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ORIGINAL RESEARCH

Implementation of telehealth primary health care services in a rural Aboriginal Community-Controlled Health Organisation during the COVID-19 pandemic: a mixed-methods study

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ABSTRACT:

Introduction: Globally, primary care organisations responded rapidly to COVID-19 physical distancing requirements through the adoption of telehealth to maintain the delivery of health care to communities. In Australia, temporary Medicare Benefits Schedule (MBS) telehealth items were introduced in March 2020 to enable the provision of telehealth services in the primary care setting. These changes included funding for two modes of telehealth delivery: videoconferencing and telephone consultations. As primary care organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) rapidly adopted telehealth consultations to maintain the delivery of primary care services to Aboriginal and Torres Strait Islander clients. The aim of the present study was to evaluate the implementation (specifically the uptake, acceptability and requirements for delivery) of telehealth primary healthcare services for Aboriginal and/or Torres Strait Islander peoples by a rural ACCHO during COVID-19.

Methods: A single-site convergent–parallel mixed–methods study was undertaken in the context of an ongoing research partnership established between a rural ACCHO and a university department of rural health. De-identified health service data from March 2020 to March 2021 was extracted, including MBS telehealth consultations and client demographics (eg age, gender and postcode). Variables were analysed using descriptive statistics to examine the uptake of telehealth by Aboriginal and Torres Strait Islander clients. A geographical analysis of postcode data was also undertaken. Semi-structured interviews were undertaken concurrently with a purposive sample of health service personnel (including health professionals) involved in the implementation or delivery of telehealth, and Aboriginal and/or Torres Strait Islander clients who had accessed telehealth, to explore the acceptability of telehealth and requirements for delivery. Thematic analysis using an inductive approach was undertaken. The analyses of quantitative and qualitative findings were merged to identify key concepts pertaining to the uptake, acceptability and requirements for telehealth delivery.

Results: During the first year of implementation, 435 telehealth primary healthcare consultations were delivered to Aboriginal and/or Torres Strait Islander clients. Seven health personnel and six Aboriginal and/or Torres Strait Islander clients participated in interviews. Merged findings from an analysis of quantitative and qualitative data were grouped under three concepts: uptake of telehealth consultations by Aboriginal and Torres Strait Islander clients, maintaining the delivery of ACCHO services during COVID-19, and implications for sustaining telehealth in an ACCHO. Findings identified that telehealth maintained the delivery of ACCHO services to Aboriginal and/or Torres Strait Islander clients across the lifespan during COVID-19, despite a preference for face-to-face consultations. A greater uptake of telephone consultations compared to videoconferencing was identified. Barriers to the utilisation of videoconferencing were largely technology related, highlighting the need for additional support for clients.

Conclusion: Telehealth was a useful addition to face-to-face consultations when used in the appropriate context such as the administration of long-term medication prescriptions by a GP. Engaging the ACCHO sector in the policy discourse around telehealth is imperative for identifying requirements for ongoing implementation.

Keywords:

Aboriginal Community Controlled Health Organisation, Australia, rural health services, telehealth.

FULL ARTICLE:

Introduction

Aboriginal Community Controlled Health Organisations (ACCHOs), like other primary care organisations in Australia and internationally, were required to respond rapidly to physical distancing requirements during the COVID-19 pandemic[1,2]. A key component of the response was the adoption of telehealth to continue meeting the healthcare needs of Aboriginal and Torres Strait Islander Peoples[1]. Temporary changes to the Medicare Benefits Schedule (MBS) item numbers (the funding structure of Medicare, the Australian universal healthcare system) accommodated for telehealth delivery using both videoconferencing and telephone[3], which provided ACCHOs with additional options to engage Aboriginal and Torres Strait Islander clients through COVID-19.

In Australia, over 140 ACCHOs are located geographically proximal to where Aboriginal and Torres Strait Islander Peoples reside[4]. Further, ACCHOs are valued for the provision of culturally appropriate holistic primary health care and are well positioned to address barriers to accessing health care (eg racism, transport, cultural needs)[5]. As approximately 44% of Aboriginal and Torres Strait Islander Peoples reside in Inner and Outer Regional Areas of Australia[6] (encompassing Modified Monash category (MM) 2–Regional centres to MM 5–Small rural towns)[7], ACCHOs located in these areas are particularly important to the delivery of primary healthcare services to Aboriginal and Torres Strait Islander Peoples who also experience additional barriers to accessing health care attributed to the rural context (eg geographical accessibility of services, availability of health professionals and other resources)[8].

While telehealth is not a novel intervention, COVID-19 proved to be a catalyst for the rapid and widespread adoption of telehealth in ACCHOs across Australia[2]. Literature examining the implementation of telehealth prior to COVID-19 has been largely focused on the delivery of specialist telehealth services to Aboriginal and Torres Strait Islander Peoples[9] and to people residing in rural areas[10]. There has been little examination of the delivery of telehealth primary healthcare services to Aboriginal and Torres Strait Islander Peoples residing in rural areas, including the acceptability of telehealth[11]. Evaluating this is important to informing policy and practice around the implementation of telehealth in this

setting and in other primary care organisations, particularly for populations who otherwise experience geographical inequities when accessing health care. This study meets the need for evaluating telehealth primary healthcare services delivered for Aboriginal and Torres Strait Islander Peoples by a rural ACCHO during COVID-19.

The aim of this study was to evaluate the implementation (specifically the uptake, acceptability and requirements for delivery) of telehealth primary healthcare services to Aboriginal and/or Torres Strait Islander Peoples by a rural ACCHO during COVID-19. The study examined three key evaluation questions: 'What was the uptake of telehealth consultations by Aboriginal and/or Torres Strait Islander clients of a rural ACCHO?', 'Was telehealth an acceptable model of service delivery from the perspectives of health service personnel and Aboriginal and/or Torres Strait Islander clients?' and 'What were the requirements for the ongoing delivery of telehealth in a rural ACCHO?'

