FINAL REPORT

TELEHEALTH PARENT COUNSELLING TRIAL

CHILD HEALTH SERVICES

JUNE 2016
Telehealth Parent Counselling Trial through Child Health Services

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- Staff of the Telehealth Support Unit whom provided training and advice to the clinicians;
- Telehealth Coordinators who answered questions and problem solved throughout the trial and
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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>Summary</td>
<td>vii</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>Purpose</td>
<td>3</td>
</tr>
<tr>
<td>Expected Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Governance</td>
<td>4</td>
</tr>
<tr>
<td>Budget</td>
<td>4</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>4</td>
</tr>
<tr>
<td>Clinicians and Trial Sites</td>
<td>4</td>
</tr>
<tr>
<td>Set up</td>
<td>5</td>
</tr>
<tr>
<td>Training</td>
<td>6</td>
</tr>
<tr>
<td>Information sheets for Parents and Clinicians</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Guidelines</td>
<td>9</td>
</tr>
<tr>
<td>Data Collection</td>
<td>9</td>
</tr>
<tr>
<td>RESULTS</td>
<td>11</td>
</tr>
<tr>
<td>Set up and Deployment</td>
<td>11</td>
</tr>
<tr>
<td>Equipment</td>
<td>11</td>
</tr>
<tr>
<td>Training</td>
<td>11</td>
</tr>
<tr>
<td>Information Sheet for Parents</td>
<td>12</td>
</tr>
<tr>
<td>Other Deployment Findings</td>
<td>13</td>
</tr>
<tr>
<td>Functionality</td>
<td>14</td>
</tr>
<tr>
<td>Delivery of video conference sessions</td>
<td>14</td>
</tr>
<tr>
<td>Cost Benefit</td>
<td>18</td>
</tr>
<tr>
<td>DISCUSSION AND RECOMMENDATIONS</td>
<td>19</td>
</tr>
<tr>
<td>Set up and Deployment</td>
<td>19</td>
</tr>
<tr>
<td>Functionality</td>
<td>21</td>
</tr>
<tr>
<td>Sustainability</td>
<td>22</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>24</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>25</td>
</tr>
<tr>
<td>Appendices</td>
<td>26</td>
</tr>
<tr>
<td>Appendix A: Trial Budget</td>
<td>26</td>
</tr>
<tr>
<td>Appendix B: Information Sheets</td>
<td>27</td>
</tr>
<tr>
<td>Appendix C: Trouble Shooting Guide</td>
<td>31</td>
</tr>
</tbody>
</table>
Figures

Figure 1  Ranking of helpful supports to the experience of telehealth by participating clinicians experience.............................................................. 12
Figure 2  Clinician rating of confidence using video conference software and equipment at end of trial................................................................. 13
Figure 3  Client reason for having a video conference session with parent counsellor......................................................................................... 17
Figure 4  Clinician rated level of satisfaction with client VC sessions .............. 18
Tables

Table 1: Sites participating in Telehealth Parent Counselling Trial……………………..5
Table 2: Peer Group Meeting- dates and topics……………………………………………8
Table 3: Trial questions according to stage of trial………………………………………9
Table 4: Survey Response Rate……………………………………………………………11
Table 5 Technical/Equipment Issue………………………………………………………14
Table 6: Video Conference Service Delivery Data………………………………………15
Summary

The aim of the trial was to investigate the feasibility of using video conferencing as a method of Child Health clinical service delivery (parenting counselling) to families living in rural and remote areas of Queensland. This part of trial was not aimed at identification of clinical outcomes as this will be investigated through the research arm of the trial which is due for completion later in this year.

Twelve Early Intervention Parenting Clinicians/Early Intervention Clinicians (EIPC/EIC) within nine child health services participated in the trial. The set up and deployment phase of the trial was successfully completed with a small number of families seen by VC. An expected benefit of the trial was the implementation of VC within service delivery models for parent counselling in rural and remote areas.

Implementation of VC equipment at the nine child health services and the completion of parent counselling sessions by VC at three centres demonstrate a potential for future use of VC delivery of parent counselling within child health services. The sites in which VC delivery was accomplished service rural and remote families and with the high satisfaction reported from clients it is a valuable option for service models in the future.

Evaluation of the trial also identified issues related to the use of this technology which will need to be considered in any future projects related to tele-health and families living in rural and remote areas.

There are ten recommendations as a result of this trial which are outlined in the report, relating to:

1. Equipment considerations
2. Clinical space requirements
3. Sustainability of the service delivery method.
BACKGROUND

Telehealth provides opportunities to work creatively, efficiently and gives clients more opportunity to access health professionals and/or services. Hospital and Health Services (HHS) in Queensland service a decentralised population with more than half of people living outside the Brisbane metropolitan area (Department of Health, 2015). Families living more than an hour away from health services face difficulties and additional costs to access services. Telehealth creates opportunities for clients and services including:

- Promoting equitable access to care,
- Improving timely access to health services,
- Reducing travel and inconvenience for individuals, carers and health service providers,
- Improving access to peer support and professional development for the rural and remote workforce and reducing clinical isolation,
- Attracting and retaining skilled professionals,
- Managing growing demands for health services within economic and financial environment,
- Optimising Hospital and Health Services expenditure on Patient Travel Subsidy Scheme (PTSS) reimbursements,
- Supporting the development of sustainable service delivery models that enhance care across the continuum and connect the healthcare community,
- Promoting integration of services and clinical handover across primary and secondary care particularly for people with chronic conditions and
- Supporting hospital avoidance strategies and optimising transfer and discharge planning. (Telehealth Strategic Plan 2015-2018)

Expansion of telehealth across Australia began in the mid-late 1990’s and today Queensland’s telehealth network is one of the largest in Australia with over 4,000 video conferencing (VC) systems in more than 200 hospitals and community facilities. There are more than 50 clinical services providing telehealth services across HHSs. (Department of Health, 2015; Qld Parliamentary Committee, 2014).

Over the last four years financial investment into telehealth ($30.9 million) by Queensland Government has seen the Department of Health expand its telehealth network to provide better care for people in rural and remote communities, increase uptake within mainstream health services and to provide support structures (Department of Health, 2015).

Due to the long distances between communities in rural Hospital and Health Services, it can be difficult for parents to access counselling services. Where services are available, clinicians often travel large distances to provide in person outreach (Simpson, Bell, Knox & Mitchell, 2005). Delivery of early intervention parenting services through VC is a potential option for both clients and clinicians in rural and remote communities to reduce travel time to appointments, increase access to services as well as connection to support and professional development:
“…there is opportunity to more permanently embed telehealth as an essential service modality…” (Department of Health, 2015, p6).

Telehealth is the delivery of health services and information using telecommunication technology (Telehealth Support Unit, 2016). Telehealth involves delivery of clinical services to patients by providers physically located at a distance (Wade, Elliott & Hiller, 2014).

The Queensland Department of Health (2014) definition of telehealth includes:

- live, audio and or/video interactive links for clinical consultations and educational purposes
- store-and-forward telehealth, including digital images, video, audio and clinical (storage) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists
- teleradiology for remote reporting and clinical advice for diagnostic images and
- Telehealth services and equipment to monitor people’s health in their home.

