER tool. These findings indicate an improvement in the practitioners' telehealth etiquette after the educational intervention.

Clinical Question 6 Results: After the educative intervention on telehealth etiquette, how did the practitioners feel they should have self-rated themselves pre-intervention based on the newly obtained knowledge?

Each practitioner was asked, "Although you rated yourself previously at the chosen rating, what was your actual rating when you now apply what you have learned to your choice?" Descriptive statistics were used to analyze the practitioners' pre-intervention self-rating (M 7.23, *SD* 1.92) and their perceived actual rating (M 6.38, *SD* 2.1) post-intervention. A dependent sample t-test was used to examine if the participants chose a significantly lower actual rating. The results were not statistically significant (M .846, *SD* 2.34) t (12) = 1.304, p = .217). Due to "pre" being asked in retrospect, a Pearson Correlation analysis was also done. Data indicated that there was no significant correlation (r = .33, p = .28). After the newly obtained knowledge, participants did not rate their perceived actual rating significantly lower. This finding indicates that the participants' telehealth comfort and telehealth etiquette competence pre-intervention was not affected by the educational intervention.

Clinical Question 7 Results: What suggestions did participants have for further developing the training?

Of the 13 participants, 10 provided feedback on their experience and recommendations to help improve the telehealth etiquette training. Feedback was positive and indicated that the practitioners enjoyed the training. Recommendations for training improvement included

providing additional scenarios and evaluating a more difficult patient. The participants' responses

were compiled into a table (Table 7).

Table 7

Feedback

Additional scenarios. Difficult patient i.e. a patient in distress or a patient who doesn't engage.

Everyone should complete it, so we have all providers on the same page.

Having different patient scenarios would be great. This training was very helpful. Personally, will recommend that every medical provider receive such training opportunity.

I think the training is excellent it wasn't too cumbersome or drawn out. I especially enjoyed the use of a live person for education.

It was great, thank you! PowerPoint instructions for the video would be awesome. I appreciate the time you took with me today!

More physical exam scenarios.

No recommendation. This is training that is needed before engaging patients with telehealth.

None, it was awesome.

Repeat practicing of telegraphy visit. Interviewing a difficult patient.

This training was amazing! I would recommend mandating all telehealth providers have this training. I will now change the way I do telehealth visits.

Summary

This chapter presented the results of my DNP clinical project. 13 participants were recruited to participate from convenience sampling requested through an email for voluntary participation. At the end of the project implementation, 7 clinical questions were analyzed. Descriptive statistics were utilized to assess the tendencies of pre-and post-intervention ratings by the participant, researcher, and standardized patient. Correlational analysis was conducted to determine if the practitioners' perception of their actual pre-intervention rating was significantly lower after receiving the telehealth etiquette education. Although there was no significant correlation between the practitioners' self-rating pre-intervention and actual rating, findings indicated a statistically significant increase in the pre-and post-intervention ratings. The telehealth etiquette education significantly increased the ratings of the practitioners' comfort in delivering patient care through telehealth and their competence in telehealth etiquette.

Chapter V

Discussion

This DNP translational research project aimed to increase the practitioners' telemedicine comfort and competence in telehealth etiquette by delivering an educational intervention on telehealth etiquette. The research study's main objective was to assess the practitioners' telemedicine comfort and competence of telehealth etiquette and determine the needed interventions to increase practitioners' comfort and competence with telehealth etiquette. This chapter will address the current study findings as it relates to the literature, limits, strengths, and future implications.

Relationship of Findings to Literature

Clinical question one and three provided the data needed to meet the aim of assessing the practitioners' telemedicine comfort and competence of telehealth etiquette. Both questions sought to find how the practitioners perceived their comfort and competence ratings in telehealth etiquette. The average reported rating by each participant prior to the intervention was 7.46 (*SD* 2.18) for telehealth comfort and 7.23 (*SD* 1.92) for telehealth competence. This rating was based off a scale of 10 = High level of competence/very comfort and 1 = No level of competence/very uncomfortable. Each practitioner felt like they had room to grow in their perceived comfort and competence in telehealth etiquette. In a study by Albarrak et al., 2021, a total of 391 physicians were assessed in their knowledge of telemedicine and it was found that most medical professionals still have low knowledge of telemedicine technology. It was also found in this study conducted in Saudi Arabia, that nearly, 77% of the professionals believed that continuous training is necessary for the use of telemedicine (P = 0.01) (Albarrak et al., 2021). The current

study helps to contribute to the literature to show that an educational intervention is needed to increase knowledge about telehealth etiquette.