Methods

Study design and setting

A convergent–parallel mixed-methods study design[12] using a community-based approach (see Appendix I under Methodologies) was used to undertake the evaluation over a period of 20 months to capture different stages of implementation and impacts of policy changes (Fig1). This involved collecting quantitative data and qualitative interview data concurrently, undertaking respective analysis and converging the interpretation of findings[12]. Like other ACCHOs, telehealth was not utilised for standard GP appointments at this ACCHO prior to COVID-19[13].

The study was undertaken at a single site in the context of an ongoing research partnership established between a rural ACCHO (located in Halls Gap, Victoria; Modified Monash Model 5–Small rural town where 6.6% of the Victorian population reside)[7,14], Budja Budja Aboriginal Co-operative (BBAC) and Deakin Rural Health (DRH, a university department of rural health funded by the Rural Health Multi-Disciplinary Training (RHMT) program)[15]. In Australia, the RHMT program supports the training of rural health students and a research agenda specific to the rural context, which includes the health and wellbeing of Aboriginal and Torres Strait Islander Peoples[16]. The purpose of the ongoing partnership is to evaluate the implementation of new models of care for Aboriginal and Torres Strait Islander Peoples in the BBAC service area and to identify opportunities for improving service delivery[17]. The partnership was developed from 2018 with the implementation and evaluation of a community-developed model of primary healthcare service delivery, the Tulku wan Wininn mobile clinic[18,19].

The study was reported using the CONSolIDated critERia for strengthening the reporting of health research involving Indigenous Peoples (CONSIDER) statement (Appendix I)[20] for transparency of the ethical and cultural approaches used to undertake the research – an approach used by other research undertaken in partnership with a rural ACCHO[21].

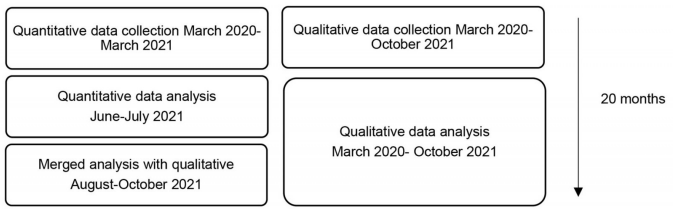


Figure 1: Convergent–parallel mixed-methods study design.

Participants and recruitment

Quantitative data: Service-level data eligible to be included were telehealth consultations undertaken at BBAC from March 2020 to March 2021 with Aboriginal and/or Torres Strait Islander clients. Eligible MBS telehealth item numbers included GP and non-GP services used by BBAC (Appendix II). Non-Indigenous telehealth consultations were excluded. Consultations meeting the eligibility criteria were identified by BBAC using Pen CS Clinical Audit Tool (PEN CAT) and Medical Director (see Appendix I under Relationships).

Qualitative data: Purposive sampling was used to identify health service personnel (including health professionals) involved in the implementation of telehealth services at BBAC who were directly invited by external DRH researchers to participate in a semi-structured interview. External DRH researchers had prior rapport with most health service personnel due to the nature of the ongoing collaborative partnership between DRH and BBAC[17]. A mutually convenient time for an interview was arranged. A plain language statement was provided after an interview time was booked. Informed written consent was then obtained prior to the interview.

Purposive sampling was also used to identify Aboriginal and/or Torres Strait Islander adult clients (aged 18 years or more) who had accessed primary healthcare services using telehealth through BBAC during COVID-19. Non-Indigenous clients who had accessed telehealth services were excluded. Recruitment was initially managed by BBAC as per the principles of data sovereignty and client confidentiality (see Appendix I). A letter of invitation was mailed to Aboriginal and/or Torres Strait Islander clients by a BBAC staff member, and they were then identified by the BBAC Practice Manager as having accessed telehealth services between March 2020 and March 2021. The letter detailed information about the study, including what participation would involve. For clients interested in participating in this study, permission was obtained from clients by BBAC to pass contact details on to external researchers. A mutually convenient time for an

interview, undertaken either by telephone or Zoom (as allowed by COVID-19 lockdown restrictions at the time) was arranged where a plain language statement was provided. Informed written consent was then obtained prior to the interview. Participants were reimbursed for their time with a voucher.

Data collection

Quantitative data: Health-service-level consultation data from 17 March 2020 to 31 March 2021 were extracted manually from PEN CAT and Medical Director using the report function by a BBAC-nominated person, as per the principles of data sovereignty and governance (see Appendix I)[22]. Data were de-identified by a BBAC-nominated person. De-identified consultation data (age, gender, MBS item number and postcode) were provided to external researchers from DRH in a spreadsheet for analysis in accordance with the evaluation plan.

Qualitative data: Semi-structured interviews were undertaken from March 2020 to October 2021, to capture the different stages of implementation in parallel with the collection and analysis of health-service-level data. Interviews were conducted remotely using videoconferencing and telephone to comply with COVID-19 physical distancing restrictions. Two topic guides were developed: one for health service personnel and the other for clients (Appendix III). Questions explored the experience of participants in either implementing, delivering or accessing telehealth primary healthcare services and the perceived acceptability of telehealth for the delivery of health care. Two researchers, one of whom is Aboriginal, who both had experience in qualitative data collection, conducted the interviews. The mean duration of interviews was 33 minutes for health service personnel and 14 minutes for clients. Researchers undertaking the interviews participated in a debrief following the interviews to discuss emerging ideas and to critically reflect on the interviews using reflexive practice, which also considered the positioning of researchers and their relationship with participants[23].

Data analysis

Quantitative data: Descriptive analyses of de-identified health-service-level data were undertaken in Microsoft Excel, with frequency distributions, proportions, ranges, medians and interquartile ranges generated where appropriate at the aggregate level to identify consultation uptake. Summaries were visually presented in the form of graphs and tables. Consultation frequency by postcode, overlaid with the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) data (deciles relative to the Australian population)[24], were mapped. This analysis included proximity to the BBAC fixed clinic, with data displayed geographically using ArcGIS map ArcMap v10.6.1 (ESRI; https://www.esri.com/arcgis-blog/products/arcgis-enterprise/announcements/whats-new-in-arcgis-enterprise-10-6-1).

Qualitative data: All interviews were audio-recorded and transcribed verbatim. A copy of transcripts was provided to participants for member checking. Transcripts were imported into NVivo v12 Plus (Lumivero; https://lumivero.com/products/nvivo) for analysis. The same two researchers involved in collecting the data also thematically analysed the data[25]. This involved inductive first-cycle open coding, which was undertaken independently and focused on the acceptability of telehealth and requirements for implementation[26]. Codes and categories were then compared and merged to form a coding framework. Second-cycle coding utilised more focused coding[26]. Themes were then developed from the refined coding framework.

Convergent analysis: Qualitative themes were then mapped to findings from the quantitative analysis, and key concepts were developed. Findings were provided to BBAC in the form of an internal evaluation report and to clients, who participated in an interview in the form of a plain language summary.

Ethics approval

Human research ethics approval was provided by the Deakin University Human Research Ethics Committee (Protocol 2019-432). A letter of support for the research was provided by BBAC as part of the ethics process.

Results

Three concepts that met the study objectives were developed from an interpretation of the quantitative and qualitative findings: uptake of telehealth consultations by Aboriginal and Torres Strait Islander clients, maintaining the delivery of ACCHO services during COVID-19, and implications for sustaining telehealth in an ACCHO.

From March 2020 to March 2021, BBAC delivered 435 telehealth primary healthcare consultations to Aboriginal and/or Torres Strait Islander clients, either by telephone or videoconferencing, across the Northern Grampians and Ararat regions of Victoria, Australia. Seven health service personnel and six Aboriginal and/or Torres Strait Islander clients participated in interviews, with three interviews repeated with clients (nine total client interviews) at different time points of the study (Table 1).

Table 1: Interview participants

Participants	Gender (female) (*n* (%))	Number of interviews	Mean duration (minutes)
Health service personnel (*n*=7)	6 (86)	7	33
Aboriginal and/or Torres Strait Islander clients (*n*=6)	3 (50)	9	14

1. Uptake of telehealth consultations by Aboriginal and Torres Strait Islander clients

Of all clinic consultations delivered to Aboriginal and Torres Strait Islander clients during this period (*n*=1107, a number

that includes face-to-face consultations), 39% (*n*=435) were telehealth consultations. Of all telehealth consultations delivered, the majority were conducted using the telephone (*n*=408, 94%), rather than videoconferencing (*n*=27, 6%) (Table 2).

Utilisation of telehealth consultations peaked in May 2020, when 75% (*n*=75) of all Aboriginal and Torres Strait Islander client consultations (*n*=100) were delivered using either telephone or videoconferencing (Fig1), aligning with the Victorian statewide COVID-19 lockdown during this period. From June 2020 to March 2021, the proportion of telehealth consultations fluctuated, ranging from 25% to 53% of total consultations delivered to Aboriginal and Torres Strait Islander clients.

A greater uptake of telephone consultations when compared to videoconferencing was supported by results in the qualitative theme 'client utilisation of telehealth services'. Health service personnel identified that the uptake of telehealth in general was slow in the first few weeks of implementation due to a general fear in the community pertaining to COVID-19 at this time, and gradually increased in subsequent weeks. The uptake of telehealth was attributed to the ability for clients and health service personnel to quickly adapt to lockdown conditions and changes in health service delivery:

> *So, I think that it's been quite a progression because when it [COVID-19] first started it was like, services dropped off, nobody wanted to come and see us, they were quite scared. No one really used, well telephones, but not for that sort of communication … but I think everyone uses it [telephone] for everything now, and everyone is actually quite comfortable and it's becoming a bit of the norm. (Health service personnel)*

From the perspectives of health service personnel, salient barriers experienced by clients to accessing videoconferencing led to a greater uptake of telephone consultations. These included poor internet availability or accessibility, financial barriers (eg no phone credit or data) and low technology literacy. These barriers were expanded on by clients to a perceived lack of compatible technology with videoconferencing platforms and the absence of support to use platforms when at home:

> *I wouldn't have a clue how to do that [use videoconferencing platform] on my end … It's just as easy to talk. I wouldn't know which button to push, I would push the wrong button. (Client)*

With the necessary supports and technology in place, some clients were receptive to using videoconferencing to speak with a GP or a practice nurse. One client shared that they used videoconferencing at the ACCHO for a specialist appointment and were supported by health service personnel to do this.

Table 2: Characteristics of telephone and videoconference consultations

Characteristic	Telephone	Videoconferencing
Number of consultations, *n* (%)	408 (94)	27 (6)
Median age in years (min, max, IQR)	41 (0.3, 71, 23)	48 (9, 58, 20)
Number of females, *n* (%)	216 (53)	11 (41)
Number of males, *n* (%)	192 (47)	16 (59)
Number of GP consultations, *n* (%)	379 (93)	24 (89)
Number of Non-GP consultations, *n* (%)†	29 (7)	3 (11)

† Includes practice nurse consultations, antenatal consultations and attendance by a non-GP medical officer.
IQR, interquartile range.

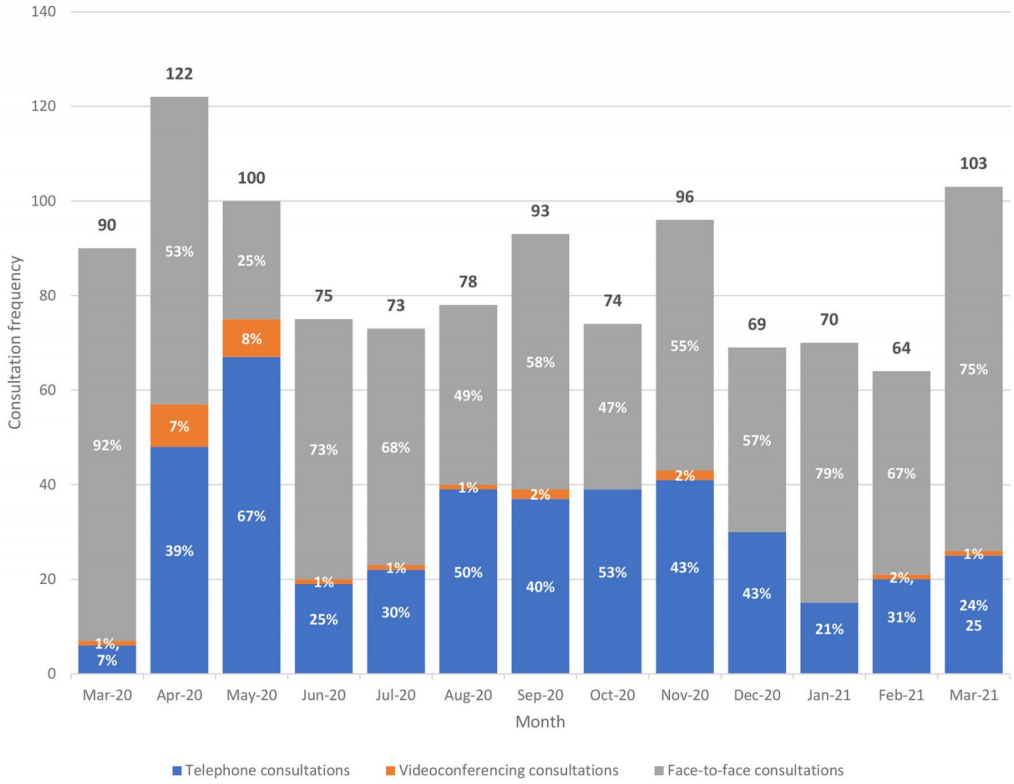


Figure 2: Percentages of telephone, videoconferencing and face-to-face consultations.

2. Maintaining the delivery of ACCHO services during COVID-19

Telehealth services were accessed by Aboriginal and Torres Strait Islander clients across the lifespan, with a median age of 41 years (interquartile range (IQR) 23) for patients using telephone, and 48 years (IQR 20) for patients using videoconferencing (Table 2). When age was analysed as a categorical variable, the highest proportion of telehealth consultations was for those aged between 50 and 54 years (*n*=73, 17% of total telehealth consultations), followed by those aged between 45 and 49 years (*n*=52, 12% of total telehealth consultations). Utilisation of telephone consultations was relatively evenly divided between males and females (47% male (*n*=192), 53% female (*n*=216)), while males accessed the majority of videoconference consultations (59% males (*n*=16), 41% females (*n*=11)).

The qualitative themes 'acceptability of telehealth consultations' and 'preference for face-to-face consultations' expanded upon the concept of maintaining the delivery of ACCHO services during COVID-19 using telehealth. Generally, telehealth consultations were acceptable to clients; however, there was an overwhelming preference for face-to-face consultations from the perspective of clients and health service personnel. Reasons for this included face-to-face being more personal and aligning with cultural ways of doing, being able to undertake a thorough clinical assessment, and being able to socialise with health service personnel and other community members at the ACCHO. Despite this preference, clients identified that telephone consultations were useful for sharing health concerns with a GP or practice nurse and for receiving reassurance, arranging medication prescriptions, reducing travel time to the ACCHO, and for generally feeling connected to health service personnel during COVID-19.

> *And now more if I just need like a prescription or something like that, something quick, I just do the telehealth appointments over the phone … if I need new scripts. [Name of nurse] made me an appointment last week and the doctor rang me in the morning and that was easy, because I don't have to go out of town … (Client)*

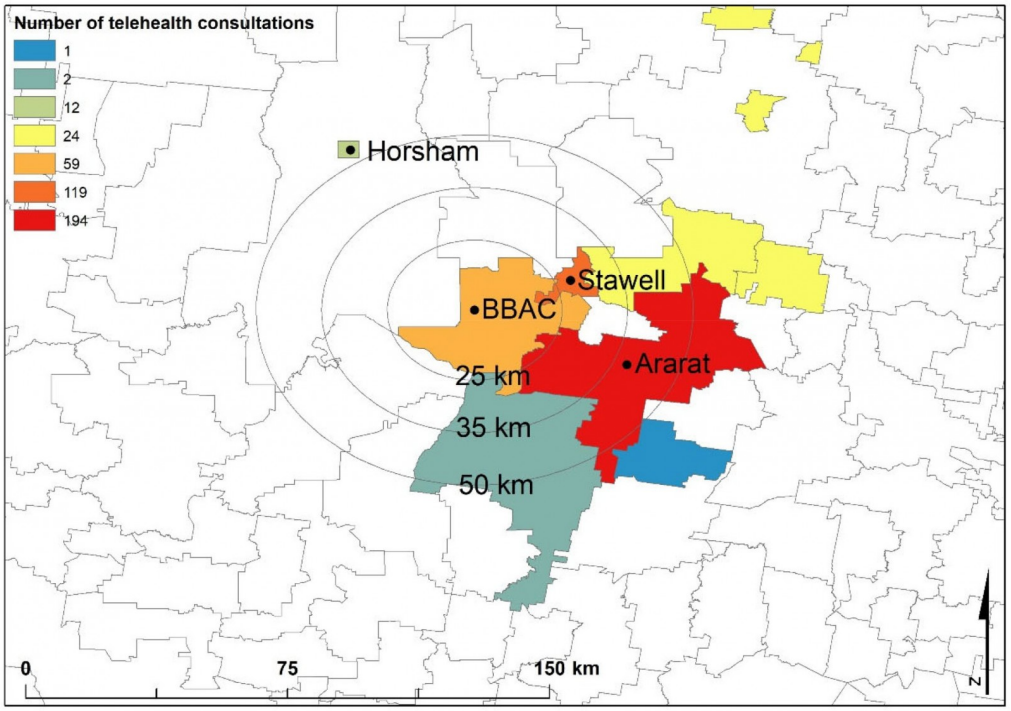
From the perspective of health service personnel, telehealth consultations were a useful tool to deliver health care, and complemented face-to-face care rather than replaced it. Of total telehealth consultations, the majority were delivered by a GP (93% of telephone consultations (*n*=379) and 89% of videoconferencing consultations (*n*=24)), with the remainder delivered by practice nurses and other medical specialists (non-GP medical officers and obstetricians). The most frequently utilised MBS item numbers were for a GP consultation lasting less than 20 minutes (91809; *n*=264, 61%), followed by a GP consultation lasting at least 20 minutes (91810; *n*=61, 14%). From the perspectives of health service personnel, telehealth consultations were identified to be most appropriate for GP consultations providing medication prescriptions, delivering health care to clients in correctional facilities, and to clients where there was a pre-existing clinical relationship, to maintain continuity of care.

As telephone consultations were used more frequently than videoconferencing consultations, key challenges were reported by health service personnel. These included the need to rely on listening to clients rather than observing non-verbal cues, the inability to conduct a visual clinical assessment (eg assessment of work of breathing), difficulty managing mental health concerns and associated risks, having clients distracted while on the phone (eg either by family members or

by being in a public space), and the difficulty ascertaining client understanding of information provided:

> *You get so much more information from sitting in the same room as someone and seeing what they look like, how they present themselves because that can, you ask a question and a person's body language changes, their voice may say the same stuff, but you might see something else shift that leads you down to think, then ask a different line of questioning and that leads to the actual problem that they may be, were a bit hesitant in talking about. I don't think anything can replace face to face interactions with clients. (Health service personnel)*

Despite these challenges, telehealth services were accessed by clients who were geographically dispersed in the Northern Grampians and Ararat regions, with the highest proportion of consultations delivered to those residing in Ararat and surrounding areas, and Stawell (45% (*n*=194) and 27% (*n*=119), respectively), followed by Halls Gap and surrounding areas (14%, *n*=59) (Fig3). Further, 77% (*n*=337) of consultations were delivered to clients residing in areas experiencing high levels of socioeconomic disadvantage and low levels of advantage, indicated by either being postcodes in a first or second IRSAD decile[16]. Included postcodes ranged from being in the first IRSAD decile to the ninth IRSAD decile.



BBAC, Budja Budja Aboriginal Co-operative.

Figure 3: Telehealth consultations by postcode.

3. Implications for sustaining telehealth in an ACCHO

Although the delivery of telehealth services as a proportion of total ACCHO clinical services varied monthly between March 2020 and March 2021 (Fig2), support for the continuation of telehealth was provided by interview participants. The qualitative theme 'future of telehealth' identified key implications for sustaining telehealth at the ACCHO. Health service personnel identified that the ACCHO had the necessary infrastructure and capacity to continue implementing telehealth services to clients as initial teething issues had been addressed (eg setting up telehealth platform, purchasing webcams, educating clients). From the perspectives of clients and health service personnel, support for the continuation of telehealth was provided due to perceived benefits (eg convenience, reduction in travel, improving access to GPs and health service personnel, overcoming transport issues, ability to attract additional MBS revenue) when used in the appropriate context despite limitations (eg less personal than face-to-face consultations). Health service personnel acknowledged that sustaining telehealth was largely dependent on government policy and the maintenance of the MBS telehealth items, which were temporary at the time of undertaking the study. At a local level, implementing education and technological support was vital to encouraging greater use of videoconferencing consultations; however, clients were generally satisfied with using telephone consultations in addition to face-to-face consultations where needed:

> *… it's probably the only thing that telehealth is not personal and you do sort of hold back a few things because you can't actually, like I've got a blown up knee, you can't actually show them how much you can move or flex, they just ask is it sore. Well that's the reason I rang because it is sore … you can't, but in saying that, I've just said to them [ACCHO health service personnel], and they've said to me a few times, it sounds like you do have to come in and see us and I've gone in and seen them. (Client)*

Discussion

To our knowledge, this is the first study examining the implementation of telehealth services for primary healthcare delivery in a rural ACCHO (MM 5–small rural town). Qualitative findings expand on other research examining the implementation of telehealth within a Victorian ACCHO (MM 2–regional centre) during COVID-19, which found that telehealth was an important adjunct to the delivery of holistic primary care services to Aboriginal and Torres Strait Islander clients[13].

Over the study period there was a greater uptake of telephone consultations relative to videoconferencing consultations, utilisation of telehealth services across the lifespan, and frequent use of telehealth for the delivery of short GP consultations (either less than or at least 20 minutes). Although the utilisation of telehealth services as a proportion of all services delivered to Aboriginal and Torres Strait Islander clients fluctuated monthly, telehealth services became embedded as a new mode of primary healthcare delivery over the 1-year period and, notably, between COVID-19 lockdowns. Further, telehealth services were acceptable to health service personnel and Aboriginal and/or Torres Strait Islander clients despite a general preference for face-to-face consultations. Sustaining telehealth was identified to depend largely on government policy and the maintenance of the MBS telehealth item numbers.

Findings illustrate the responsiveness of a rural ACCHO in rapidly adopting telehealth during COVID-19 to continue delivering primary healthcare services to Aboriginal and Torres Strait Islander clients. This rapid adoption of telehealth was also observed in primary care organisations across Australia and internationally[2,27]. Responding to the healthcare needs of Aboriginal and Torres Strait Islander Peoples is an identified strength of ACCHOs[28,29]. Another example of responsiveness demonstrated by ACCHOs during the early phase of COVID-19 was the culturally appropriate communication of health messages to Aboriginal and Torres Strait Islander Peoples[30].

These findings are consistent with an analysis of national data that identified a strong preference for GP-delivered telephone consultations, and an apparent under-utilisation of GP videoconferencing consultations in the general population[27]. Understanding the preference for telephone consultations and barriers to the utilisation of videoconferencing is an important area for future research examining the equity of telehealth delivery, both for the general population and for Aboriginal and Torres Strait Islander Peoples, particularly given the preference of policymakers for videoconferencing[27]. This study provides some insights as to why there may be an under-utilisation of videoconferencing in a rural ACCHO from the perspectives of health service personnel and Aboriginal and/or Torres Strait Islander clients (eg access and availability of technology and internet, financial barriers, low technology literacy).

Further, this study addresses the need to examine the acceptability of telehealth and utilisation of telephone consultations by Aboriginal and/or Torres Strait Islander clients through qualitative research – a need identified by a previous literature review[11]. Despite a preference for face-to-face consultations, clients were appreciative of having access to ACCHO health service personnel with whom they had a pre-existing relationship through telehealth services during COVID-19 and identified other benefits of telehealth consultations (eg saving travel time, arranging medication prescriptions). Health service personnel also found telehealth acceptable when used in the appropriate clinical context. This resonates with other qualitative research undertaken in the Australian primary care setting during COVID-19 that identified similar benefits and challenges of telehealth, finding that GPs thought telehealth should complement rather than replace face-to-face care[31].

Translation and implementation

The preference of policymakers for videoconferencing consultations, reflected in the 2021 amendments to telehealth MBS item numbers for GPs that removed item numbers frequently utilised by GPs at BBAC (MBS item number 91809 and 91810)[3], does not align with the needs and preferences of the ACCHO and their clients identified in this study. In Victoria, the Western Victoria Primary Health Network and collaborating ACCHOs advocated to the Department of Health to restore these MBS item numbers. They shared preliminary findings from this evaluation in a letter around the delivery of telehealth services to Aboriginal and/or Torres Strait Islander clients residing in rural postcodes known to have high levels of socioeconomic disadvantage and low levels of advantage. It is also likely that these clients already experience other known barriers to accessing primary healthcare services for Aboriginal and Torres Strait Islander Peoples (eg transport, financial)[32,33].

Strengths, limitations and future research

Limitations of this study include reliance on the provided health-service-level consultation data, rather than on client-level data, and the inability to extrapolate findings to other variables (eg area-level socioeconomic status at the appropriate scale, which is currently limited to postcodes). Further, the qualitative sample and subsequently the data collected depended on relationships established with health service personnel and clients. Due to this, there is a potential that this study captured data from clients who were more engaged with the ACCHO and telehealth services. Future research should expand upon this study and examine the perspectives and experiences of Aboriginal and Torres Strait Islander Peoples in accessing telehealth services across other ACCHOs, geographical and clinical settings, in addition to the experiences of health professionals in delivering health care through telehealth across other settings.

A strength of this study is the evaluation of telehealth using a mixed-methods approach and in partnership with a rural ACCHO for the purpose of identifying opportunities to improve the delivery of primary healthcare services. This work contributes to furthering the evidence base around models of care for Aboriginal and Torres Strait Islander Peoples residing in rural areas – a need identified by a previous review[33]. With the extension of the MBS telehealth items, it is recommended that policymakers engage with the ACCHO sector, and Aboriginal and Torres Strait Islander leaders, to understand the experience of other communities in implementing

telehealth services[17].

Conclusion

This study provides mixed-methods findings around the first year of implementing telehealth services for the delivery of primary care by a rural ACCHO. A greater uptake of telephone consultations rather than videoconferencing, and frequent use of short GP consultations delivered by telephone, were key findings of the study and consistent with a larger national investigation. Reasons for this were largely related to technology and infrastructure. Generally, telehealth was acceptable to both health service personnel and clients, with benefits and challenges identified. Telehealth provided a useful adjunct to face-to-face consultations when used in the appropriate context. Future research should examine these benefits and challenges in other ACCHOs, particularly in rural areas. Engagement of the ACCHO sector in the policy discourse around telehealth going forward is important to ensure localised responsiveness to the needs of Aboriginal and Torres Strait Islander Peoples is supported at a national level.

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Conflicts of interest

The authors declare no conflicts of interest.

Data availability

The data generated and analysed in this study are not publicly available as participants consented to their data being used only for the purposes described in this study.

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APPENDIX I:

Appendix I: Application of the CONSIDER Statement^

Domain	Mixed methods evaluation of telehealth for Aboriginal and/or Torres Strait Islander clients of BBAC
Governance	
1. Describe partnership agreements between the research institution and Indigenous-governing organisation for the research, (eg Informal agreements through to MOU (Memorandum of Understanding) or MOA (Memorandum of Agreement)).	Deakin University (DU) and Budja Budja Aboriginal Cooperative (BBAC) do not have a MOU. Rather multiple letters of support were provided by BBAC to submit with ethics and funding applications which reflect the nature of the partnership which includes clinical placements, evaluation work and cultural competency training.
2. Describe accountability and review mechanisms within the partnership agreement that addresses harm minimisation.	Part of working in a respectful partnership means that all work, including drafts of manuscripts, is reviewed by BBAC prior to dissemination. Further, regular meetings were established between DRH external researchers and appointed BBAC personnel to provide evaluation updates and identify any areas which required improvement.
3. Specify how the research partnership agreement includes protection of Indigenous intellectual property and knowledge arising from the research, including financial and intellectual benefits generated (eg development of traditional medicines for commercial purposes or supporting the Indigenous community to develop commercialisation proposals generated from the research).	The project had little scope for commercial benefit. The NHMRC Human Research Ethics Application (HREA) submitted to DUHREC was focused on how cultural knowledge would be managed through the project.
Prioritisation	
4. Explain how the research aims emerged from priorities identified by either Indigenous stakeholders, governing bodies, funders, non-government organisation(s), stakeholders, consumers, and empirical evidence.	The evaluation was designed in conjunction with BBAC leaders in the context of needing to understand Aboriginal and Torres Strait Islander client telehealth preferences. This is part of a larger body of work led by BBAC in partnership with Deakin Rural Health (DU) around evaluating different ACCHO service models to improve health care accessibility for Aboriginal and Torres Strait Islander community members in the region.
Relationships (Indigenous stakeholders/participants and Research team)	
5. Specify measures that adhere and honour Indigenous ethical guidelines, processes, and approvals for all relevant Indigenous stakeholders, recognising that multiple Indigenous partners may be involved, eg Indigenous ethics committee approval, regional/national ethics approval processes.	As there is no formal process for having research projects involving Aboriginal and/or Torres Strait Islander peoples reviewed by an Indigenous-specific ethics committee in Victoria, local processes were used to ensure the cultural appropriateness and safety of the research project. This involved having BBAC review all documents prior to submitting a formal ethics application to DUHREC and discussing other ethical issues at length.
6. Report how Indigenous stakeholders were involved in the research processes (i.e., research design, funding, implementation, analysis, dissemination/recruitment).	Evaluation design including identifying data sources and variables to analyse, was agreed upon by BBAC and DRH, with input from Aboriginal academics from DU. The funding submission had input from BBAC and DU researchers, including Aboriginal academics. A BBAC appointed person undertook data extraction of service data from clinical databases, and supported the recruitment of participants to the qualitative interviews.
7. Describe the expertise of the research team in Indigenous health and research.	The DU research team included public health and clinical experience in Aboriginal and Torres Strait Islander health. This included a participatory action research project which was undertaken in collaboration with another rural ACCHO to engage the perspectives of Aboriginal and/or Torres Strait Islander community members around chronic disease.19 Other relevant experience in the team included working on other research with BBAC such as around evaluating a mobile clinic a partnership involving a mobile clinic and involvement in policy activities.17
Methodologies	
8. Describe the methodological approach of the research including a rationale of methods used and implication for Indigenous stakeholders, eg privacy and confidentiality (individual and collective).	A community-based methodology was used to design the mixed methods evaluation. This involved having BBAC personnel involved in the study design, interviews, extraction of health service data and recruitment of Aboriginal and/or Torres Strait Islander clients to the interviews. Due to the overlap of BBAC personnel in the study components, strict ethical data management protocols were adhered to. This included storing de-identified interview transcripts on a DU password protected computer drive and only sharing this with the respective participants as part of member checking. Data analysis and interpretation were also only shared with BBAC personnel in the form of summaries and an evaluation report in order to protect the confidentiality of participants.
9. Describe how the research methodology incorporated consideration of the physical, social, economic and cultural environment of the participants and prospective participants. (eg impacts of colonisation, racism, and social justice). As well as Indigenous worldviews.	A community-based methodology ensured all aspects of the study were overseen by BBAC personnel. Further, the leadership of Aboriginal academics in the study ensured the study was conducted in a manner which was culturally appropriate. In the context of ongoing COVID-19 lockdowns and the inability to meet face-to-face with Aboriginal and/or Torres Strait Islander community members, this involved having BBAC health service personnel invite clients to the study, meeting via telephone, and sometimes having multiple telephone interviews with clients to develop rapport.
Participation	
10. Specify how individual and collective consent was sought to conduct future analysis on collected samples and data (eg additional secondary analyses; third-parties accessing samples (genetic, tissue, blood) for further analyses).	Prior to each interview, consent forms with plain language statements were provided to participants. The content of these were also agreed upon by BBAC and DU Aboriginal academics.
11. Describe how the resource demands (current and future) placed on Indigenous participants and communities involved in the research were identified and agreed upon including any resourcing for participation, knowledge, and expertise.	As the evaluation received funding, resourcing demands were considered and accounted for. This included funding for BBAC administrative support (extraction of health service level data and recruitment of clients), reimbursement for Aboriginal and/or Torres Strait Islander clients participating in the interviews, salary for a DU Aboriginal Associate Research Fellow to support data collection and analysis, and funding for webcams to support the roll out of telehealth services at BBAC.
12. Specify how biological tissue and other samples including data were stored, explaining the processes of removal from traditional lands, if done, and of disposal.	Not applicable to this study.
Capacity	
13. Explain how the research supported the development and maintenance of Indigenous research capacity (eg specific funding of Indigenous researchers).	As part of evaluation, funding was received to support an Aboriginal Associate Research Fellow with DU to assist with data collection and analysis, and to provide cultural guidance to non-Indigenous researchers.
14. Discuss how the research team undertook professional development opportunities to develop the capacity to partner with Indigenous stakeholders?	This process took place through regular meetings between BBAC and DRH during the evaluation timeline and following. Non-Indigenous researchers also participated in cultural awareness training hosted by BBAC to develop skills and an understanding of the local community.
Analysis and interpretation	
15. Specify how the research analysis and reporting supported critical inquiry and a strength-based approach that was inclusive of Indigenous	Research analysis and reporting were supported by an Aboriginal Associate Research Fellow who guided interpretation of findings within a strengths-based

values.	approach.
Dissemination	
16. Describe the dissemination of the research findings to relevant Indigenous governing bodies and peoples.	A one-page summary of the evaluation was provided to clients who participated in the interviews in order to inform them of how their feedback was understood. An internal evaluation report with all findings was provided to BBAC.
17. Discuss the process for knowledge translation and implementation to support Indigenous advancement (eg research capacity, policy, investment).	In addition to the evaluation report being shared with BBAC, preliminary evaluation findings were disseminated to the Federal Minister for Health in the context of removing MBS telehealth items most frequently used by ACCHOs (telephone MBS item numbers) in mid-2021. It was communicated that this was an equity issue, as ACCHOs provide services to clients who already experience barriers to accessing services and reside in geographical areas experiencing high-levels of socio-economic disadvantage (evidenced by the findings of this evaluation).

^ Huria T, Palmer SC, Pitama S, Beckert L, Lacey C, Ewen S, Smith LT. Consolidated criteria for strengthening reporting of health research involving indigenous peoples: the CONSIDER statement. *BMC medical research methodology*. 2019;19(1):173.

APPENDIX II:

Appendix II: Eligible MBS telehealth item numbers

MBS item number^	Description
General Practitioner services	
91795	Phone attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task
91800	Telehealth (i.e. videoconferencing) attendance by a general practitioner lasting less than 20 minutes
91801	Telehealth attendance by a general practitioner lasting at least 20 minutes
91809	Phone attendance by a general practitioner lasting less than 20 minutes
91810	Phone attendance by a general practitioner lasting at least 20 minutes
91811	Phone attendance by a general practitioner lasting at least 40 minutes
91818	Telehealth attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders
91842	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders
92004	Telehealth attendance by a general practitioner for a health assessment of a patient
92016	Phone attendance by a general practitioner for a health assessment of a patient
92068	Phone attendance by a general practitioner, for preparation of a GP management plan for a patient
92069	Phone attendance by a general practitioner, to coordinate the development of team care arrangements for a patient
92072	Phone attendance by a general practitioner to review or coordinate a review of GP management plan, team care arrangements
92116	Telehealth attendance, by a general practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan
92126	Phone attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner
92127	Phone attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration
92128	Phone attendance, by a general practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient
92129	Phone attendance, by a general practitioner who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient
Other non-GP services	
91808	Telehealth attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), in an eligible area, of at least 45 minutes in duration
91853	Antenatal telehealth attendance
93202	Follow-up phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner
93203	Phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease if the person has a GP management plan, TCA, or MD plan

^ as of March 2021. Note changes were made to COVID-19 temporary MBS telehealth services from 16 July 2021 which removed some telephone consultation GP item numbers, including 91809 and 91810 – the two most frequently utilised MBS item numbers during the evaluation period.

APPENDIX III:

Appendix III: Interview guides

Interview guide for health service personnel

1. Tell me about your role and experience of delivering health care services during COVID-19.

Prompts – What clinical services do you provide? How long have you been working with Budja Budja Aboriginal Cooperative?

2. How would you describe the initial implementation of telehealth services during the COVID-19 lockdown?

Prompts – Is this the first time you have delivered health care services through a telehealth modality? What are some contextual barriers and enablers to implementation?

3. What are the strengths of delivering health care through telehealth services for Aboriginal and Torres Strait Islander people?

Prompts- What are some weaknesses? What cultural factors have affected implementation? Were there any teething issues?

4. What adaptations were made to the delivery of telehealth services during the COVID-19 lockdown?

Prompts – Why were these adaptations made? What other adaptations are required?

5. How engaged do you think Community members are with a telehealth mode of health care delivery?

Prompts – Do you have any specific examples you could share with me? Why do you think Community members may not be engaged with a telehealth mode of health care? How could engagement issues be overcome?

6. What are your observations regarding Community acceptability of telehealth as a mode of health care delivery?

Prompts – Do you have any specific examples you could share with me? Have any Community members expressed dissatisfaction with telehealth?

7. What is required for the ongoing implementation of a telehealth mode of health care delivery?

Prompts – Do you have any specific examples you could share with me?

8. What challenges do you foresee for the ongoing implementation of a telehealth mode of health care delivery for Aboriginal Community members?

Prompts – How could these challenges be addressed? Do you have any further feedback?

Interview guide for Community Members

- Introduce researcher and purpose of evaluation
- Discuss plain language statement and consent form

If community member is happy to proceed, then ask following questions. Also, provide Community Member with the option to have the interview at another time that is more convenient.

1. What was it like to access health care through the phone or via a computer (telehealth) during COVID-19?
(Optional prompts – How did this compare with going into the clinic and seeing the doctor/nurse/health professional?)
2. What are your thoughts about telehealth in general?
(Optional prompts – What do you like about the service? What do you not like?
3. If telehealth was to be ongoing, how could it be made better for community who use it?
(Optional prompts- What changes are required?)

Is there anything else you would like to share?

Thank you for your time. We look forward to meeting with you in person once COVID-19 lockdown has been lifted.