

**Uncovering healthcare staff attitudes to the rapid deployment of telehealth in Victoria,
2020-2021: a 12-month telehealth experience.**

Shannon, M.M., Allied Health Research Translation Lead, Peninsula Health, Monash University
Callum, S.M., Telehealth Project Development Coordinator, Peninsula Health
Callisaya, M.L. Senior Research Fellow, Peninsula Clinical School, Central Clinical School Monash University

Shannon, M.M. study design, data collection, data analysis and interpretation, report writing

Callum, S.M. study design, data collection, data interpretation, report review

Callisaya, M.L. study design, ethics application, data interpretation, report review

Contact Author: Shannon, M.M. Academic Unit, Frankston Hospital, 2 Hastings road, Frankston, Victoria. 0410778504

EMAIL: michelleshannon@phcn.vic.gov.au

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Abstract 250 words

Background

Telehealth was widely adopted in health services during the Covid-19 pandemic. It is unknown what the attitudes and ongoing needs of healthcare staff are after a rapid implementation of telehealth.

Aims

To evaluate staff attitudes to telehealth utilisation after a rapid implementation.

Methods

A health service-wide bespoke survey was sent to all clinicians, managers, and administration staff in June-July 2021. We evaluated attitudes to (i) telehealth application in the model of care and (ii) the barriers and enablers to use of telehealth. Descriptive statistics were used for quantitative data, and content analysis for the textual data.

Results

A hundred and thirty-four respondents completed the survey (response rate =22.5% of healthdirect users (71/315), and =3.2% of total healthcare staff population). Most commonly, telehealth was identified as being important (78%) and safe (79%) by clinicians; important (100%) and encouraged (88%) by managers. In contrast, telehealth was identified as not the same as face-to-face (56%, 50%); but easy to add to usual work arrangements (43%, 44%) by clinicians and managers, respectively. The most common enablers of telehealth were: (i) having others use the same telehealth platform (74.3%, 100%), and (ii) completing training (68.9%, 72.7%) by clinicians and managers, respectively. The most common barriers were having (i) reliable internet connectivity (39.2%, 45.5%) by clinicians and managers respectively, (ii) the right equipment (clinician 37.8%), and (iii) a private area (managers 36.3%).

Conclusions

Despite training and having support from colleagues to implement telehealth, ongoing needs were identified that may promote uptake in specific health settings.

Keywords: telehealth, telemedicine, survey, implementation, health service utilisation

Introduction

The sudden onset of Covid-19 led to a paradigm shift in how healthcare was structured to avoid unnecessary face-to-face healthcare delivery ¹⁻⁴. With future pandemic preparedness in mind ^{2,5}, continuity of telehealth is essential for ongoing viability of use ⁶.

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Telehealth involves clinical assessment, and/or intervention by a health professional to a patient using audio-visual information technologies ^{1,7}. Remote exchange of health information to diagnose and manage disease or injury occurs during telehealth. Telehealth is employed for rural Australian patients to access time-critical healthcare, such as in hyper-acute stroke care ⁸ or for chemotherapy ^{9,10}. Development of telehealth in non-medical healthcare is also building, including exercise programs for brain injury ^{11,12}, cardiac rehabilitation ¹³ and group healthcare information exchange^{7,14}. However, pre-Covid-19, uptake of telehealth across Australia was not widespread. Few people (13%) in remote parts of Queensland accessed telehealth, despite 60% having awareness of it ¹⁵. Also, a third of those eligible (7.5% of out-patients) received telehealth ¹⁶.

Prior to commencing a telehealth service, twelve critical access factors should be addressed, including ‘strong leadership’, ‘engagement of key stakeholders’, and ‘matching of technology to clinical needs’⁷. However, the rapidity with which telehealth was deployed during Covid-19, meant that no time was available to do so ¹⁷. It is therefore timely to assess how the rapid implementation of telehealth has been incorporated into everyday working for future planning.

Our aim was to examine the attitudes of healthcare staff (clinicians, managers, administration and support workers) to rapid telehealth utilisation from 2020-2021. We planned to answer the following research questions:

- (i) How suitable and acceptable is telehealth in clinical practice?
- (ii) How is telehealth operationalised?
- (iii) What are the enablers and barriers to uptake of telehealth and does familiarisation with telehealth expand (or reduce) its utilisation?

Materials and Methods

Study Design

This was a web-based survey conducted with clinicians, managers, administrative and reception staff. Human ethics approval was granted on 24th June 2021 (QA/77155/PH-2021-270446(V2)).

Participants

Health service staff (acute, sub-acute, and ambulatory services, including mental health) were eligible to complete the survey. Recruitment was by service-wide invitation newsletter, fliers, and emails sent out at the end of June 2021. Reminders to consider participation were sent out on two pre-approved dates following initial invitation (July 2021).

Study Location

The survey was conducted at a single tertiary public health service network, Melbourne, Victoria.