The Telehealth Parent Counselling Trial piloted the introduction of VC equipment to provide clinical services (parent counselling) within child health services across Queensland. The sites and clinicians involved have not previously used VC as a service delivery option for parent counselling. This trial of telehealth service to deliver parent counselling via video conference assists with providing accessible services - ensure access to appropriate health services is simple, equitable and timely for allQueenslanders (Queensland Health Strategic Plan 2012-2016).

The literature on psychotherapy (VC) has demonstrated similar therapeutic alliance and psychological outcomes between face to face and video conference therapy. Psychotherapy VC can reduce travel burden, costs and increase access for geographically isolated populations (Backhaus et al 2012). Other studies have indicated that some clients may prefer counselling through video conference (Simpson et al 2005). VC for early intervention parenting has not been investigated and telehealth skills training for parents of children with special needs are in preliminary stages (Xie Y. et al. 2013).

Interest for telehealth delivery for early intervention support and parent counselling within child health services began in 2014 with a clinical staff (later the Trial Project Manager) becoming aware of an opportunity to work with supervisees and clients using telehealth after attending the Rural and Remote Telehealth Conference in 2014 held in Toowoomba. Between 2014 and 2015 the Project Manager promoted the idea of VC as a delivery option for parent counselling services and as a way to access supervision, professional development and meetings without traveling long distances to EIPS/EICs and other staff.

Clinician acceptance of telehealth is the key to integrating this type of delivery into health care services and will assist in the successful implementation of telehealth. Wade et al (2014) reviewed 54 telehealth services across Australia to develop a model of uptake and sustainability of telehealth services. Their finding suggests clinician acceptance has the greatest impact on implementation of telehealth were it an optional method of service delivery. The Parliamentary Committee inquiry into telehealth reported the barriers to adoption of telehealth by clinicians are as follows:

- lack of information or knowledge, e.g. clinicians may be unfamiliar with telehealth use in their area of clinical practice,
• negative experiences with telehealth, including an absence of technical or administrative support, or clinical support with the patient,
• concerns about quality of care, or lack of an agreed model of care, and/or
• lack of clarity about consent, credentialing, clinical record-keeping, professional indemnity, and
• clinical responsibility for ‘remote’ patients (Parliamentary Committee, 2014, p67).

Wade et al (2014) propose once a telehealth service moves beyond the project phase then clinician acceptance becomes a key factor in the future success and sustainable delivery of telehealth.

**Purpose**

The objective of the trial was to investigate the feasibility of VC as a method of delivery of parent counselling to families who do not have ready access to child health services (i.e. those living in rural and remote areas or those with transport difficulties). The trial was designed to provide a small number of families access to parent counselling via VC, and investigate the feasibility of this method of delivery with respect to the experience and satisfaction of clinicians and clients involved in the trial. It was beyond the scope of this trial to provide clients of the service with equipment such as web cameras or electronic tablets. The pilot methodology was designed to be incorporated into existing roles of clinicians as an alternate mode of service delivery as opposed to providing an additional service. The trial ran for six months (January-June 2016) with allowance for three months in which VC sessions were to be delivered. Collective findings of both the clients and counsellors experience will help inform decision making on how to effectively include VC as a service delivery option within parent counselling as part of the overall child health services.

The trial investigation did not include investigating clinical outcomes or changes to parental capacity as a result of VC which is being examined with a separate research project.

**Expected Benefits**

Expected outcomes and benefits resulting from the trial are:

1. Parents of young children who have caregiving challenges will have equitable access to a counselling service regardless of where people live in Queensland.
2. Working partnerships established between Child Health service providers and Telehealth Coordinators.
3. Telehealth parent counselling (specifically video conference) will become part of Child Health’s service delivery model state-wide and specifically in rural and remote areas.
4. A Child Health information sheet on telehealth options is produced.
5. Increase counsellors' skills in telehealth service provision including ongoing professional development.
6. Clinical and technical guidelines are written for counsellors providing telehealth parenting interventions.
Governance

Children’s Health Queensland (CHQ) sponsored the project through the Director of Child and Youth Community Health. The trial was auspiced by the State-wide Child Health Sub Network and a steering committee was formed in January 2016 to oversee the Telehealth Parent Counselling Trial. The Steering Committee was a body of representatives from across the state which included:

- Director Child and Youth Services (Project Sponsor & Chair) with Nursing Director Child & Youth Community Health as proxy,
- Project Officer, Telehealth Parent Counselling Trial (Secretary)
- Clinical Practice Supervisor EIPC Central Qld (Social Worker) (Project Manager),
- Principal Project Officer, Telehealth Support Unit,
- State-wide Child Health Sub Network Support Officer,
- Telehealth Coordinator (Sunshine Coast),
- Clinical Practice Supervisor EIPS Northern Qld (Psychologist) and
- Team leader, QLD Hearing Loss Family Support Service (Social Worker)

The steering committee met monthly during the trial period. Members worked at different sites across Queensland so many used VC to attend meetings.

Budget

The trial was funded by the Department of Health, Healthcare Improvement Unit. Funds were used to employ a part-time temporary Project Officer and travel to trial sites. The Healthcare Improvement Unit also funded 11 Cisco Jabber for Telehealth Presence™ for sites participating in the trial. Purchase and delivery of these units were organised by staff of the Telehealth Unit. Refer to Appendix A for complete budget expenditure.

METHODOLOGY

Clinicians and Trial Sites

Essential to the trial were clinicians interested in using VC as a method to work with parents. A total of 17 EIPC/EIC volunteered or were approach to participate in the trial (refer to Table 1). Professional background of these clinicians is either social work or psychology. The clinicians either self-nominated or were encouraged by their Nurse Unit Manager or Clinical Supervisor due to their location in remote communities as well as interest in telehealth. The clinicians were situated across nine Community Health Centres.

Table 1: Sites Participating in Telehealth Parent Counselling Trial
Set up

The initial stage of the trial involved the following activities:

- deployment and set up of VC equipment to the participating trial sites,
- training in the use of video conference equipment and software at peer group meetings and

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1 The clinician servicing Townsville is based in Cairns

2 The clinician servicing Mossman is based in Noosa
• Promotion of the trial and broader telehealth support services within Queensland Health to other clinicians and staff.

Additionally, clinicians during the set up phase also spoke about the trial to potential clients and provided information about the options for video session either in their homes or health/hospital centres. The video sessions were planned to take place with the client in either their home or health centre or hospital. Clients who utilised the service in their homes would require the following:

• Desktop computer or laptop with web camera, speaker and microphone or
• I pad or tablet device
• Internet connection with minimum speed of 2/MB/second and
• A data plan to support a consumption rate of approximately 500mb/hour

The Healthcare Improvement Unit through the Telehealth Support Unit provided 10 Cisco Jabber Video for TelePresence™ Units to clinicians and child health services interested in participating in the trial. The equipment was allocated to the centres as an incentive for ongoing telehealth use after the trial. Queensland Health uses Cisco Jabber for Telepresence™ as the VC platform for its secure network. During the trial, the Telehealth Support Unit provided clients with the mobile software to download onto their home computer or tablet device.

