Southern NSW Local Health District

Quality and competence in video virtual care by allied health professionals in rural settings

Background

Video virtual care has proven benefits for a broad range of allied health interventions, has acceptance by health consumers as a valid means to deliver health services, and has the potential to provide more equitable services to people in rural, regional and remote NSW.

Despite a rapid adoption of video virtual care during COVID-19, the rate of providing video virtual care has, in many cases, declined for allied health.

In order to encourage allied health to provide a service we need to know what a quality service looks like.

Method

This mixed methods study surveyed allied health professionals across rural, regional and remote areas in NSW Health. The survey questions were guided by evidence in the literature and used the Donabedian constructs on quality (Structure, Process, Outcome) as a theoretical basis for defining a quality intervention.

Focus groups were then conducted to gain further insights into the findings of the survey.
The study included 74 survey participants and 8 focus group participants.

The study provides insights into factors that provide a quality experience when conducting video virtual care with clients and what is required for current and future competencies.

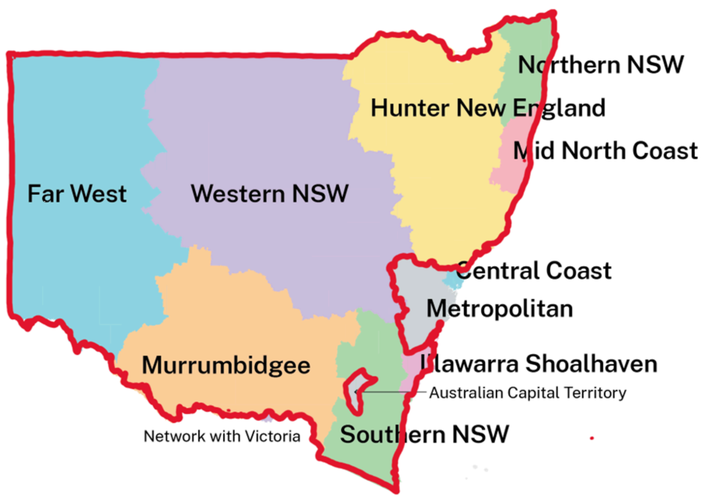


Fig. 1: Rural Local Health Districts included in the study

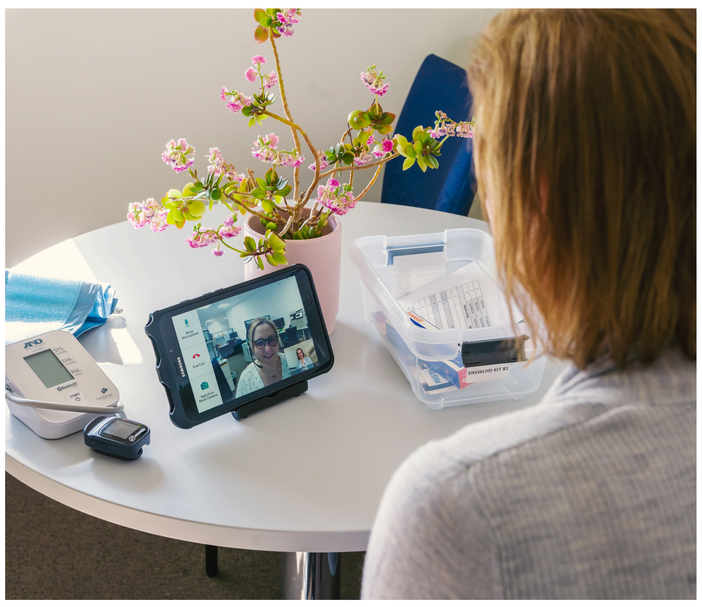


Fig. 2: A consumer participating in a virtual care environment

Results

Structure (assessing the ability to use, safety aspects and establishing set-up)

75% were providing video virtual care in a separate office

A gauge of health literacy of your patients was not conducted by most **(82.4%)** of respondents.

Participants preferred a pre assessment trial run. Where this screening occurred, it assisted to determine appropriateness and risks, or determine whether a face-to-face appointment was more appropriate.

Process (intervention offered including best practice, interventions and tools, creating effective relationships with clients)

Set up and explanation to patients to begin the session was indicated by respondents as a factor that makes their video virtual care session an effective intervention **(67.6%).**

About a third reported that having a set list of things to do on the day and having engaging tools such as games or visual prompts (such as a game sheet, videos, or photos) as a contributing factor to making their video virtual care session an effective intervention.

Best practice was achieved through access and user capability to technology, equipment and the internet (23.8%); using standardised assessments and evidence-based practice (13%); having information or education tools available in paper or visual formats (10.7%); or providing same intervention as at face to face intervention (10.7%).

Over **58.1%** could be said to be ambivalent that they are able to provide best practice video virtual care.

Assessments and resources that are designed or validated for Aboriginal and Torres Strait Islanders or CALD populations were generally not available.

Most clinicians were adjusting tests and outcome measures to suit the video virtual care environment.
The most common adaptation was to miss sections of the test due to safety and other concerns, or use a carer, allied health assistant or nurse to assist, modifying tests to the patients home environment.