Instruments

A bespoke survey was created in Microsoft Forms® by researchers with backgrounds in social work, physiotherapy, and the telehealth project development officer. The survey was designed to capture responses from diverse staff groups. Questions were a mix of free text, check-box, and a 5-point Likert scale (strongly disagree, disagree, unsure, agree, strongly agree). The survey was intended to be not longer than 5 minutes to complete.

The content of the survey questions sought to gather details about the study participants (profession, location where telehealth used), platform used, and appointment types (e.g. new assessment, review, group). The main section questioned the fit of telehealth within their service model, including suitability. A final section asked about operationalisation during Covid-19, and barriers and enablers to use. Staff perspectives were gathered about healthdirect VideoCall® (the primary telehealth platform nominated by the health service), and their perspectives of other telehealth platforms used. Open-ended questions were included to gather further detail about the groups of patients that worked well with telehealth, versus those that did not work so well. The surveys for manager, clinician, and administrative staff can be found in Appendices 1-3.

Analysis

Descriptive statistics were used to summarise responses from categorical data by the three staff groups. We used thematic (content) analysis to sort, code, and develop themes around the open-ended textual survey data about uptake of telehealth. To do this, the textual content was separated into (i) high or (ii) low uptake, and was uploaded to NVivo12® for coding. Immersion in the open-text data (MS, SC) permitted grouping into categories with similar broad concepts (12). Themes (with sub-themes) were developed to encompass grouped categories where this could be done. Then thematic analysis was used to either confirm or refute the quantitative survey findings in a sequential explanatory process¹⁸. Finally, we narratively presented findings according to each healthcare group about how familiarization with telehealth influenced its use.

Results

Of the available healthcare staff (n=4179.4 monthly average) , n=315 of these staff were active registered Health Direct users 26th April-26th June, 2021. Data were collected from 25th June 2021 until the 19th July 2021. Overall, a hundred and thirty-four respondents completed the survey (response rate =22.5% of healthdirect users (71/315), and =3.2% of total healthcare staff population). The results are shown by the healthcare group: (i) clinicians, (ii) managers, and (iii) administrative/clerical staff for each research question. Details about the healthcare groups and settings in which telehealth was utilised can be found in Appendix 4.

(i) How suitable and acceptable is telehealth in clinical practice?

Figure 1. shows the frequency distributions of participants (clinician, manager) who agreed or disagreed with the statements including, whether telehealth was safe for patients, suitable, and easy to add to work arrangements. Administrative staff did not respond to this section.

Clinician

All clinicians (105) responded to this section. The two most common statements identified with suitability and acceptability were that (i) 79% agreed/strongly agreed telehealth was safe for patients, and (ii) 78% agreed/strongly agreed it was important to offer telehealth to patients. In contrast, respondents disagreed/strongly disagreed that telehealth was the same as face-to-face care (56.2%). A third disagreed/strongly disagreed with the statement pertaining to the ease of adding telehealth to usual work arrangements (42.0%) as shown in Figure 1.

If no more Covid-19 restrictions occurred, an equal proportion (43.1%) planned to continue to offer telehealth as those planning to expand its use (43.1%), while fewer (9.5%) planned to reduce its usage.

Figure 1. HERE

Manager

Eight-nine percent (16/18) of managers responded to this section. The two most common factors identified as contributing to suitability and acceptability were (i) importance of offering telehealth to patients (100%), and (ii) managers encouragement of use of telehealth (88% agreed/strongly agreed)(Figure 1). In contrast, 50.0% and 31.1% of managers disagreed or strongly disagreed that their staff can provide the same standard of care by telehealth as in-person care, and that patients can be helped to connect when technical issues arise, respectively.

Most managers planned to continue (38.9%), twenty-eight percent planned to reduce, and the remainder expand (22.2%) telehealth use, if no further social restrictions occur.

(ii) How is telehealth operationalised?

The frequency distributions of participants who agreed or disagreed with the statements about operationalisation are shown in Figure 2.

Clinician

The result was calculated from the count of clinicians who responded in the affirmative (74/105) when asked about whether they had utilised the nominated telehealth platform (healthdirect VideoCall®). The remainder stated that they did not use this telehealth platform with 41.6% (15/36) utilising 'WebEx', 55.6% (20/36) 'Zoom', 13.9% (5/36) 'Skype'/'Facetime', and 5.6% (2/36) telephone. Further textual information about the reasons why

they preferred to utilise telehealth platforms other than healthdirect VideoCall® are presented in Appendix 5.

Figure 2. HERE

The two most common enablers of telehealth that clinicians identified (agreed/strongly agreed) were having (i) their colleagues use the same telehealth platform (74.3%), and having (ii) training available (68.9%) . On the other hand, the two most commonly identified barriers clinicians identified (disagreed or strongly disagreed) were having (i) access to a reliable internet connection (39.2%), and (ii) the right equipment (37.8%).