The next aim of determining the needed interventions to increase practitioner comfort and competence with telehealth etiquette was supported with clinical questions two thru seven. Post-intervention, the average reported rating by each participant was 9.1 (SD .64) for telehealth comfort and 9.4 (SD .77). These findings showed an increase from the reported ratings prior to the intervention. This increase in scores provides support that an educational intervention on telehealth etiquette was needed to increase the practitioner's perception of their telehealth etiquette comfort and competence. The impact of the practitioner's newfound knowledge was reflected in their re-evaluation of their simulated telehealth visit by the researcher and standardized patient. Findings showed significant changes in the reported ratings from the researcher and SP as discussed in the previous chapter. In a study by Esper et al. 2020, Emory Healthcare provided clinicians with telehealth training and certification. In this study, 2374 providers ranging from including physicians, residents, and APRNs provided over 53,000 telehealth patient visits; patients were just as satisfied with a telehealth visit as they were with an in-person visit (Esper et al. 2020). Practitioners with sufficient telehealth etiquette training are prepared to deliver excellent telehealth patient care.

<div align="center">**Strength and Limitations**</div>

The project's most notable strength was that it highlighted the need for education in bridging a particular knowledge and competence gap in telehealth etiquette among practitioners. It is envisioned that the practitioners' increased knowledge and competence with telemedicine will result in successful patient encounters. Another finding from this research demonstrates how a brief educational training may have a significant impact. This intervention can be accomplished

during a lunch break or a quick morning huddle. Finally, another of the project's greatest

strengths was the considerable time investment of the 13 participants. The project would not

have been feasible without them. However, the project also had a few limitations. The sample

size was the most constraining factor. A limited sample size might make evaluating a

participant's strength more challenging (Hackshaw, 2008).

On the other hand, a small sample size might make research quicker to finish in a

shorter period, which can be advantageous in some instances (Hackshaw, 2008). In addition, the

13-person study sample can sometimes not accurately reflect the organization's overall

workforce. The practitioners recruited for this study were drawn from a convenience sample of

the telemedicine team rather than the entire organization. There were also no physicians who

volunteered to participate. Therefore, the findings may not apply to other practitioners, such as

physicians. The educational intervention was originally intended to be conducted in a group

setting, but because of the obstacles of the COVID-19 pandemic, it was shifted to an online

setting. As a result, people unfamiliar with a virtual learning intervention may have declined to

participate in this study. Furthermore, the two-week time constraint for collecting data could

have been problematic for prospective participants, and they may have opted not to partake in the

study consequently. This research should be replicated with larger sample size and a longer data

collecting duration to support the findings.

Future Research Implications

According to the results, the educational intervention strengthened the practitioners'

comfort and competence in telehealth etiquette of those who took part in this research. These

findings corroborate the available research, which emphasizes the importance of telehealth

etiquette training and enhancing patient experiences. There is a need for providers to be trained

and be competent in their skills using telehealth (White and Walley, 2022). The goal is that the practitioners' newfound comfort and expertise in telehealth etiquette ultimately reflect into practice, resulting in improved patient experiences and favorable patient outcomes for the organization. Furthermore, since telehealth education is not included in most curricula, the findings of this project reveal the importance of telehealth etiquette education for all practitioners. As a result, continual telemedicine education is vital, and it should be tailored for all tiers and styles of telemedicine practitioners (Lamb & Shea, 2019). Patients are comfortable with phone and email conversations, but the new telehealth patient-provider engagement platform necessitates a distinct skill set. Telehealth etiquette ensures that healthcare providers alter their ethical behavior and communication to accommodate telehealth sessions (Lamb & Shea, 2019). The results of this research may be used to make informed practice recommendations and replicated, or similar studies aimed at improving the practitioner-patient telehealth experience. The findings support that training on telehealth etiquette can effectively increase the comfort and competence of practitioners for successful telehealth patient encounters. This project analysis provides meaningful data along with suggestions for future research.

