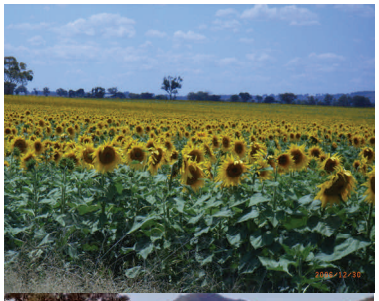





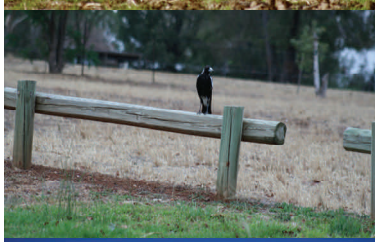


Is using telehealth to deliver a phase 2 Chronic Disease Rehabilitation program (education & exercise components) a feasible, appropriate and acceptable model of care?

HETI HEALTH EDUCATION & TRAINING INSTITUTE

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Aim:

To determine if using telehealth to deliver a phase two Chronic Disease Rehabilitation program (CDR program) incorporating education and exercise components is a feasible, appropriate and acceptable model of care in a rural environment.

Method:

This study involved delivering a standard eight week group based CDR program using videoconferencing services between two sites. Patient participants were chosen who had a post code of 2361 (Ashford) and had a chronic disease and had been admitted to hospital in the past 12 months or who had been referred to a CDR program. Participants attended the programs in Ashford (remote site) while exercise instruction and education were provided from the specialist site of Inverell or Bundarra. Observation logs were completed each week by the researcher on the technical feasibility of using telehealth. Baseline data from both patient and staff participants and responses to questionnaires were distributed at weeks one (beginning of program) and weeks eight (end of program).

Results:

Two groups of four participants were held during the pilot program. Although a third program was planned this was cancelled due to lack of appropriate participants. Acceptability of the program was high, with 100% of patient participants either strongly agreeing or agreeing that the group education and exercise sessions were enjoyable, that they could understand the instructions and key messages given, and that they could see the instructor adequately. All patient participants would prefer to see a health care provider via telehealth rather than travel and all would recommend telehealth to family and friends. The majority agreed (63%) that they would not have travelled to Inverell to participate in a program. Hearing was the biggest issue for patients with 50% unsure that they could clearly hear the clinicians during the program sessions.

The majority of staff participants all strongly agreed, or agreed that they were provided with enough training and felt confident in using telehealth equipment. All staff strongly agreed, or agreed, that patients understood the key messages that were delivered and 75% strongly agreed, or agreed, that the audio and visual quality worked well throughout the sessions.

However, based on observation logs technical problems of varying degrees were encountered in 81% of all sessions. These appeared to be related to the mobile, non-dedicated videoconferencing unit used at the sites, especially at the specialist site which required connecting and disconnecting the unit for each weekly session.

Conclusion:

In this small pilot study, a CDR program delivered by telehealth was acceptable, appropriate and feasible for staff and patients in a rural environment. More detailed troubleshooting guides and resolution of identified technical hurdles need further examination if telehealth is to embraced further in the delivery of group based education programs.

For the full report on this project visit our website, follow the link to the Rural Research Capacity Building Program and click on 'view completed projects'

Belinda Robinson is a Nurse Unit Manager at Inverell Community Health, Hunter New England Health District. She has 20 years' experience working in Community Health and has a special interest in Chronic Disease Rehabilitation.

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