Manager

This result was calculated from the total count of 11/18 (61.1%) managers who reported their staff were utilising telehealth.

The two most common enablers of telehealth that managers identified (agreed or strongly agreed) were having (i) staff encouraged to use telehealth (100%) and (ii) staff training available (72.7%). In contrast, the two most commonly identified barriers managers (disagreed or strongly disagreed) were (i) reliability of the internet (45.5%), and (ii) access to a private area (36.4%).

Administrative staff

55.6% (5/9) of administrative staff responded that they used telehealth.

Figure 3. HERE

Figure 3 shows that the two most common enablers of telehealth for administrative staff (agreed or strongly agreed) were (i) access to technical support (80%), and (ii) the right equipment (60%). While in contrast, the two most common barriers (disagreed or strongly disagreed), were (i) access to a private area (60%), and (ii) all other remaining statements were equal (20%).

(iii) What are the enablers and barriers to uptake of telehealth?

Five main overarching qualitative themes were found. These themes were: (i) Familiarity and Infrastructure critical to technology uptake, (ii) Determining telehealth eligibility, (iii) Age of the telehealth consumer influences use, (iv) Cognitive or Communication impairment limits interacting with telehealth, and (v) Having a support person can help, or can impact privacy (Figure 4).

Figure 4 HERE

i) This theme describes how patients must have access to *devices* and *internet connectivity* (30 references), and be *familiar with its use* (21 references). Patients needed sufficient internet data and personal computing devices to support telehealth. Further, patient skill in accessing the telehealth platform is vital, otherwise staff reverted to telephone use. For example, lower uptake was shown by:

“Those with limited access to technology or ability to use technology in this way”.

Conversely, respondents described how having access to devices/data (7 references) and familiarity with technology (15 references) supported telehealth, for example,

“Those with smart devices, good internet connectivity. Ability to troubleshoot issues and not be overwhelmed”.

The qualitative findings converge with the survey quantitative results (disagreed/strongly disagreed) that when staff are unable to help patients connect when technical difficulties occur, telehealth is perceived as not suitable.

(ii) This theme illustrates the patient-staff therapeutic interactions that either benefitted from (40 references), or were hindered by (23 references), telehealth. Provided healthcare staff had established a rapport with their patients, then often patient reviews, or pre-discharge visits could be conducted via telehealth. Group education was more flexible for childbirth, or when structured with supplemental activity packs through telehealth. An example of higher uptake was shown by:

“Once families were familiar with the concerns, and the home programme, most were happy to continue telehealth reviews with a face to face r/v further down the track and definitely prior to D/C”.

However, many respondents illustrated how telehealth was not the same as face-to-face contact (14 references clinicians, 3 references managers). If physical examination was needed e.g. assessing an airway pre-surgery or measuring limb spasticity, then telehealth could not be utilised.

The qualitative findings provide otherwise unknown information about why patient reviews are most commonly identified as suitable for telehealth by clinicians and managers.

(iii) Lower telehealth uptake was reported for older patients (24 references), or where the patient was a young child (10 references). The older age group was perceived as less likely to have access to suitable technology and to have a lower digital literacy as illustrated below:

“Many elderly patients are not set up for video calls and struggle with the technology/logging on; others without a laptop or computer use their mobile which often have less video features...”

Higher uptake of telehealth was described for those patients who were of working age (24 references). This age group was perceived to have digital access and literacy, as well as being more likely to engage in telehealth.

iv) This theme (20 references) refers to lower uptake when nuanced or sensitive communication issues require navigation such as breaking bad news, or the escalation of risk to a patient with family violence. Furthermore, lower uptake occurred with patient sensory, cognitive, or language factors. For example: *“acutely mentally unwell clients with significant level of distress...clients who experience delusional ideas of reference regarding the Internet and/or electronic devices even if they are not currently acutely unwell”*.

(v) This theme (8 references) refers to the social and familial supports perceived important when connecting patients with telehealth e.g., *“if a client has a support person to assist this worked well as could move the camera about to see different thing- walking, ability to stand from a chair”*.

Lower telehealth uptake was described (11 references) when a support person was not present, that went beyond access to devices/data. For example, “*Clients in supported accommodation with changing support workers*”. Concerns were raised by respondents with patient privacy, and poor and/or coercive social and familial relationships when a support person was present.

(iii)-(v) These qualitative findings provide new insights about latent factors to be considered for patients needing to access telehealth.

iii) Familiarisation with telehealth – staff perceptions and attitudes

The narrative summary for the three clinician groups is presented in Appendix 6. In brief, familiarity with telehealth meant that uptake was unchanged in clinicians (50%) and managers (20%), while telehealth usage was increased in clinicians and managers (42.3%, 80%, respectively).