A gradual role out of the Cisco Jabber for Telepresence™ equipment (e.g. web camera, speaker and headset) took place over three months from November 2015 - January 2016. Clinicians reported the video conference equipment was set up on computers located in either their offices or clinic rooms. A number of clinicians share office spaces which enabled them to support other clinical staff within their teams to use the VC equipment.

The last site to join the trial was the Mossman Multi-Purpose Health Service. With an additional Cisco Jabber Video for Telepresence™, the number of VC units funded for the trial totalled 11. Mossman was the only sight to participate that did not have an EIPC/EIC as part of their service. As such the counselling would be provided by another EIPC/EIC located in a different HHS as part of the trial. Mossman has a large Aboriginal and Torres Strait Islander community it was important to liaise with local Health Workers (Indigenous health professionals) who would be connecting and talking with families about the option to VC with a parent counsellor. Several meetings via VC were conducted to promote the trial and support the setup of VC equipment on site.

The Health workers in Mossman were also linked with their local Telehealth Coordinator in Cairns.

The set-up of equipment concluded with the first peer group meeting in February 2016 as this meeting took place via VC. For a few clinicians, this was the first opportunity to test out the equipment and software.

**Training**

The trial focussed on supporting clinician's development of skills and knowledge in telehealth service provision and professional development through a peer group which was identified as a benefit of the trial. It was anticipated that this group approach would
bring the clinicians together to share experiences using VC, expand professional knowledge and simultaneously allow them to test out the Cisco Jabber equipment and software in a supportive environment.

A total of five meetings were held with the clinicians participating in the trial. The meetings were held monthly via VC and took place over one hour. The purpose of these meetings was to increase the counsellor’s skills in telehealth service provision by providing technical and clinical information and training and professional development. Conducting the meetings and sessions in this mode allows for an in vivo experience for the clinicians as they experiment with the technology they would be using with their clients. Developing new skills around technology and increasing knowledge of the telehealth services within Queensland Health assisted with problem solving and knowledge of where to go for help if technical issues arouse during VC sessions with their clients. These factors are important long term for VC delivery as they create a positive experience for the clinicians who can use the skills developed to deliver VC service after the trial period.

Training components of the meetings involved guest presenters from Department of Health Telehealth Support Unit who gave demonstrations in the use of Cisco Jabber software i.e. changing audio and video settings. The Department of Health Telehealth network experienced ongoing development and expansion throughout the trial period and clinicians were kept up to date with the changes through the monthly meetings. The challenge was to ensure participants did not become overloaded with new technical information.

During the trial, access to video conferencing software changed with the roll out of Windows 7 across Queensland Health and required the clinicians to download Cisco Jabber for Telepresence™ software onto their computers/laptops from the ‘QH App Store’.

Additionally, the participant clinician group received demonstrations in the use of the Queensland Health Telehealth Portal Website which was due to go live during the trial. The portal is a tool which will allow Queensland Health staff to generate an internet link to connect the client with the VC software externally from either in their homes or with the community health centre and or hospital. Although the portal was not ready for use during the trial the clinicians gained skills which can be used once the portal is operational. Knowledge about the portal is an additional outcome from the trial as the 12 EIPC/EIC now have the knowledge to use the new system once it is fully operational.

Clinically, the group explored how VC can be incorporated into daily practice through the adoption of new technologies and process during the trial. The group considered potential change to clinical practice that is evident with delivering sessions through video, i.e. what a session might look like. Particular issues related to VC include room set up, noise lighting, and solving technical issues in session. Refer to Table 2 for details of group sessions and training provided.
<table>
<thead>
<tr>
<th>Date</th>
<th>Topics</th>
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</thead>
</table>
| **Initial Meeting** 10/2/2016 | Initial check of equipment and dial in using MOVIs  
Training session by Telehealth Support Unit  
- ‘Navigating settings on screen’  
- Telehealth Options for clients- home or health centre  
- Potential equipment issues  
- Questions for Telehealth  
Update on Trial and research  
Using telehealth with clients |
| 10/03/2016    | Training session by Telehealth Support Unit  
- Review of settings and equipment issues  
- Questions for Telehealth  
Update on Trial and research  
Using telehealth with clients  
- presentation of YouTube clips of client and workers video conferencing  
- Choosing potential clients  
- Planning the first session |
| 14/04/2016    | Training session by Telehealth Support Unit  
- Queensland Health Portal  
- Creating a virtual link- demo  
- Questions for Telehealth  
Update on Trial and research  
Using telehealth with clients  
- Booking video sessions  
- Client Information sheet  
- Post session survey |
| 05/05/2016    | Training session by Telehealth Support Unit  
- Update on Queensland Health Portal  
- Creating a virtual link- demo  
- Questions for Telehealth  
Update on Trial and research  
Using telehealth with clients  
- Practice stories from the group |
| 26/05/2016    | Update on Trial and research  
Using telehealth with clients  
- What do sessions look like  
- Barriers/challenges  
- Practice stories from the group |

**Information sheets for Parents and Clinicians**

An expected outcome from the trial was the promotion and education of both clinicians and parents about the trial and VC delivery option. Participant information sheets were created as a tool to promote the trial to both clinicians and potential clients. The Clinician Information Sheet contained information about the trial, expected tasks for participants of the trial and contact information on where to obtain technical support and help. Throughout the trial clinicians were encouraged to access established telehealth support services such as local Telehealth Coordinators if they had any technical or booking process issues.
The Parents Information Sheet contained information about the trial and information on how the client could access VC equipment either in their homes, health centre or hospital and internet usage and speed requirements. An additional page was developed for when the Research component commences. Refer to Appendix B for the Clinician and Parent Information Sheets.

**Clinical Guidelines**

An expected outcome from the trial was the writing of technical guidelines for counsellors providing VC parenting interventions. A trouble shooting guide was developed for the clinicians. The guide was designed to be a visual aid during sessions and contained information on the steps to take if technical issues arouse during a VC session and where to go for help and support. Please refer to Appendix C.

**Data Collection**

Data collection employed three methods over the three stages of the trial. Clinicians were asked to complete a data table over the course of the trial to record issues, VC usage and demographic details. Surveys were conducted with both clinicians and parents (clients). Clinicians were asked to provide feedback after each VC session completed and at the end of the trial. Parents were asked to complete a survey upon completion of the trial. Finally, the project officer conducted individual phone interviews with clinician participants. Table 3 outlines the pilot questions used to guide data collection according to stages of the trial. Stages of the trial coincided with the set-up, on-going functioning and long term sustainability of VC service delivery.