Outcome (changes that have occurred as a result of video virtual care, competence)

The top **four factors** that contributed to competence were:

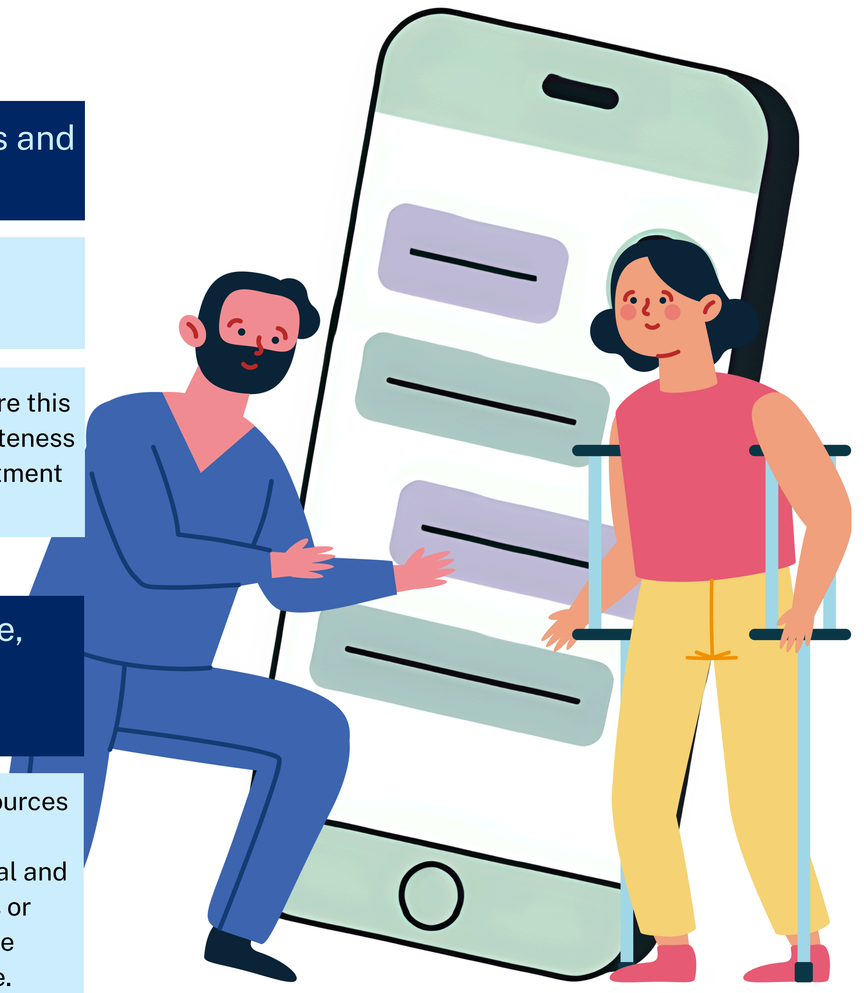
- Having the ability to alternate therapy appointments between virtual and face to face (75.7% of respondents)
- Having a partner/carer or therapy aid in the home to assist in virtual care (60.81% of respondents)
- Providing a pre virtual care home visit for client set up and education on equipment use (44.6% of respondents)
- A guideline or checklist to use for each session (37.8% of respondents).

The focus groups supported this.

Allied health were able to be responsive to the need of individual patients to create a positive patient experience. They were generally positive that they felt their patients were able to progress in their treatment.

Factors that contributed to this positive experience were client engagement and participation (35/112) as well as ability to access the internet and have available technology (34/112).

Two thirds (66.2%) responded that they “did not know” whether assessment tools had been validated to the video virtual care or telehealth environment and 24.3% answered “no” to this question



Conclusion

Overall allied health were positive that they were able to be responsive to individual patients, and positive that their patients were able to progress in their treatment. A dominant theme of the research was that achieving a quality process depended on getting the set up correct before proceeding with video virtual care. Quality was linked to having a pre-assessment trial run and the ability to alternate between video virtual care and face-to-face appointments.

The need for resources that were Easy Read, translated or appropriate for the Aboriginal and Torres Strait Islander people and video virtual care was apparent.

A process to determine health literacy or the general understanding of the participant in order for them to participate in virtual care requires further exploration.

Overall allied health clinicians were not positive that they were providing best practice. Most clinicians were adjusting tests and outcome measures to suit the video virtual care environment. Exploring assessments and interventions validated for the video virtual care environment should form part of future allied health research and quality activities.

The top four factors that contributed to competence were:

- Having the ability to alternate therapy appointments between virtual and face-to-face
- Having a partner/carer or therapy aid in the home to assist in virtual care
- Providing a pre virtual care home visit for client set up and education on equipment use
- A guideline or checklist to use for each session.

Similarly, competence in delivering video virtual care improves by getting the structure or set up of the video virtual care session correct first, leading to competence of the clinician

With thanks to the support of the Health Education and Training Institute (HETI) Rural Research Capacity Building Program.
For further information contact Marcella Levey, Southern NSW Local Health District at Marcella.levey@health.nsw.gov.au