Discussion

Our study provides comprehensive information on the attitudes of > 100 healthcare staff (both clinical and non-clinical). In contrast, prior studies have examined the perspectives of small numbers of patients towards telehealth in, for example, gestational diabetes¹⁹, cancer¹⁰, or in community-dwelling healthcare consumers¹⁵. Furthermore, single healthcare disciplines using telehealth have been examined, e.g. geriatrician or memory clinics²⁰, cancer care⁹, or haematology²¹.

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Firstly, our results showed that telehealth can fit with usual clinical practices (in ambulatory community settings), when therapeutic rapport has been established i.e., reviews, pre-discharge planning, or for educational interactions. Reassuringly, many clinicians (40-50%) and managers (39-60%) in these settings planned to continue or to increase their utilisation of telehealth if no more virus outbreaks occur. Both managers and clinicians identified that telehealth was safe for patients and important during pandemic conditions.

However, for continued telehealth usage it seems that other factors need to be consistently working well. Only forty percent of clinicians (and managers) identified strongly that telehealth is easy to embed in usual work arrangements. Our findings point to ongoing concerns about being able to connect patients to telehealth, and to making decisions that telehealth is not suitable. In agreement with others, telehealth cannot replace face-to-face interactions, when physical examination is required^{20,21}, or when vulnerable patients are at risk. There were very few respondents in our study working in inpatient care to be able to assess how telehealth was perceived in acute hospital wards.

Healthcare staff, primarily clinicians, are now making decisions about eligibility of patients for telehealth. Our qualitative findings showed that staff use a range of patient factors (age, cognition, infrastructure availability) to assess if telehealth can be employed with patients. This finding has not previously been identified in other research, where specific patient groups have been studied. In non-pandemic situations, it may be worthy to pursue a hybrid approach also recommended by Callisaya, Lee²⁰, whereby non-complex, reviews can avail of telehealth. Thus, patients with no support person, or with little familiarity with devices/internet connectivity, could continue to be offered in-person consultations. The

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success of telemonitoring for appropriately selected self-management in hypertensive patients²², and a personalised e-health system²³ points to research-informed digital solutions that must now be re-visited to obviate unnecessary in-person clinic attendance⁴. For example, vital sign sensors with patient-specific thresholds set were deployed in one study to activate a remote-monitoring telecommunications system in minor stroke, which allowed patients to be supported at home with no serious complications²³.

Secondly, we sought to explore the barriers and enablers to the uptake of telehealth, shedding light on what staff think about the twelve critical factors previously identified by the Victorian Department of Health and Human Services⁷. Technology factors (infrastructure, technical support) were confirmed by most participants, supporting the guidelines. These factors can be enablers or barriers if not delivered optimally. Lack of optimal infrastructure could mean that telehealth was impossible, as was highlighted for older people, people with cognitive impairment, or with young children. Difficulty of gaining access to healthcare when telehealth infrastructure is limited has been raised in other conditions such the glycaemic control of pregnant women¹⁹, and in people accessing geriatrician clinics²⁰. For example, geriatricians reported the necessity of ‘being prepared’, ‘selecting telehealth-appropriate care’ e.g. rationalising medications, and using ‘additional communication strategies’ with telehealth²⁰. Wade, Elliott²⁴ have argued following their qualitative synthesis and modelling study (36 clinicians) that clinician acceptance explains much of the variance of telehealth use. Staff having confidence with internet reliability was the only factor highlighted in another study¹⁹.

The social desirability of using telehealth was evident in our results. Half of clinicians (53%) identified having management support for, as well as potentially seeing (or knowing) their

colleagues were utilising (74%), telehealth. These findings, in conjunction with most managers (77%) reporting their encouragement of staff to utilise telehealth, suggest that building telehealth into everyday work tasks can be influenced by social norms. This is new information that may underpin the role of leadership in driving forwards a digital solution to ongoing healthcare. Social factors, including cultural and organisational, are important for building technology acceptance ²⁵. We also speculate that survey respondents may have been influenced by the necessity to be able to continue working, and contribute to patient care, in a pandemic when other options were much reduced as discussed by Fisk, Livingstone ⁴.

Limitations

There are limitations that must be acknowledged with this study. We were unable to obtain information on non-responders so we cannot comment on the level of responder bias.

Although there were many healthdirect Video Call® registered users, not all of these completed the survey. The roll-out of the telehealth survey occurred at the same time as a hospital-wide employee satisfaction survey. Interviewing of healthcare staff was not done, which might have provided more rich information about how continuous telehealth use influenced uptake.

Conclusions

Telehealth as a modality for vital healthcare provider-patient contact has wide regard in community and ambulatory care, when familiarity and infrastructure is present. Opportunities to continue telehealth utilisation beyond pandemic conditions exist once eligibility can be determined, and with infrastructure, familiarity, and social support deployed. When planning for future use of telehealth targeted use of telehealth for key patient groups is now timely.