**Table 3: Trial questions according to stage of trial**

<table>
<thead>
<tr>
<th>Trial Stage</th>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td>Set up and deployment</td>
<td>Is the necessary telehealth equipment readily available and affordable?</td>
</tr>
<tr>
<td></td>
<td>Is the distribution and set up of the equipment reasonably achievable?</td>
</tr>
<tr>
<td></td>
<td>Is the associated training (for both clients and counsellors) reasonably achievable?</td>
</tr>
<tr>
<td></td>
<td>Were there any other notable experiences related to initial stages?</td>
</tr>
<tr>
<td>Functionality</td>
<td>Was the telehealth equipment and associated supports suitable for the delivery of parent counselling?</td>
</tr>
<tr>
<td></td>
<td>Were clients and counsellors satisfied with the delivery of parent counselling via telehealth?</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Is telehealth, as a method of delivery for parent counselling, sustainable?</td>
</tr>
<tr>
<td></td>
<td>Are there any other input/perspectives related to sustainability?</td>
</tr>
</tbody>
</table>

Firstly, pre-trial information was obtained from both parents and counsellors who included:

- Basic parent (client) and counsellor descriptors,
• General description of type of service to be received/delivered and
• Current technology available e.g. home and office computers

Secondly, over the course of the trial parents and counsellors kept records or notes on:
• Counselling session frequency and duration, (excluding actual counselling content)
• Equipment and/or technical maintenance, issues and costs and
• Other experiences and/or issues occurring across the trial

Finally, end of trial data was obtained from counsellors and parents. Counsellors provided information relating to their:
• Experience with using telehealth. (e.g. technical and service delivery issues; availability of telehealth equipment and support) and
• General experience within the trial (e.g. Successes; challenges; issues; would you use the telehealth service again?)

Parents provided similar information relating to their:
• General experience within the trial (e.g. successes; challenges; issues; would you use the telehealth service again?)

Three surveys were designed to collect information from the clinicians and parents (clients) using Survey Monkey Gold Standard™. The surveys included rating and ranking scales, nominal data and open ended questions. The clinicians were asked to complete ‘End of Session’ Survey after each video conference session as well as an ‘End of Trial’ survey which was completed in the last week of data collection before the final phone interviews with the Project Officer. All clinicians completed phone interviews expect one however data from this clinician was gathered by email during the trial. The surveys were emailed as an internet link within an email. The client satisfaction survey was given to clients by the parent counsellor as an internet link within an email at the end of the trial period. Refer to Appendix D for a copy of the three surveys.

Additionally, information obtained by project staff includes the following:
• Client and counsellor participation records
• Technology acquisition and implementation records
• Training records including evaluation
• Records of equipment/technical maintenance, issues and costs (in addition to those collected by clients and counsellors)
• Notes on other experiences/issues occurring across the trial (in addition to those collected by clients and counsellors)
RESULTS

Generally, there was a high response rate for each of the surveys. However, the sample for client satisfaction is small due to the small number of clients seen during the short trial period. As this pilot was to trial the implementation of new technology VC equipment to service clients wishing parent counselling it is envisaged it will take longer for the adoption of VC for parent counselling services by clients.

Table 4: Survey response rate

<table>
<thead>
<tr>
<th>Survey</th>
<th>Surveys completed</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician End of Session</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Clinician End of Trial</td>
<td>11</td>
<td>91%</td>
</tr>
<tr>
<td>Client Satisfaction</td>
<td>3</td>
<td>75%</td>
</tr>
</tbody>
</table>

Set up and Deployment

Equipment

The establishment of telehealth as a method of delivery for parent counselling early intervention services was successfully implemented. Nine child health centres received equipment to deliver parent counselling sessions by video conference. A total of eight video conference sessions were completed during the trial involving four parents. All participating clinicians successfully set up and downloaded the Cisco Jabber software. Although not all EIPC/EIC who participated in the trial were able to VC with clients, all reported an increase in use of the VC equipment for clinical supervision as well as other meetings (including the monthly peer group). A total of 25 clinical supervision sessions across all 12 EIPC/EIC by VC took place during the trial period.

Receiving the Cisco Jabber/MOVI equipment was reported (91%) as the most useful part of participating in the Telehealth Parent Counselling Trial by clinicians.

Training

A total of five peer group meetings were held during the trial and training sessions formed a part of the meeting (refer to Table 2). There was a 90% participation rate at peer group meetings. Information on the effectiveness of the training was gathered from the ‘End of Trial’ survey. Seven respondents or 64% strongly agreed that the training component of the peer group meetings increased their knowledge about Cisco Jabber software and equipment. The other four respondents (36%) agreed the training component of the peer group meetings increased their knowledge about Cisco Jabber software and equipment. Training by Telehealth staff during the peer group meetings was ranked as extremely helpful (73%) by clinicians, and 82% of clinicians identified training in the use of Cisco Jabber software and equipment was a useful part of participating in the trial. Two clinicians commented:
“It was good to see the equipment in action and even some of the difficulties that we all experience”

“The peer group meetings are very helpful, with the opportunity to troubleshoot and hear from others”

During the set up phase of the trial, focus was on informing the clinicians about solving potential technical issues during sessions and current support structures in relation to operating a VC session within Queensland Health. This was achieved through the peer group meetings, the production of information sheets, reflective practice tool and a Troubleshooting Guide.

Generally clinicians found the support structures helpful, with a number of clinicians indicating that certain supports such as local booking procedures were not applicable to their experience using VC technology in the workplace (see Figure 1). Of note, some clinicians experienced time consuming booking processes especially when booking VC equipment for clients in health centres outside their HHS. One clinician identified “improved ease of appointment booking and recording activity” as a suggestion to make telehealth an integral part of the workplace.

![Figure 1](image)

**Figure 1** Ranking of helpful supports to the experience of telehealth by participating clinicians experience

**Information Sheet for Parents**

Clinicians were asked for their feedback about the Parent Information Sheet (Appendix B) as this was a primary promotional tool produced for the trial. One expected outcome was the future production of a Telehealth brochure for child health services.

More than half of the clinician respondents (63%) agreed it was a useful tool to explain to caregivers about the telehealth trial. Two clinicians provided written comments about the information sheets:

“It was a lot of information…preferred it to more succinct”
“More family and child friendly photos”

The clinician Trouble Shooting Guide was produced to provide technical guidance during VC sessions. However, clinicians found this less useful than other supports such as receiving Cisco Jabber equipment, training and peer group meetings. Less than half of the clinicians (36%) indicated the troubleshooting guide was a useful part of the trial.

Important to the success of the trial was determining whether the training and peer group, and use of VC equipment increased the skills of the clinicians. At the end of the trial, clinicians were asked in a survey to rate their level of confidence with using video conference software and equipment on a seven point rating scale (see Figure 2). Nearly half of the clinicians (11) ranked their confidence in the middle between confident and not confident. Of note, only three clinicians completed VC sessions with clients which may have affected confidence levels using VC. Other clinicians’ experience was based on attending peer groups and clinical supervision/other meetings.

![Figure 2](attachment:image.png)  
**Figure 2**  Clinician rating of confidence using video conference software and equipment at end of trial.

**Other Deployment Findings**

**Technical issues preventing client participation**

There were a high proportion of clients interested in delivery of parent counselling by video conference who could not be seen due to technical barriers (see Table 3). Fifteen clients (35%) who were provided information about the trial agreed to participate. Unfortunately, due to internet issues such as poor speed and/or lack of video conference equipment at home, they were not able to VC from home.

This was an identified barrier to service for five clients who also had no local health or hospital service nearby to access for telehealth delivery. Three clients living on the Bay Islands (with no local health facility) received service by phone. Two clients living locally near a health/hospital service accessed the EIPC/EIC directly at a clinic and via
a home visit. One client with internet issues declined to participate in the trial all together. Four clients accessed VC equipment at a health centre or hospital to receive a parent counselling session.