Conclusion

Telehealth's impact is limitless as patients can seek specialist care without having to travel long distances, healthcare access is improved, practitioners can visit their patients in their very own homes, and exchange of data is available instantly (Seto et al., 2019). According to Rutledge et al., 2021, even in the middle of isolation and quarantine orders, quality of care is strengthened, patient outcomes are practically met, and continuity of treatment is preserved. The influence of telehealth on the healthcare community has been demonstrated through evidence-based research. Our healthcare system will continue to need telehealth services, and technology

capabilities will continue to improve. The need for competent telehealth providers will keep rising. Convenience and comfort of care are essential but the dedication to quality should always take precedence. The cornerstone for effective and successful patient encounters is telehealth etiquette. Practitioners must be adequately trained in telehealth etiquette to maintain the quality of care delivered through telehealth.

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Appendix A: Teaching Interpersonal Skills in Telehealth checklist

Teaching Interpersonal Skills in Telehealth checklist

Group #:_____

Patient Case:_____

As you view each version of a video consultation, please critique how well the clinicians demonstrate interpersonal skills using this checklist of 12 Critical Behaviors. For each critical behavior, three to five competencies that support the behavior are listed. Indicate the rating from 1 to 5 that you think applies best about the performance of each Critical Behavior using the following response scale:
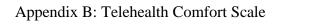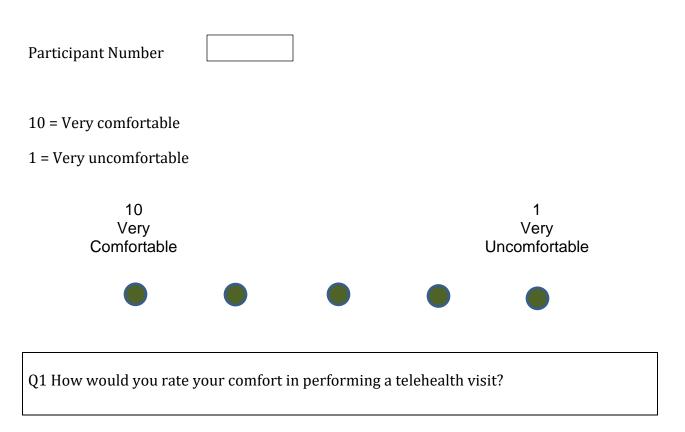**1 = very poor performance; 2 = poor performance; 3 = fair performance; 4 = good performance;**
5 = very good performance.

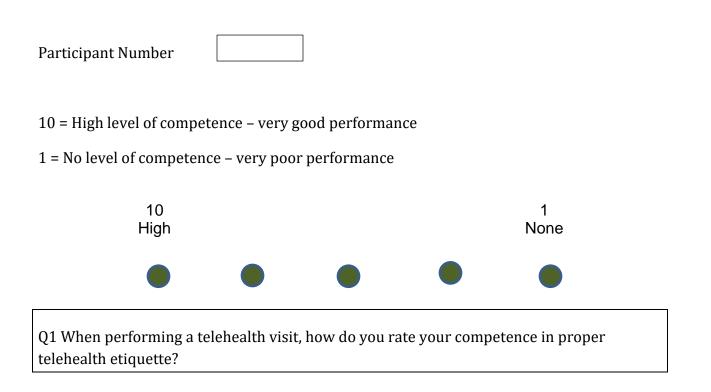**You can also add Coaching Comments at the end that you might say to the clinician.**