REFERENCES

1. Monaghesh E, Hajizadeh A. The role of telehealth during COVID-19 outbreak: a systematic review based on current evidence. *BMC public health* 2020;20:1193.
2. Furlanis G, Ajcevic M, Naccarato M, et al. e-Health vs COVID-19: home patient telemonitoring to maintain TIA continuum of care. *Neurol Sci* 2020;41:2023-4.
3. Dhamija S. DURING COVID-19 HOSPITALIST STAFFING SHORTAGES: AN INITIAL PILOT MODEL AND QUALITATIVE STUDY. *Physician Leadership Journal* 2020;47-55.
4. Fisk M, Livingstone A, Pit SW. Telehealth in the Context of COVID-19: Changing Perspectives in Australia, the United Kingdom, and the United States. *J Med Internet Res* 2020;22:e19264.
5. Sirleaf EJ, Clark H. Report of the Independent Panel for Pandemic Preparedness and Response: making COVID-19 the last pandemic. *The Lancet* 2021;398:101-3.
6. Duckett S. Continuity is key to keeping telehealth viable. <https://grattaneduau/news/continuity-is-key-to-keeping-telehealth-viable/>: The Grattan Institute; 2020.
7. DHHS DoHaHS. Critical success factors:how to establish a successful telehealth service. 1 Treasury Place, Melbourne 2015.
8. Bladin CF, Kim J, Bagot KL, et al. Improving acute stroke care in regional hospitals: clinical evaluation of the Victorian Stroke Telemedicine program. *Med J Aust* 2020;212:371-7.
9. Sabesan S, Simcox K, Marr I. Medical oncology clinics through videoconferencing: an acceptable telehealth model for rural patients and health workers. *Intern Med J* 2012;42:780-5.
10. Sabesan S, Kelly J, Evans R, Larkins S. A tele-oncology model replacing face-to-face specialist cancer care: perspectives of patients in North Queensland. *Journal of telemedicine and telecare* 2014;20:207-11.
11. Ramage ER, Fini N, Lynch EA, et al. Look Before You Leap: Interventions Supervised via Telehealth Involving Activities in Weight-Bearing or Standing Positions for People After Stroke—A Scoping Review. *Physical Therapy* 2021;101.
12. Beare B, Doogan CE, Douglass-Kirk P, Leff AP, Ward N. Neuro-Rehabilitation OnLine (N-ROL): description and evaluation of a group-based telerehabilitation programme for acquired brain injury. *J Neurol Neurosurg Psychiatry* 2021.
13. Keteyian SJ, Grimshaw C, Brawner CA, et al. A Comparison of Exercise Intensity in Hybrid Versus Standard Phase Two Cardiac Rehabilitation. *J Cardiopulm Rehabil Prev* 2021;41:19-22.
14. Banbury A, Parkinson L, Nancarrow S, Dart J, Gray LC, Buckley J. Delivering patient education by group videoconferencing into the home: Lessons learnt from the Telehealth Literacy Project. *Journal of telemedicine and telecare* 2016;22:483-8.
15. Bradford NK, Caffery LJ, Smith AC. Awareness, experiences and perceptions of telehealth in a rural Queensland community. *BMC Health Serv Res* 2015;15:427.
16. Caffery LJ, Taylor M, Lucas K, Smith AC. Substitution rates of video consultations for traditional consultations at a tertiary public hospital. *Journal of telemedicine and telecare* 2016;22:453-8.
17. Snoswell CL, Caffery LJ, Haydon HM, Thomas EE, Smith AC. Telehealth uptake in general practice as a result of the coronavirus (COVID-19) pandemic. *Australian health review : a publication of the Australian Hospital Association* 2020;44:737-40.
18. Feters MD, Curry, Creswell JW. Achieving integration in mixed methods designs—principles and practices. 2013.

19. Rasekaba T, Nightingale H, Furler J, Lim WK, Triay J, Blackberry I. Women, clinician and IT staff perspectives on telehealth for enhanced gestational diabetes mellitus management in an Australian rural/regional setting. *Rural Remote Health* 2021;21:5983.
20. Callisaya ML, Lee AH, Khushu A. Rapid implementation of telehealth in geriatric outpatient clinics due to COVID-19. *Intern Med J* 2021;51:1151-5.
21. Primholdt Christensen N, Skou KE, Boe Danbjorg D. Health Care Professionals' Experiences With the Use of Video Consultation: Qualitative Study. *JMIR Form Res* 2021;5:e27094.
22. McManus RJ, Mant J, Bray EP, et al. Telemonitoring and self-management in the control of hypertension (TASMINH2): a randomised controlled trial. *The Lancet* 2010;376:163-72.
23. Ajcevic M, Furlanis G, Naccarato M, et al. e-Health solution for home patient telemonitoring in early post-acute TIA/Minor stroke during COVID-19 pandemic. *International journal of medical informatics* 2021;152:104442.
24. Wade VA, Elliott JA, Hiller JE. Clinician Acceptance is the Key Factor for Sustainable Telehealth Services. *Qualitative Health Research* 2014;24:682-94.
25. Taylor A. Healthcare Technology in Context: Lessons for telehealth in the age of Covid-19. Flinders University, South Australia, Australia: Palgrave, MacMillan; 2021.