Table 5: Trial technical and equipment issues

<table>
<thead>
<tr>
<th>Health Centre/Service</th>
<th>Technical Issues</th>
<th>Location of Client</th>
<th>Description</th>
<th>Delivery of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Well-being Service Group</td>
<td>1</td>
<td>Townsville</td>
<td>No web camera</td>
<td>Face to Face in clinic at Kirwan Health Centre</td>
</tr>
<tr>
<td>(Townsville)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Dalby</td>
<td>3</td>
<td>Chinchilla Town</td>
<td>Low internet speed</td>
<td>All three VC at Health/Hospital Centre-Chinchilla and Wandoan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chinchilla &amp; Tara</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wandoan Town</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Family Health Centre</td>
<td>2</td>
<td>Gayndah</td>
<td>No Internet at home</td>
<td>Travel distance too far to Health Centre</td>
</tr>
<tr>
<td>Bundaberg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Community Health Services</td>
<td>3</td>
<td>Tin Can Bay</td>
<td>No computer</td>
<td>No Local Health Facility but exploring VC at GP/Medical Centre</td>
</tr>
<tr>
<td>Gympie</td>
<td></td>
<td>Cooloola</td>
<td>No internet at home</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No internet at home</td>
<td></td>
</tr>
<tr>
<td>Deception Bay Child Health</td>
<td>1</td>
<td>Deception Bay</td>
<td>Technical limitations of Cisco Jabber</td>
<td>Home visited</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>prevented sharing of parenting DVD</td>
<td></td>
</tr>
<tr>
<td>Wynnum Child Health</td>
<td>3</td>
<td>Russel Island</td>
<td>No internet at home</td>
<td>No Local Health Facility delivery by phone and exploring QH IPad with Wi-Fi to VC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bay Island Mcleay Island</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipswich Community Health Plaza</td>
<td>2</td>
<td>Gatton</td>
<td>No Internet at home</td>
<td>VC at Health/Hospital Centre Gatton Client declined VC at Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No speaker</td>
<td></td>
</tr>
</tbody>
</table>

**Functionality**

**Delivery of video conference sessions**

A total of eight video conference sessions were completed during the trial involving four clients. The clinicians involved in the trial report that they provided information about the trial and telehealth to a total of 42 clients. Twenty-one (50%) parents declined the option of VC session.
Sites servicing rural and remote communities such as Dalby, Ipswich and Bundaberg had the most uptake of video conference by clients. Clinicians were planning to continue to offer video conferencing sessions to clients after the trial period. There were 4 sites that have video conference sessions planned post trial, two of these sites were unable to complete video conference sessions during the trial due to the short time frame.
### Table 6: Video Conference Service Delivery Data

<table>
<thead>
<tr>
<th>Health Centre/Service</th>
<th>Clients approached</th>
<th>Clients declined</th>
<th>Technical issuesEquipment preventing VC from home</th>
<th>VC Delivered Sessions</th>
<th>VC Planned Post Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Well-being Service Group (Townsville)</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Community Health Mossman</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Dalby</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community Family Health Centre Bundaberg</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Child Community Health Services Gympie</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Deception Bay Child Health</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Wynnum Child Health</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Caboolture Child Health</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ipswich Community Health Plaza</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Child Community Health Services Noosa</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Clinicians reported in the final interview that the client’s reasons for declining the option of VC varied. However, a few central themes emerged:

- Preference for face to face with counsellor (4)
- Client disengagement (2)
- Pregnancy and/or new baby (2)
- Other services meeting clients’ needs and subsequent no need for EIPS/EIC service (2)
- Did not want video option (2)
- Lack of privacy at home (1)

Most client sessions took place between April and May with one clinician conducting a session in February. All eight sessions took place with the client using VC equipment.
at a health or community centre including hospitals. Four of the sessions were for 30-60 minutes duration, while the other four were between 60-90 minutes.

Figure 3 depicts reasons clients chose to have a VC session with a parent counsellor. 75% of clinicians responded their clients choose a VC session as there was “no EIPC/EICs service in local area”, the other 25% of clinicians stated their clients chose to have a VC session due to limited transport. The client’s response for their reason for having a video conference session with their parent counsellor was similar to the responses by the clinicians.

**Figure 3**  
Client reason for having a video conference session with parent counsellor

Clinicians reported in the ‘End of session survey that three clients wished to re-book another VC session. One client did not wish to rebook a VC session instead preferring to see the clinician in person. The Client Satisfaction survey suggests clients are extremely likely (mean 9.6) to recommend parent counselling by VC to other parents. All three clients responded to the satisfaction survey (100%) the “agreed” they were satisfied with how the video conference session went. However, despite this satisfaction one client preferred face-to-face interaction.

“Whilst video conferencing is a great resource, having a real people dispatched to remote locations would be ideal.”

Clinicin satisfaction with client VC sessions was gauged (refer to Figure 4). Overall clinicians reported they were happy the VC sessions.
Two clinicians reported in the ‘End of Session’ survey they were able to assist the client with some minor technical issues such as audio settings. Conversely, all client respondents did not report experiencing any technical issues during the video conference sessions.

The Telehealth Parent Counselling Trial piloted the introduction of Cisco Jabber Presence™ equipment (web camera, speaker and headset) into nine child health services sites to delivery parent counselling through VC. Three clinicians completed VC sessions with clients during the trial and two additional sites have clients planned post trial. The Client Satisfaction Survey results support that the clients who completed the survey (3) would be extremely likely to recommend counselling by VC to other parents.

“Please make this available to everyone all the time…not just for the trial period”

There was overwhelming support from the clinicians participating that they would like to continue to offer telehealth to clients as well as continue with professional development through an ongoing peer group. All respondents to the ‘End of Trial’ Survey said they would participate in an ongoing telehealth peer group. The benefits of the peer group were increased confidence using the VC software and equipment as well as clinical aspects of delivering counselling through video and a platform to trial technology and gain both technological and clinical knowledge. Clinicians identified in the ‘end of trial’ survey that they would like to keep up their knowledge and way of working with clients.

“keep using MOVI for meetings an supervision to keep up knowledge…”

“It needs to be part of the everyday client offerings for service delivery”

“Continue to use and practice video conferencing”

“I think it is helpful to have a range of options available to work with clients”

“It would be good to have telehealth become a standard choice/option for clients”

Cost Benefit

A benefit of using VC within health services has been its potential to increase efficiency and reduce costs to both client and clinician. An additional benefit from the trial was the anecdotal evidence of trial participants about the time and travel distance they might save using VC with clients. The trial examined the potential savings to clinicians in terms of travel time and travelling distance by asking the clinicians to estimate how
much time and distance they saved during the trial using VC sessions. Four EIPC/EICs, who used VC with clients during the trial, estimated on the ‘End of Trial’ Survey that they saved between 200-400 kilometres in distance travelled during the trial.