Critical Behavior ✓ Competency	RATING
1. Orientation ✓ Explained expectations for the televisit ✓ Expressed positive views of telecare ✓ Checked for cultural/regional differences ✓ Introduced self ✓ Explained role on the health care team	1 2 3 4 5
2. Verbal Clarity ✓ Used clear language ✓ Avoids or explains abbreviations and technical language ✓ Clarified unclear statements as needed	1 2 3 4 5
3. Active Listening ✓ Used repetition and summarizing to reinforce information ✓ Specifically invited questions ✓ Checked for clear understanding of what the patient was saying ✓ Avoided interrupting patient	1 2 3 4 5
4. Patient-Focused ✓ Explored problem impact in the patient's life ✓ Allowed the patient to set the pace for the consultation ✓ Used adequate open-ended follow up questions to obtain a view of the whole health problem	1 2 3 4 5

	1 2 3 4 5
5. Tone of Voice ✓ Friendly ✓ Softened tone when conveying emotional content ✓ Used appropriate vocal volume and rate for patient understanding	1 2 3 4 5
6. Eye Contact ✓ Made eye contact before speaking ✓ Appropriate length to enhance patient comfort ✓ Stayed visually attentive	1 2 3 4 5
7. Other Body Language ✓ Open posture- arms uncrossed (neutral/positive) ✓ Appropriate and engaging facial expressions ✓ Kept position facing patient/camera and unobscured ✓ Limited distracting movements or note-taking ✓ Appeared comfortable in the virtual environment	1 2 3 4 5
8. Empathy ✓ Conveyed empathy nonverbally ✓ Showed openness to patient's emotions ✓ Showed acceptance of patient's emotions ✓ Responded to patient's nonverbal indicators of emotional state ✓ Used silences to facilitate the patient's expression of thoughts and feelings	1 2 3 4 5
9. Rapport ✓ Created rapport ✓ Encouraged patient to express self ✓ Showed interest in the patient as a person	1 2 3 4 5
10. Respect ✓ Acknowledged patient's coping efforts ✓ Accepted legitimacy of patient's views and feelings; is not judgmental	1 2 3 4 5
11. Therapeutic Alliance ✓ Responded to patient with emotional vs. informational comments, appropriately ✓ Collaborated with decision-making ✓ Offered partnership ✓ Dealt with embarrassing topics sensitively	1 2 3 4 5
12. Environment ✓ Limited background noise or distractions ✓ Explained role of any others present ✓ Explained setting ✓ Assured privacy of patient consultation	1 2 3 4 5
Overall Rating **Coaching comments:**	1 2 3 4 5

Appendix B: Telehealth Comfort Scale

Participant Number

10 = Very comfortable

1 = Very uncomfortable

10 Very Comfortable				1 Very Uncomfortable
●	●	●	●	●

Q1 How would you rate your comfort in performing a telehealth visit?

Appendix C: Telehealth Etiquette Competence Scale

Participant Number

10 = High level of competence – very good performance

1 = No level of competence – very poor performance

10 High				1 None
●	●	●	●	●

Q1 When performing a telehealth visit, how do you rate your competence in proper telehealth etiquette?

Appendix D: Demographics Sheet

Telehealth Etiquette Education: Preparing Practitioners for Successful Patient Encounters

Participant Number [   ]

Gender: _____

Credentials/Profession: _____

Number of Years in Practice: _____

Number of Years Practicing Telehealth: _____

Have you received formal telehealth training before? Yes or No

      If so, how long ago was it? _____

      Did it include telehealth etiquette? Yes or No

Appendix E: Informed Consent Form

Title: Telehealth Etiquette Education: Preparing Practitioners for Successful Patient Encounters

Principle Investigator: Shuvory Green, MSN, APRN, FNP-C Georgia College & State University Graduate Student

I, _____, agree to participate in the study "Telehealth Etiquette Education: Preparing Practitioners for Successful Patient Encounters" which is being conducted by {Shuvory Green}, who can be reached at {Shuvory.green@bobcats.gcsu.edu}. I understand that my participation is voluntary; I can withdraw my consent at any time. If I withdraw my consent, my data will not be used as part of the study and will be destroyed.

The following points have been explained to me:

1)   Purpose:

You are invited to join a research study. The intent of this scholarly project is to determine your telemedicine comfort in delivering telehealth and your competence in telehealth etiquette. The goal is to increase your telehealth comfort and competence in telehealth etiquette by delivering an educational intervention on telehealth etiquette.

2)   Procedures:

If you are willing to participate in the study, the procedures are as follows: you will be asked to sign this consent form, complete a demographic form, a pre-intervention self-assessment, a post-intervention self-assessment, and a completion satisfaction survey. Each scale takes 5-10 minutes to complete.

3)   Risks:

You are not likely to experience physical, psychological, social, or legal risks. Your name will not be connected to your data. Therefore, the information gathered will be confidential.

4) Benefits:

1. Participation in this study will have an indirect impact on the participant's self-confidence in delivering telehealth and competence of telehealth etiquette for successful patient encounters.

5) Voluntary Participation and Withdrawal:

Participation is voluntary and participants can withdraw from the study at any time without providing a reason.

6) Confidentiality:

Confidentiality will be provided to all subjects. Participants will be given a participant number that will only be known to the participant and primary investigator. The dissemination of the overall study findings may be in healthcare journal publications, poster, or conference presentations. Your contribution to the study will not be personally identifiable, all content will be presented in group form.

7) Costs:

There are no associated costs to you for participating in this study.

8) Compensation:

There is no compensation provided by this study to participants.

By signing and returning this form, you are willing to participate in this research study and that you are 18 years of age or older.

The investigator will answer any further questions about the research should you have them now or in the future (see above contact information).

_____   _____

Participant Signature   Date

Appendix F: SP confidentiality Agreement Form

SP Participation Agreement

I,_____, agree to the following:

1.   As a Standardized Patient (SP), a volunteer, I will always conduct myself in a professional manner and will maintain standards including reliability, promptness, objectivity, flexibility and commitment to Middle Georgia State University programs and needs.

2.   In my capacity as a SP, I understand that I may be interviewed and examined by health professionals in a manner like that which I might experience if I were an actual patient. Specifically, this may include aspects of the physical examination that are normally part that require skin visualization and assessment of the upper torso and lower extremities.

3.   I may be required to assess health professional performance by providing both qualitative (comments) and quantitative (scores) data. I understand that I have no right, title, or interest to such assessments or data, and I hereby consent to the use of such assessments or data in any analyses for research purposes. I further understand that my name will not be associated with any such research. Any research that concerns my performance as a SP, however, will require my informed consent to do such and will be strictly voluntary.

4.   I understand that case materials and any information related to SP exercise are confidential. I agree to restrict any discussion concerning such to students, staff, or other participating SPs. In no event shall I disclose any information about an individual's performance to any third party.

5.   All questions pertaining to the terms or conditions of this agreement or my rights as a volunteer, shall be directed to, Principal Investigator of this study at Shuvory.green@bobcats.gcsu.edu.

I hereby certify that I am at least 18 years old, have read this participation agreement, or it has been read to me, and that my signature constitutes acceptance of all of the terms and conditions stated herein.

Print Name

_____

Signature

_____

Date:

Appendix G: Telehealth Training Course Completion

OLD DOMINION UNIVERSITY
College of Health Sciences
School of Nursing

CERTIFICATE OF CONTINUING EDUCATION

Awarded to

Shuvory Green

In Recognition of Participation in
"Telehealth Certification for Healthcare Providers"
Center for Telehealth Innovation, Education, and Research (C-TIER)
Old Dominion University
School of Nursing
Virginia Beach, VA 23453

20 Contact Hours Granted
DATE: 04/09/2021

Christianne Nesbitt RN, DNP, GNP-BC, PMHNP-BC
Old Dominion University
School of Nursing
Virginia Beach, VA 23453

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Appendix H: G-PACER 12 Item

G-PACER-12 Item-Total

Item

1. Used an unhurried manner, allowing time to respond.

2. Obtained information regarding your perception of the problem.

3. Legitimated your concerns.

4. Used verbal and non-verbal cues to show connection.

5. Allowed for silence.

6. Asked for your preferences in treatment plan.

7. Responded to your mental/emotional state.

8. Offered clear information about what to expect during visit and after.

9. Offered choices whenever possible about visit.

10. Listened carefully to your needs, questions, and concerns

11. Gave information that empowered you

12. Conveyed optimism about health and life style outcomes.

Note: Respondents were provided with the stem "For the following items, please check the box that best describes how well you thought that the provider...." Each item was scored on a five-point Likert scale with the following choices: Not Done (1), Poor (2), Acceptable (3), Very Good (4), Outstanding (5).

Appendix I: Satisfaction survey

What suggestions do you have for further developing the training?

Appendix J: Telehealth Toolkit Flyer

Appendix K: Four P's Conceptual Framework

The Four P's of Telehealth: Planning, Preparing, Providing, and Performance Evaluation

- **Identifying** requirements and specifications for implementations of a telelhealth program

Planning

Preparing

- **Establishing** the Knowledge & skills, protocols, site and equipment for the actual delivery of the telehealth program

Performance Evaluation

Providing

- **Evaluating** the outcomes of the telehealth program

- **Delivering** the telehealth encounters

Note: This Model was developed by the lead author (C.M. Rutledge).

Appendix L: Site Permission Letter

Site Permission Letter

10/04/2021

Dear GC IRB,

Based on my review of the proposed research by Shuvory Green, I give permission for Shuvory Green to conduct the study entitled Telehealth Etiquette Education: Preparing Practitioners for Successful Patient Encounters within the Piedmont Urgent Care by Wellstreet. As part of this study, I authorize the researcher(s) to email providers for volunteer participation and educate the willing providers on Telehealth Etiquette through Zoom. Individuals' participation will be voluntary and at their own discretion.

We reserve the right to withdraw from the study at any time if our circumstances change.

We understand that the research will include observation of each provider pre and post the educational intervention. No identifiable personal information will be collected to maintain confidentiality. A satisfaction survey will be completed post training.

This authorization covers the time period of October 2021-December 2021.

I confirm that I am authorized to approve research in this setting. The researcher has discussed the project fully with me and answered any questions I have about the project.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Georgia College IRB.

Sincerely,

Cassandra B Donnelly D.O.
Regional Medical Director
Piedmont Urgent Care
3350 Riverwood Pkwy SE, Suite 1850, Atlanta, GA 30339
C: 973-592-2060 | E-fax: 850-807-6653
E: cdonnelly@wellstreet.com | W:www.wellstreet.com

Appendix M: Instrument Permission

DNP Project

shuvory green
Tue 4/6/2021 6:24 PM

To: Rutledge, Carolyn <CRutledg@odu.edu>

Hi Dr. Rutledge, I am truly enjoying your telehealth course. I have learned so much these past 2 weeks, such valuable information. I am reaching out for permission to use your telehealth checklist as part of my DNP project. I am currently a student at Georgia Collge in Milledgeville, Ga. Dr. Sallie Coke is my chair. My project is focused on telehealth etiquette for practitioners in Urgent Care. I currently work at an urgent care and we were, like many others, thrown into telemedicine without any training or education about it. We have several providers that do not prefer doing telemedicine visits because they feel unsure with managing the patient without the ability to physically examine the patient. My project purpose is to implement telehealth etiquette training to the practitioners at my facility to assist with them being more comfortable and skilled at delivering telemedicine. Your checklist is the tool that would fit great with my project. It would be a honor to be able to use it and provide credits to you in my project for its usage. Thank you for your consideration.

Shuvory Green, APRN, FNP-C

Rutledge, Carolyn <CRutledg@odu.edu>
Tue 4/6/2021 6:40 PM

To: shuvory green <shuvory.green@bobcats.gcsu.edu>

You can use it if we get credit. If you want to use the You Tube videos, feel free. The evaluation tool and the videos can go hand and hand. We have both the telehealth etiquette and the conducting of the physical exam videos. If you need any outside help, let me know.

Carolyn

Carolyn Rutledge, PhD, FNP-BC
Professor
Associate Chair, School of Nursing
Director Doctor of Nursing Practice (DNP) Program
Old Dominion University
Virginia Beach, VA

757-469-6735 (Cell)
757-469-6735 (Office)

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