Figure Legends

Figure 1.

Attitudes of clinicians and managers to acceptability and suitability of telehealth for clinical practice. Note: "M"=Manager, n=16 responses "C"=Clinician, n=105 responses"(note: F2F= face-to-face consultation; DoNotAttends=patients scheduled for consultation who do not attend.

Figure 2.

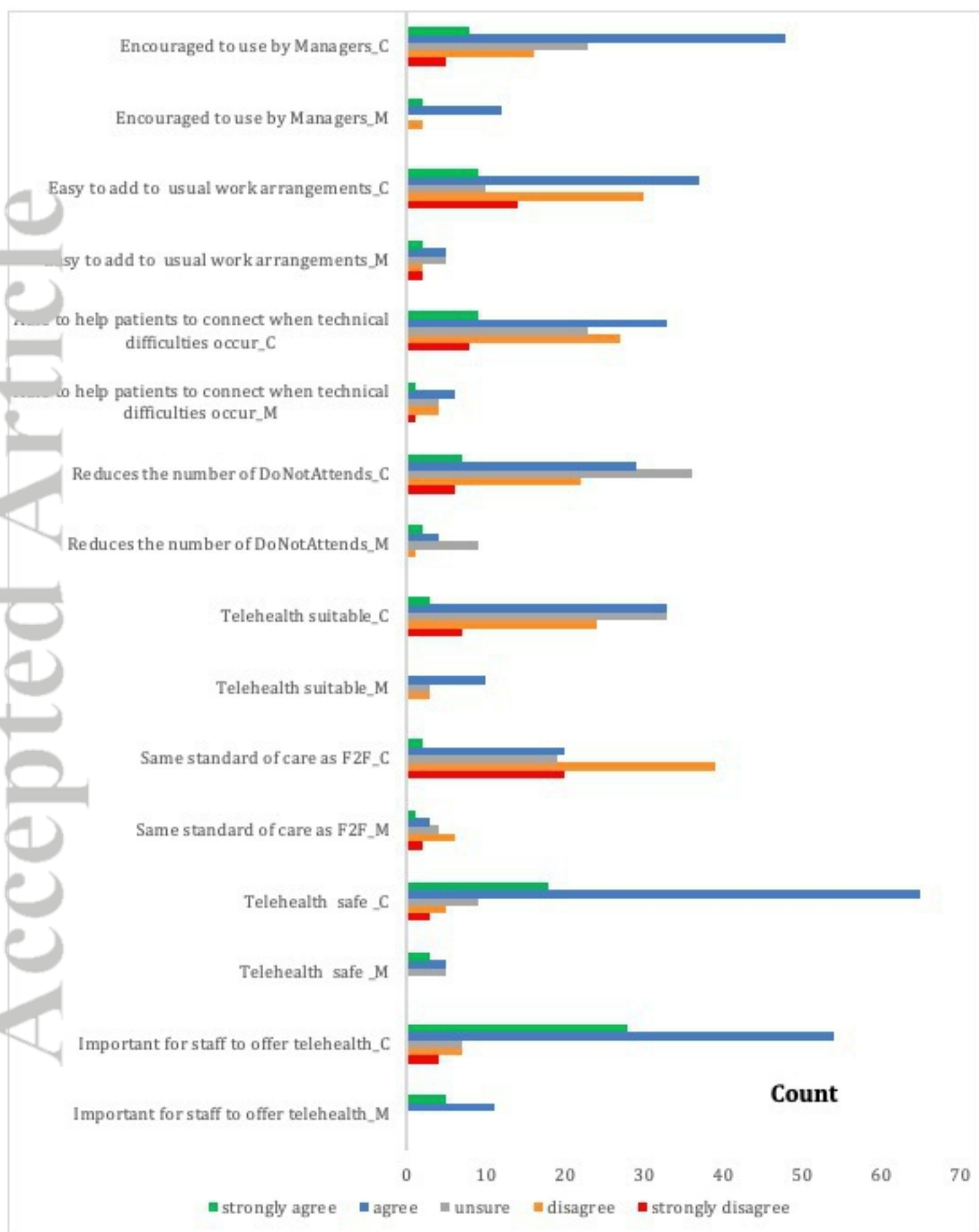
Figure 2. Attitudes of clinicians and managers to enablers of operationalisation of telehealth
Note: "M"=Manager, n=11 responses, "C"=Clinician, n=74 responses

Figure 3.

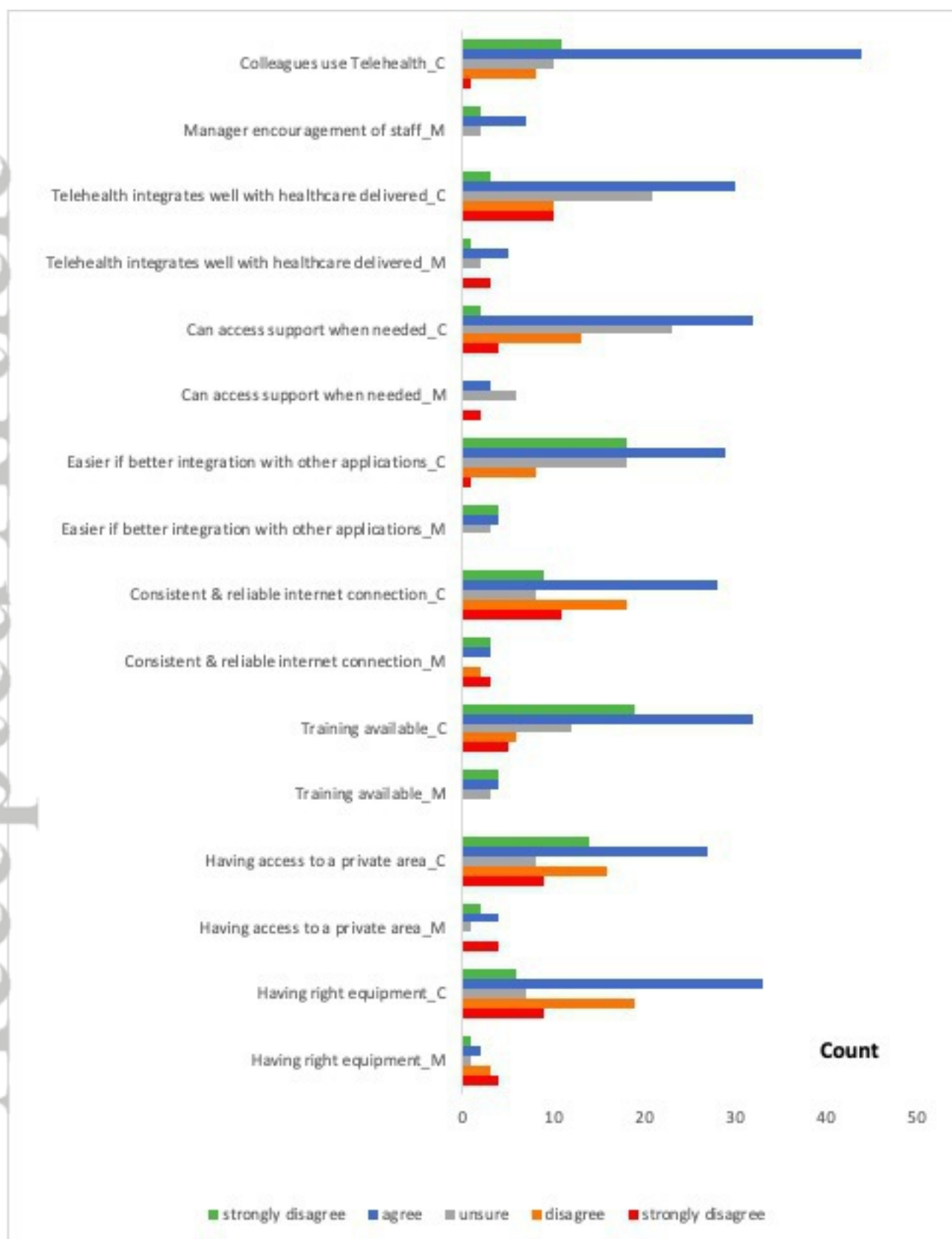
Figure 3. Administration/Reception staff attitudes to enablers of operationalisation of telehealth. n=5 responses

Figure 4.

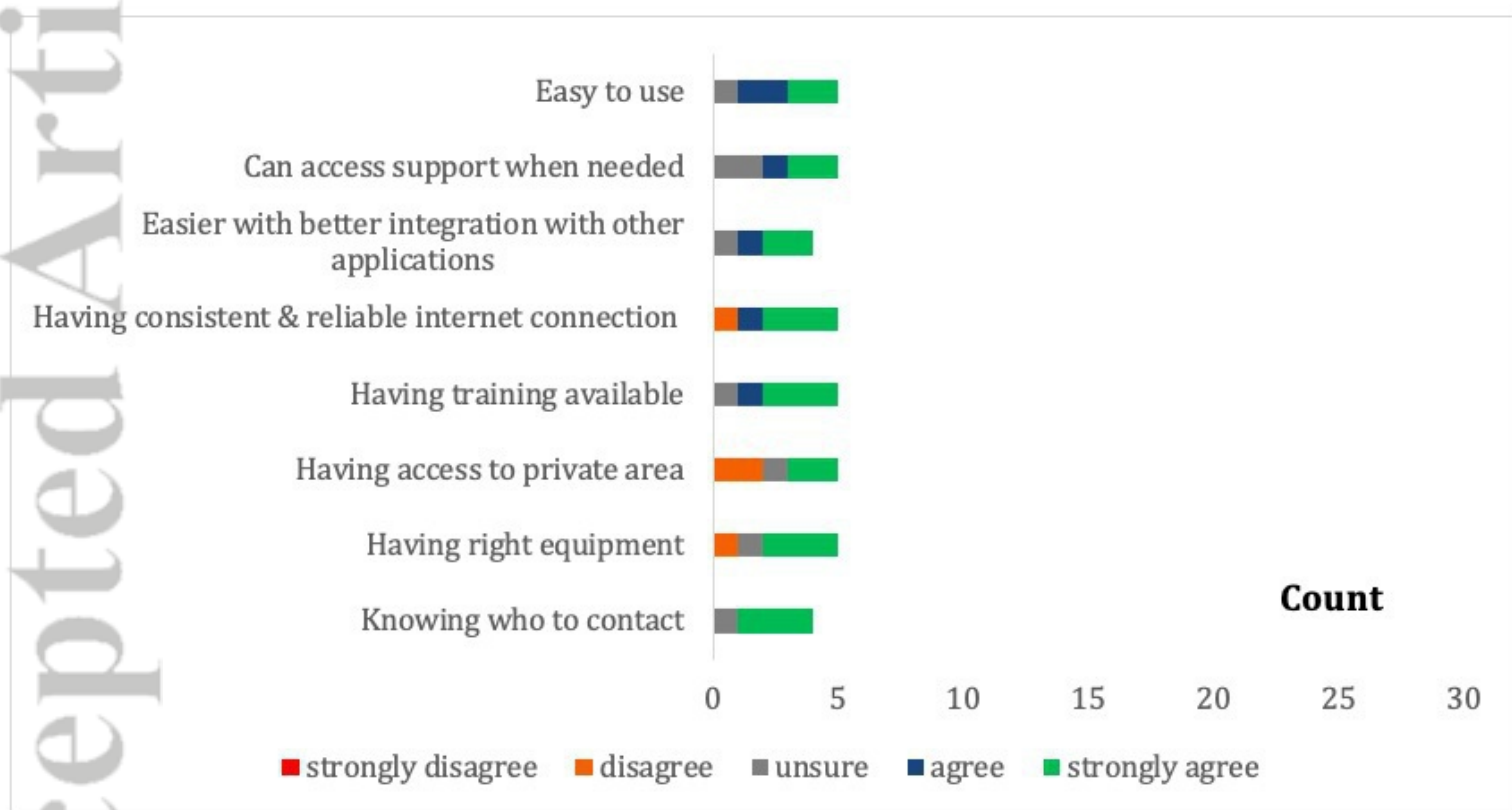
Qualitative analysis- lower and higher uptake of telehealth



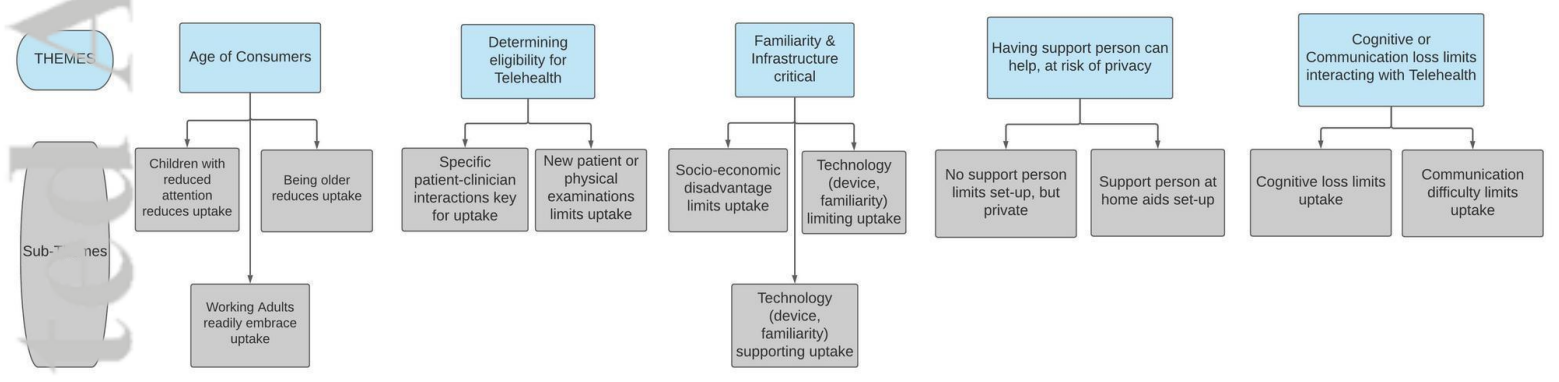
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