The clinicians were also asked if they would use the MOVI equipment for other meetings. Ten (91%) indicated “Yes” and one respondent was undecided. They were also asked to estimate how much travel time they would save per month for other meetings. Eight responded with a total minutes they saved equalling 2380 minutes or (40 hours). Clinicians all reported time saved in travel to meetings and the opportunity to participate in professional development activities they might not attend due to travel distance was a benefit of having VC equipment. One clinician highlighted the cost savings for VC.

“VC works out far more efficient in terms of being able to offer sessions to families in our outlying areas, but also saves heaps re: mileage, time out for driving (e.g. 4hrs of wages), potential incidents on the road, possibly overnight expenses, and travel for clients as well”.

DISCUSSION AND RECOMMENDATIONS

Set up and Deployment

Is the necessary telehealth equipment readily available and affordable?
Is the distribution and set up of the equipment reasonably achievable?
Is the associated training (for both clients and counsellors) reasonably achievable?
Were there any other notable experiences related to initial stages?

The set up and deployment phase of the trial was successfully completed with a small number of families seen by VC. An expected benefit of the trial was the implementation of VC within service delivery models for parent counselling in rural and remote areas. The implementation of VC equipment at the nine child health services and the completion of parent counselling sessions by VC at three centres demonstrate a potential for future use of VC delivery of parent counselling within child health services. The sites in which VC delivery was accomplished service rural and remote families and with the high satisfaction reported from clients it is a valuable option for service models in the future.

The VC equipment (Cisco Jabber) is user friendly and affordable. The set up phase of the trial was completed on time by all participants with minimal issues except suitable office locations to conduct VC at some sites. With the equipment set up complete and operating effectively it is expected that future costs to maintain the VC equipment in trial sites is minimal unless specific components such as head set require replacement or services invest in peripheral equipment.

The parent and clinician information sheets and troubleshooting guide developed during the set up phase with the benefit of promoting the trial to potential clients and other health staff such as child health nurses.
VC delivery is affected by technical issues such as internet coverage. Poor internet connection and/or no internet service have been identified as an issue for remote communities. It is a barrier for telehealth services when there are no other VC service options or local health/hospital service. The trial highlighted client participation and access to health centres in remote areas without appropriate internet speed/coverage needs creative and technological solutions. It is expected that the roll out of NBN and associated increase in upload speeds will increase coverage into the future (Parliamentary Committee, 2014).

The technology requirements for clients accessing services from their homes needs consideration in future telehealth service delivery models of care. Limited internet services and/or no internet were a barrier for five clients who were approached about the trial.

Some clinicians reported that they had to set up the MOVI on computers in shared spaces and either move the equipment to another room/computer for the VC session or negotiated time for VC appointment when office was unoccupied.

**Recommendation 1: Set up of VC equipment for counselling occurs in spaces that offer privacy such as office or clinic rooms.**

All VC sessions took place with clients located at health or hospital facilities with clinicians negotiating booking process and support for clients at the other end. Delivery by VC may include the use of facilities at a distance which requires knowledge of local booking procedures and staff. In communicates without a health or hospital service VC options may include local medical centres and/or GP offices.

**Recommendation 2: Child health services continue to establish relationships with staff at health, hospital or GP facilities were VC equipment is available for clients to access.**

Additional considerations for VC delivery during the set up phase were funding, booking procedures and recordkeeping. These additional issues were discussed at peer group meetings in which Telehealth Unit staff provided advice to clinicians. Clinicians who completed VC sessions utilised their local Telehealth Coordinators for support and information relating to incentive payments and booking procedures. Telehealth incentive payments are available to some community based health services depending if they are linked to a hospital service. To receive Incentive payments specific requirements need to be met including, medical staff engagement in the appointment, booking and record keeping requirements these may differ between HHSs.

**Recommendation 3: Future child health VC services consider telehealth funding opportunities and utilise local Telehealth Coordinators for assistance.**

There were a number of expected benefits from the trial in relation to increasing the knowledge and skill base of the EIPC/EICs as well as strengthening partnerships with their local Telehealth Coordinators. The training of EIPC/EIC in the use of Cisco Jabber software and equipment was achieved and the use of a peer group to achieve the expected outcomes was successful. Clinicians indicated they were satisfied with the training provided.

**Recommendation 4: Future VC services within child health services incorporate training for staff in use of Cisco Jabber software and equipment and clinical guidelines for VC delivery**
Overall the set up and deployment phase of the trial was successful with equipment being delivered and set up on time as well as training completed. Embedding delivery of parent counselling by VC within child health services and models of care across HHSs creates a foundation on which technology can be used to improve access to services for families living rural and remote communities.

**Functionality**

Was the telehealth equipment and associated supports suitable for the delivery of parent counselling?

Were clients and counsellors satisfied with the delivery of parent counselling via telehealth?

Future telehealth trials and or services for families using VC are dependent on telehealth technology, equipment and support systems. The telehealth parent counselling trial established that VC equipment (Cisco Jabber for Telehealth Presence™) and associated telehealth supports are appropriate for implementation and ongoing delivery of parent counselling by VC within trial sites.

Knowledge and liaison with Telehealth Coordinators is vital for ongoing VC delivery to rural and remote communities. An identified benefit of the trial was the working partnership between EIPC/EIC and local Telehealth Coordinators. Several of the clinicians contacted their local Telehealth Coordinator during the trial and found them helpful.

Functionality phase of the trial involved promotion of trial to potential clients and child health staff. Clinician participants also utilised telehealth supports such as the 1800 support line and local Telehealth Coordinators to plan and complete VC sessions. Skills and expertise gained by trial participants can be used to promote telehealth delivery to other EIPC/EICs and stakeholders such as nurses, managers, booking officers, doctors, GP, hospitals, other health services and community organisations.

Child health services offering VC delivery of parent counselling to rural and remote communities require partnership with health staff such as clinical nurses and Health Workers to help with client adoption of VC and provide that ‘link’ at a distance by connecting families to the EIPC/EIC.

Information from the Parent Information Sheet can be used to develop future telehealth service brochure or client information sheet. Clinician participants suggested using family friendly and culturally appropriate photos of parents and children using telehealth.

**Recommendation 5:** A brochure and/or client information sheet is produced in partnership with the Telehealth Support Unit, using child and family and culturally appropriate photos.

There were minimal technical issues reported during VC sessions. However, a number of other issues reported by participating clinicians emerged during the trial:

- Noise and distraction from children in the room
- Background noise at clinician end
- Interruption by other staff during session
- Lack of child and or family telehealth rooms for clients using VC equipment at health centre
- Technology restrictions and barriers of software in particular sharing of video
- Counselling through video when more than one caregiver involved in session

Recommendation 6: VC equipment at health or hospital services occurs in child and family friendly rooms.

Participating clinicians identified technical limits to the Cisco Jabber software in being able to ‘share’ video content with clients. The EIPC/EIC role involves showing of ‘clips’ or parenting DVDs as a means of parent education and support. The peer group attempted to problem solve and came up with using a portable DVD Player at the clinician end to be played and shown through the web camera. More permanent technical solutions such peripheral equipment to increase the range of therapeutic activities during a VC session can be considered. For example, visualiser magnifies a document such as text from a book or handout so the clients can see clearly (McCarthy and North, 2012).

The clinician’s acceptance of VC for peer group meetings and training sessions is valuable to their ongoing willingness to use VC for parent counselling sessions and will assist in future implementation of VC within service delivery models. Clinician participants reported that they would like to continue to use telehealth as an option to work with clients. Clinicians also wished to maintain contact with each other throughout the research component which is ongoing until November 2016.

Recommendation 7: Clinician participants continue to offer and promote VC delivery to clients.

Recommendation 8: Monthly VC peer group meetings and training sessions continue for duration of research.

Sustainability

Is telehealth, as a method of delivery for parent counselling, sustainable?

Are there any other input/perspectives related to sustainability?

Overall the implementation and delivery of parent counselling by VC is sustainable as the equipment is easily set up and affordable and can be used with either minimal training by Telehealth staff, in house practice through meetings or mentoring from other more experienced clinicians. The introduction of equipment increased the use of VC for all EIPC/EIC involved in the trial and anecdotal evidence from participants during peer group meetings were other staff in their office were interested in using the technology.

An expected outcome from the trial was ‘equitable’ access to parent counselling service. The set up phase highlighted that a number of families in rural and remote areas approached to take part in the trial experienced barriers to VC due to internet issues like bandwidth speed. It was identified at the beginning of the trial that three potential risks may affect outcomes from the trial:

- Internet bandwidth inadequate in some rural areas
- In adequate access to other telehealth units in rural/remote areas and...
• Minimal numbers of participants being interested in the trial in a short time period

Findings from the data suggest that these limitations were experienced during the trial and reduced the total number of participant families. Future promotion of VC as an option for parent counselling and continual roll out of the NBS, will enable more clients in the trial sites and other rural and remote areas the opportunity to access VC from home or a health or hospital service.

The future of telehealth services is pointed toward processes that help clients connect with VC services from private computers and or electronic devices. Trial participants gain knowledge and skills relating to the Queensland Health telehealth during peer group meetings (refer to Table 2). The portal has been developed to streamline the connection processes between client and clinician/service and will allow clients to quickly connect from home into the secure telehealth network provided the National Broadband Network coverage reaches those clients in rural and remote communities.

Families have potential to VC their parent counsellor from home and or office. It is a potential service delivery option for caregivers in full time work and caregivers with FIFO partners. Telehealth portal creates opportunity for ease of access to telehealth services.

**Recommendation 9: Telehealth portal is promoted and implemented into future VC service models within child health services**

Although not a primary objective of the trial initial investigation into the cost effectiveness of VC service delivery in terms of reduced travel time and distance show that clinicians who delivered VC sessions estimated they saved travel time. Future savings is expected now that the VC equipment is set up and clinicians can participate in clinical supervision and other meetings via VC. The cost benefit of VC supports its ongoing implementation within service models.

Collaboration and partnership with services currently utilising telehealth is vital to newly established VC services. Within the trial period a number of other pilot projects in paediatric services were assessing the feasibility of telehealth as a delivery method as well as other services already delivering telehealth such as the QLD Hearing and Loss State-wide Service (QHLSS). There is potential to continue to grow a network of clinicians with interests in telehealth across or within all HHSs and to ensure partnerships with Telehealth Coordinators and the Telehealth Support Unit. Telehealth is a growing area of clinical practice and with the expanding ‘technology platform’ within Queensland Health a network to share information, resources and project outcomes across would benefit best practice.

**Recommendation 10: Across service telehealth practice networks are utilised to promote telehealth clinical best practice.**
CONCLUSION

Telehealth is a mode of service delivery that is new to parent counselling services within child health services. The Telehealth Parent Counselling Trial investigated the feasibility of telehealth as a method of delivery for parent counselling in terms of set up and deployment, functionality and sustainability and aimed to have at least 18 families from rural, remote communities engaged in parent counselling through VC. An expected benefit of the trial was the implementation of VC within service delivery models for parent counselling in rural and remote areas.

The establishment of VC as a method of delivery for parent counselling early intervention services was successfully implemented with nine Child Health Centres receiving VC equipment to deliver parent counselling sessions and 12 EIPC/EIC trained in how to use the equipment and software in these sites.

Limitations identified such as internet services and lack of VC equipment such as web camera were barriers for clients interested in accessing parent counselling services via VC. The trial highlighted client participation and access to health centres in remote areas without appropriate internet speed and or coverage needs creative and technological solutions.

There were a number of expected benefits from the trial in relation to increasing the knowledge and skill base of the EIPC/EICs as well as strengthening partnerships with their local Telehealth Coordinators. The training of EIPC/EIC in the use of Cisco Jabber software and equipment was achieved and partnerships formed with local Telehealth Coordinators.

EIPC/EIC participants support ongoing use of VC to deliver parent counselling services to clients. As well as the development of ongoing partnerships with other telehealth services through a community or network of telehealth practice.

Four caregivers/families were seen by VC during the trial and those clients indicated that they were satisfied with VC as a method of service delivery and all would recommend VC to other families.

A number of recommendations emerged from the trial to consider the future development of VC delivery options within child health services across HHSs.
REFERENCES


State of Queensland (Department of Health) annual report 2012-13

State of Queensland (Department of Health) annual report 2014–15

State of Queensland (Queensland Health), February 2015 Allied Health Telehealth Capacity Building Scoping Project Completion Report


Queensland Health Strategic Plan 2012-2016

## Appendix A: Trial Budget

<table>
<thead>
<tr>
<th>Budget item</th>
<th>2015-16 ($)</th>
<th>Additional costs</th>
<th>Total ($)</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project officer HP4 .4 25 weeks 13/1/16 – 30/6/16</td>
<td>$ 19 011.38 (gross hourly rate)</td>
<td>$ 5 703 (30% approx. oncost)</td>
<td>$ 27 714.79</td>
<td>2 days a week for 25 weeks.</td>
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<tr>
<td>RIDBC Teleschool book.</td>
<td>$ 50.00</td>
<td></td>
<td>$ 50.00</td>
<td>In original budget. Includes guiding principles for AH VC.</td>
</tr>
<tr>
<td>One year Gold Plan survey monkey licence.</td>
<td>$ 300.00</td>
<td></td>
<td>$ 300.00</td>
<td>Being used for trial and research questionnaires.</td>
</tr>
<tr>
<td>One return flight – Cairns to Townsville. One nights accommodation</td>
<td>$ 260.00</td>
<td>$ 150.00</td>
<td>$ 410.00</td>
<td>To support clinician with engaging clients is contact person in SSA for Cairns and Townsville.</td>
</tr>
<tr>
<td><strong>Total current budget expenditure:</strong></td>
<td><strong>$ 28 474.79</strong></td>
<td></td>
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<tr>
<td>Proposal: Extend project officer HP4 for 5 additional days.</td>
<td>$ 1 901.00</td>
<td>$ 570 (30% approx. oncost)</td>
<td>$ 2 471.00</td>
<td>Extra days will assist with tasks required to complete the project.</td>
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<td><strong>Total expenditure with additional days:</strong></td>
<td><strong>$30 945.79</strong></td>
<td></td>
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<td><strong>Total allocated by Healthcare Improvement Unit:</strong></td>
<td><strong>$31 542.00</strong></td>
<td></td>
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</table>
Appendix B: Information Sheets

Telehealth parent counselling trial

The Telehealth Parent Counselling Trial is looking at telehealth video appointments (video conferencing) as a way of delivering parent counselling to families in rural and remote areas or those unable to access a Child Health Centre. As an Early intervention Parenting Clinician or an Early Intervention Clinician (EIP/C/EIC) you will be providing the parenting counselling intervention as part of Child Health Services.

Your participation in the trial
To support your participation in this trial the Queensland Health Telehealth Support Unit has provided your office with MOVJ Jabber Video software and equipment. Throughout the trial we will also provide professional development and peer support with monthly video conference sessions and a reflective practice sheet. This sheet is a tool for your use to record any clinical or technical issues that occurred during the telehealth sessions and can be used to inform your professional development at the monthly peer supervision sessions. The reflective practice sheets will not be collected as part of the trial. If you have questions or require more information on the trial, please contact Stephanie Golden Roser (07) 5433 8001 or email stephanie.goldenrosen@health.qld.gov.au. Information on the technical assistance available from telehealth support services is available below.

Telehealth video appointments
Telehealth should be promoted as an option to eligible clients at trial sites. Eligible clients will include those who live in rural or remote areas, have transport difficulties or are unable to access this service outside of the telehealth trial. The project officer will ask you to keep a record of the numbers of clients you spoke to about telehealth and the reasons why people were interested or not interested in participating in the trial. This feedback will be collated by the project officer and will not contain any confidential or identifying information.

The normal referral criteria and triage processes that you currently use in your Child Health or Community Health Centres for an EIP/C/EIC referral will be used for the trial. A telehealth video appointment is conducted just like a regular health appointment except your client/s are on a screen and their voice is heard through speakers. The telehealth video sessions can take place either at:

- the clients home or
- a local health or medical centre.
Before the telehealth video appointment in a client's home

To conduct a telehealth counselling appointment in a client's home, they will need the following equipment:

- Computer/laptop with microphone, speaker and webcam
- Or iPad or other tablet device
- Internet connection with minimum speed of 3 Mbps/second
- Enough data in their plan to cover a data consumption rate of approximately 500mb/hour

You will generate an Internet link that contains a virtual meeting room (VMR) number. This link can be given to your client and at the time of the video session the client will click on the link and be taken to your meeting room. You will dial into meeting room from your computer. The VMR is secure and private to conduct counselling sessions.

At a Local Health Centre

Video conferencing equipment can also be booked at a local health centre, hospital or participating doctor through the local medical centre. The local telehealth coordinator in your hospital and health service will assist you with booking this equipment in a health service near the clients' home.

Potential technical problems

As part of the trial, we will support you in the use of telehealth technology. If you experience any technical issues during the telehealth video appointment that you are unable to resolve, the Statewide Telehealth Service is available on 1800 333 885. If these issues are not resolved in a reasonable time the session can be completed by contacting the client on their mobile or home phone.

After the telehealth trial

The trial period will end on Friday 27 May 2016 and the final peer group video conference will take place in June; however, your telehealth sessions can go beyond this date as clinically required. At the end of the trial the Project Officer will ask you to complete a satisfaction questionnaire with your clients either at the end of a telehealth session or over the phone. This questionnaire will take no more than five minutes to complete. The Project Officer will also get your feedback about the Reflective Practice sheet.
Telehealth parent counselling trial

The Telehealth Parent Counselling Trial is looking at telehealth video appointments (video conferencing) as a way of delivering parent counselling to families in rural, remote areas or those unable to access a Child Health Centre. All counselling is provided by fully qualified professional social workers or psychologists known as Early Intervention Parenting Clinicians/Early Intervention Clinicians (EIPC/EICs). EIPC/EICs assist families with children aged 0 – 8 years where they are facing challenges in their parenting/caregiving, they are experiencing difficulties with their child’s emotions or behaviours or are facing other difficulties that are affecting their parenting abilities.

Telehealth video appointment

A telehealth video appointment is conducted just like a regular health appointment except that the health professional is on a screen and their voice is heard through speakers. The telehealth video sessions can take place either:

- in your home or
- at your local health or medical centre.

If you would like to have sessions in your home you will need the following equipment:

- computer/laptop with microphone, speaker and web camera
- OR an iPad or other tablet device.
- Internet connection with minimum speed of 2MB/second
- enough data on your plan to cover a data consumption rate of approximately 500MB/hour.

Alternatively we can book video conferencing equipment at a local health centre, hospital or participating GPs through local medical centres. We will provide you with all the technical support and assistance you need to successfully use the video conferencing equipment for your appointment.
Before the telehealth video appointment at your home

The parenting clinician will email you a videoconference number for you to connect to Queensland Health’s secure and private telehealth portal.

Check your equipment (webcam and microphone) and let other family members know you will be videoconferencing. It is helpful if other household members reduce their use of the internet during videoconferences as it may impact on the quality of the image on screen. If you and your counselor think it is useful, a partner or your children may join you for part of a session for a holistic approach to understanding the challenges you and your family are experiencing.

Have the computer or tablet in a quiet place where you can have privacy or interruptions are less likely to occur. To maintain your privacy your counselor will be in a private office or clinic room just as if you were there in person.

At a Local Health Centre

If your telehealth video appointment is at a health centre we will organise the telehealth facilities for you and the equipment will be set up and the call made for you by support staff.

Potential technical problems

Technical issues may arise during your video conference appointment and the clinician will assist with resolving these. If you experience any significant technical issues, the session will be completed by the counsellor ringing you on your mobile or home phone.

At any stage you can stop using telehealth and switch to face-to-face appointments if the telehealth video appointment does not suit you. The only exception is the parents accessing telehealth through Mossman Community Health Centre, where telehealth parent counselling is being provided only temporarily as part of this trial and face-to-face appointments are not available at this time. We can assist you in accessing alternative assistance if required.

After the telehealth trial

You will be asked a few brief questions from the clinician about your level of satisfaction and experience of the telehealth parent counselling sessions.

If you have any questions or enquiries about the Telehealth Parent Counselling Trial, you can talk to your local participating Child Health Service or call the project officer Stephanie Golden Cross on (07) 5433 2005 or email her on stephanie.golden@health.qld.gov.au.
Appendix C: Trouble Shooting Guide

Telehealth Parent Counselling Trial

VIDEO SESSION

TROUBLESHOOTING

Audio

Ask client about the audio- Can you hear me? How is the sound quality? Do you notice any delay in sound?

1. Check microphone
   - Is microphone connected properly and turned on? Make sure it’s not muted. Is microphone close enough to person speaking.
   - Ask the client to check the volume on their equipment.
   - Is microphone setting set to the audio equipment i.e. headset or camera.
   - Check audio settings on Jabber.

![Image of computer interface]

2. Check the background noise
   - Is the microphone causing echo or feedback?
   - Is the speaker causing echo or feedback?
   - Is there competing background noise- outside, hallway, paper rustling, other household members etc.

3. Check the volume on computer monitor or audio settings

4. End and re-dial into video session

5. Ring Telehealth help desk 1800 066 888

End video session and ring client on landline/mobile