Health Literacy Project 2020-21

Action Research Report

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Acknowledgements

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We extend our recognition of the generosity and support of our community service providers and health care providers. Their interest in the project, and time spent sharing their insights, learnings, and knowledge, contributes to a richer understanding of service delivery and how we can improve the experience for consumers.

TasCOSS thanks the Steering Committee and those people involved at a governance and oversight level. Primary Health Tasmania and Public Health Services are to be particularly commended for their innovation and creative thinking in shaping this project. Their collaborative approach and genuineness in exploring new ideas and ways of thinking has allowed this project to take form and flourish.

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Executive Summary

The Tasmanian Council of Social Service (TasCOSS) engaged with members of the Tasmanian community to find out what people want and need from digital or online service delivery models.

The Health Literacy Project was about understanding the experiences of Tasmanians using health or community services via technology (online or by phone) during COVID-19. The aim of this project was to hear stories, anecdotes, and experiences of people and services, and how they were impacted. The goal was to understand what support our industry needs so that online service delivery models can be delivered efficiently and alongside best practice health literacy principles.

How did we do this?

Through focus groups and interviews, we spoke to people with lived experience about their time during COVID-19. We explored barriers to service access, what worked well, what didn't work well, and what might be improved. We used these findings to help design our two community surveys: A consumer survey open to the general public, and a provider survey for health care and community service providers.

What did we find?

Digital service delivery models generally improved service delivery for consumers and providers. Providers were able to improve their digital skills, more consumers could be reached, and online appointments became quite convenient. People appreciated being connected to local services and often used personal networks and connections to find information. During COVID, telephone and in-person appointments were common, with online appointments used occasionally.

However, digital service delivery models were not accessible for all Tasmanians. Access, affordability, and digital ability issues were evident particularly in our focus groups. From our focus groups five key themes emerged:

1. Cost of devices
2. Data access
3. Digital literacy skills
4. Service navigation
5. User experience of online appointments

Poor digital literacy had an impact on mental health, and this was compounded by difficulty navigating services and where to go to find information. Digital service delivery was seen not as a complete replacement, but as a tool that can be used where needed.

What do we need to do?

Both providers and consumers suggested that service providers would benefit from greater support and training for digital delivery. Providers should involve their consumers more when designing online services, understand the importance of diversity, and communicate clearly. Information and design of digital platforms should be accurate, easy-to-navigate, and written in plain language. Training or mentoring should be provided to consumers where necessary to help them use an online service.

Where do we go from here?

The information collected helps us understand what people want and need from digital or online service delivery models. This feedback will be shared more broadly with the industry and policy makers. It will also be used as part of the project to develop tailored resources and workshops to support the health and community services industry to deliver services confidently and effectively

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via technology, meaning more Tasmanians can have access to the supports they need in ways most accessible to them.

We have included a visual illustration of the findings of the project which can be found on the next page.

Background

Since 2016, the Tasmanian Council of Social Service Inc (TasCOSS) has received joint funding for health literacy project work from Primary Health Tasmania (PHT) under the auspices of the Federal Government and Public Health Services (PHS) under the auspices of the Tasmanian Government.

These three organisations have worked together in a collaborative partnership to increase health literacy understanding within the community services and health care industries in Tasmania. A specific toolkit was developed to assist organisations to view themselves through a health literacy "lens" so that they can build capacity and consider elements such as communication, leadership, consumer involvement, workforce development, inclusivity, and access and navigation.

This toolkit is referred to as the HeLLOTas! Toolkit, which is an acronym for Health Literate Learning Organisations Tasmania. More information can be found at https://www.hellotas.org.au/

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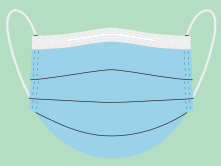
WHAT DO PEOPLE WANT AND NEED FROM ONLINE SERVICES?

COVID-19 caused a lot of things to change quickly. We wanted to know what these changes meant for health and community providers and their consumers.



We consulted with 157 community members and service providers in Tasmania to find out what people want and need from digital/online service delivery models.

26
Community focus group participants

14
Interviews with service providers

53
Community surveys completed

64
Service provider surveys completed

HOW DID PEOPLE ENGAGE WITH SERVICES?

87%
People used telephone to reach their provider

62%
People used smartphone or computers

92%
Primary health most frequently used service

74%
People felt confident using a phone or computer

30%
Increase in online video appointments after COVID (in-person and phone still preferred)

WHAT WORKED WELL FOR ONLINE SERVICE DELIVERY?

CONSUMERS LIKED THAT...

- Online appointments were convenient and easy to access
- Allowed for flexibility
- Good for simple consultations
- Removed transport barriers
- Created opportunities for consumers and providers to learn together

PROVIDERS LIKED THAT...

- They could reach more consumers and offer more appointments
- Appointments online could be more efficient
- Staff improved their digital skills
- Providers used social media
- Business practices could be reviewed and improved

WHAT WERE THE BIGGEST BARRIERS?

Our focus group participants shared many stories and experiences about what it was like for people who may have been disproportionately impacted by COVID-19. These are the most important themes from our consultations.

DEVICE COST
Devices and smartphones are expensive. It makes it hard to balancing daily living expenses on a low income.

DATA
Data is essential for video appointments. People run out of data quickly. It is expensive.

DIGITAL LITERACY
If people don't have digital skills they avoid, give up easily, or rely on others.

NAVIGATION
It is hard for people to know where to go, or who to talk to.

EXPERIENCE
Online appointments simply feel different. Some people prefer face-to-face.

HOW CAN WE IMPROVE OUR SERVICE DELIVERY?

Based on what people have said, we have produced some principles of digital health literacy. These can be used as talking points for service providers to consider how digital literacy can impact on people who use their services.

DIGITAL LITERACY
Everyone has different levels of digital literacy. This causes stress. Not everyone knows how to use devices. Have a back-up plan like a phone number.

COST OF DEVICES & DATA
Devices and data are expensive. Not everyone can get the internet. Data runs out. People need to budget. This causes stress. Be considerate of this. Online can be just as expensive as in-person.

CONSUMER CO-DESIGN
Provide support or mentoring to your consumers where you can. If your consumer gave up, explore why and where. Encourage feedback. They are their own experts. They know what works best for them.

PRIVACY & CHOICE
Online appointments are different. Be aware of privacy in shared spaces. In-person works for some people. Online works for others. People appreciate having a choice. Don’t assume what people need. Ask them.

Introduction

The coronavirus (COVID-19) pandemic has resulted in widespread social and economic disruption across international borders and arguably almost every community in the world. Some of the largest impacts include business, tourism and educational institution closures, social distancing, home isolation, quarantining measures, travel restrictions, border closures, health care restrictions, and physical distancing requirements between family, friends, and communities. The Australian Federal Government implemented several economic and social measures that largely prevented wide-scale mortality and devastation seen in other countries globally.

We acknowledge that the pandemic is ongoing in Australia, and we recognise that Tasmania hasn't been affected as much as other states. Tasmania was the first state in Australia to initiate hard border closures and non-essential travel. The Premier of Tasmania, Peter Gutwein stated: "[These new measures] will be the toughest in the country. We need to ensure that we protect Tasmanian lives."[1] These measures were effective in reducing the spread of COVID-19, however, the literature is still emerging as to what the impact of these measures were on individual and collective community wellbeing.

What is health literacy?

Health literacy is defined as having adequate knowledge of one's own health, what services are available, and how to access these health care systems. It is an issue that has become increasingly complex and harder to understand. Health literacy is important because it impacts on an individual's ability to make decisions and take ownership and agency to manage their own health care needs. The complexity of the system means that policymakers and managers must be at the forefront of understanding their consumers' relationships to the services that they use.
Health literacy can be broadly understood across two domains: Individual health literacy and the health literacy environment.[2]

Individual health literacy is the "skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action."
Examples of individual health literacy may include:

- Understanding and responding to preventative health messages, medication, and care plans.
- Completing health forms and undertaking administration related to one's health.
- Knowing where, how, and why to search for a health care provider or to make appointments.

[1] L Donald, 'Tasmania announces hardline coronavirus response, forcing all non-essential travellers into isolation', in *ABC News*. 28 March 2020, viewed on 24 April 2021, https://www.abc.net.au/news/2020-03-28/tasmania-introduces-new-coronavirus-response/12099368

[2] Australian Commission on Safety and Quality in Health Care, 'Health literacy: Taking action to improve safety and quality', in *ACSQHC*. 2014, viewed on 24 April 2021, https://www.safetyandquality.gov.au/publications-and-resources/resource-library/health-literacy-taking-action-improve-safety-and-quality

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- Navigating health care systems and understanding referrals, processes, and flow.
- Knowing how to way-find and navigate within and between services.

The health literacy environment is the "Infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services."
Examples of the health literacy environment include:

- The policies that decide how, where, when and why people receive health care and treatment.
- The written or verbal materials, brochures, websites, and information that is on display, distributed to, talked about, and given to consumers.
- The delivery of sensitive and/or delicate information, particularly regarding health professionals, including cultural and population awareness needs.
- The physical and digital layout of how services are found, accessed, navigated, and engaged with, including the number of times, visits, and touch points in the system.

What is the Tasmanian health context?

The Tasmanian Government has set an ambitious goal of making Tasmania the healthiest population in Australia by 2025. However, more than half of adult Tasmanians have low levels of literacy, which makes it very hard for them to get the health care they need. Despite efforts, health and community services in our state are not making it easy enough for Tasmanians to access, understand and use services to improve their health and wellbeing. As a result, Tasmanians currently experience some of the worst health outcomes in the country, with high rates of chronic disease and health risk factors like smoking, obesity, poor nutrition, low physical activity levels, and risky alcohol consumption.

In consultations with Tasmanians on low incomes, TasCOSS consistently hears that health is one of the most important concerns. This concern is borne out by data: Tasmanians in disadvantaged communities have much poorer health than their more advantaged peers.

The University of Tasmania undertook a survey sampling 3,000 respondents to provide Tasmanian residents with the opportunity to share their ideas and opinions with the Premier's Economic and Social Recovery Advisory Council (PESRAC). Health was identified as the biggest concern, with respondents frequently reported feeling anxious, depressed uncertain or lonely.[3] Rolling up this information into a broad consultation, PESRAC reported that Tasmanians regard health as their highest priority of concern, and that mental health issues have been exacerbated by COVID-19. In addition, many Tasmanians simply do not have access to digital networks, devices, and literacy to enable a transition to a digital arena. Tasmanians living with disadvantage (such as low-income households) are more likely to be digitally excluded. Many respondents reported that internet

[3] L. Lester, et al. 'Report for the Premier's Economic and Social Recovery Advisory Committee: The Tasmania Project Wellbeing Survey', in *Institute for Social Change, University of Tasmania*, March 2021, viewed 23 March 2021, https://www.utas.edu.au/tasmania-project

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access is now an essential service, and that people should not have to choose between food and internet access.[4]

What is the role of digital technology?

Digital technology is an enabler of access, allowing people unprecedented access to information and services. It has become increasingly integrated into daily life. Banking and paying bills, searching and applying for jobs, managing health care, research, and study, accessing essential services, and even socialising with friends are increasingly happening online. This has brought clear benefits for business and the community, making commerce and personal transactions faster and cheaper and making it easier to access a range of services, especially for those in regional and remote areas.[5]

It can also foster a sense of community and reduce social isolation by acting as a tool to build and maintain relationships over large distances. However, these benefits are not being enjoyed by everyone in Tasmania. As digital technologies become ever more pervasive, and more aspects of life require digital access and ability, some people risk becoming increasingly digitally excluded. Those most at risk of digital exclusion are people who already experience disadvantage in some form, such as unemployment or a low level of formal education. Further digital exclusion will compound the barriers they face which precludes full participation in the social and economic lives of their communities and of Tasmania.

Work at the Federal government level is occurring to address parts of this. The Australian Digital Health Agency was established in 2016 and has recently undertaken work across 71 community organisations to teach digital health literacy skills through the *Health My Way* program.[6] Underpinned by the *National Digital Health Strategy*, this work has been commissioned to the Good Things Foundation which has engaged over 3,500 community partners and 232 digital health mentors.[7] The initiative has developed a suite of resources[8] and upskill participants across areas such as My Health Record, using health and wellbeing apps, finding reliable health and wellbeing information online, and understanding privacy and data concerns.[9]

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[4] Tasmanian Government, 'Premier's Economic and Social Recovery Advisory Council: Final Report', in *PESRAC Reports*. March 2021, viewed on 22 April 2021, https://www.pesrac.tas.gov.au/__data/assets/pdf_file/0011/283196/Final_Report_WCAG2.pdf

[5] ACCAN, 'NetNecessity', in ACCAN. