Using Telehealth to Build Capacity:

Twelve Lessons

September 2007

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Using Telehealth to Build Capacity

Smoking during pregnancy is a major public health concern. In 2006 and 2007 Nova Scotia's South Shore Health (Public Health and Addiction Services) coordinated a Health Canada funded project. The goal: a district-wide best practice approach to pregnancy and tobacco. Early training initiatives, in partnership with the Centre for Addictions and Mental Health in Toronto, raised interest with other health districts in the province who wanted to somehow get involved. The challenges: building capacity over a province-wide area, budget restrictions, lack of local expertise coupled with a desire to use technology without losing the personable and participatory aspect of good adult education principles.

The solution developed was a unique, participant-driven telehealth series. It provided case-based learning opportunities to 125 health intermediaries in 11 locations and all health districts throughout Nova Scotia. The innovative 5-session series used an engaging, collaborative and interdisciplinary process. The training sessions were a catalyst for enhanced local, province-wide and inter-provincial communication and partnership building. The following are the lessons from that process.

Twelve Lessons

1) Telehealth can reduce barriers caused by distances, geography and cost. It can be a good tool to bring people together around an issue, build capacity and provide training.

Approximately 125 people took part in training at eleven sites across Nova Scotia. Telehealth gave them access to experts not otherwise available in the province.

2) Following sound adult education principles improves telehealth learning.

Adults focus on goals; they want information they can use. Learners want a program that is well organized. Goals and objectives should be clear and relevant.

Adults need input into what they learn. Program planning and delivery should involve all stakeholders and draw on the experiences of learners. Monitoring and evaluation are also critical.

Adults bring their own experiences, knowledge and values to the learning process. Participatory and case-based teaching methods show respect and built on that knowledge.

Adults have competing interests (work, social, etc.) We kept participants on task by responding quickly to feedback, using a variety of teaching methods and audio-visual materials, and encouraging small group study sessions.

Adults need a respectful and supportive environment. Participants were pleased that our presenter related the work directly to their day to day reality. They appreciated that concerns were heard and responded to appropriately.

3) **Many hands make light (er) work**.

Our broad based team greatly helped the process. Distinct roles and responsibilities were assigned. Subgroups (overseen by an advisory committee) coordinated promotion, program planning, evaluation, logistics, and technical issues. Each site had a telehealth coordinator who handled the technical issues

Each site also had a "session facilitator." The session facilitator's role was to

- promote the course locally,
- communicate with their participants,
- facilitate introductions and local organizing of group assignments, and
- coordinate logistics (e.g. refreshments, prizes, comfort level of room, etc.).

The originating site (Toronto) also had both a technical facilitator and a content facilitator to support the presenter. The content facilitator (ie. the presenter's assistant) was a vital member of the programming planning committee. This ensured good communication between the two provinces and between presenter and participants.

4) **A network of local facilitators makes it easier to connect with the community. This provides the personal contact and "human touch" often missing in telehealth training.**

Having this network of local facilitators

- increased community ownership in the project;
- supported the building of relationships, local collaboration and capacity;
- prepared for further work in the community around the issue of pregnancy and tobacco

It also worked well to provide local leaders with a small amount of funding for refreshments, travel support, photocopying and other needs.

5) **A thorough needs assessment and ongoing evaluation increases participant buy-in and promotes continuous improvement.**

Project organizers distributed a needs assessment early in their planning. This guided how program content and process was designed. It also acted as early publicity for the series. A prize for respondents increased survey response rates, with 170 received.

The needs assessment gave us a foundation on which to build the course and learning objectives. It also acted as a bench mark for evaluation.

We evaluated each session as we went along. This showed us what we needed to change or keep. The positive feedback, as well as constructive criticism, also encouraged us to keep striving for a high quality. Responses to participant suggestions seemed to motivate others to give us all the more feedback.

Each session was also evaluated from the perspective of the session facilitator, who was able to act as an observer and reporter of how the session was received. This gave us a different perspective than that of participants.

Online survey software ("Survey Monkey") was used for easy and timely processing of results.

6) Increasing learner engagement through interaction, relevant content and effective use of technology requires a lot of attention to detail.

The participatory process and tailored content took three times longer than would have been the case for face-to-face training. However, we felt that this was needed to maintain quality. The training method was varied, with lots of question and answers, homework exercises and review of homework. We spent also spent time brain-storming and problem-solving around some of the challenges posed by telehealth technology.

We arranged for one person to make sure that each session was taped. We learned that each site should ensure its own session is taped. Tapes can then be given out right after the session to those who missed it or wanted to review it. This also ensures that each session is taped in the event of single-site technical problems.

7) Presenters need to use different techniques when using telehealth.

Presenters need to be more disciplined and engaging. Group participation is appropriate at points during the presentation. There are also times when teaching needs to be more didactic. At those times the lack of both visual and oral feedback can mean the facilitator needs to be more internally motivated (even "thick-skinned") to maintain engagement.

8) Some things that work well in workshops don't necessarily "come across" in telehealth.

In live presentations people seem to like the option of going to many different slides. In our telehealth series people didn't like to have many slides. Having the camera focused just on the slides put distance between the audience and presenter; they couldn't see the presenter at the same time as the slide. Shifting focus the slides and the presenter provided more opportunity to connect with audience.

It was hard to find the right balance between enough and too much use of paper handouts. It may be wise to limit handouts to a number of slides. The full presentation can be burned to CD's or posted to a website.

Process issues are important to telehealth. This would involve such things as making sure people do not speak over the presenter.

9) Dedicated technical support makes the process easier. It also builds the technical skills and confidence level of organizers and participants.

This was new "territory" for the project organizers. A telehealth coordinator on the advisory committee helped organizers understand what was required, anticipate potential problems and develop solutions. She also dealt with the technical issues involved with working between provinces.

Having onsite telehealth coordinators allowed session facilitators to concentrate on the non-technical process issues. This contributed to the success of each event. It also meant organizers and participants were able to gradually increase their comfort level with using the equipment.

10) A test run before the first session makes session facilitators more comfortable with the process. This also prevents possible problems.

Technical support was most important in the early stages of the project. Early technical glitches may have discouraged participant engagement and future attendance.

11) Having a series of sessions spaced a month apart helps people learn better. This also promotes better program planning.

Some people said they would have preferred weekly sessions. This would have been very challenging. There was too much preparation involved (review of evaluations, preparation of new agenda and presentation materials, sending handouts to session facilitators for copying, etc.) Monthly sessions enabled more participatory aspects to the series, such as:

- group meetings,
- communication with our Toronto presenter and his assistant, and
- responses to suggestions from evaluations.

Monthly sessions allowed participants to digest the material, reflect on what they had learned and put it into practice. Presenting the workshops as a series was seen as helpful. Participation got better and the process richer as the series progressed.

12) Time spent in relationship building and communication pays off in the long-run.

Trust over a distance can be built through:

- ❑ Frequent debriefing
- ❑ Clearly worded emails
- ❑ Respect for each other's work
- ❑ Informal "celebrating" of successes

Relationships and experiences fostered over the course of the project left a foundation for local and provincial leadership. This positive experience and pride in a "job well done" led to a willingness to take on further work in developing a provincial "community of practice" on pregnancy and tobacco.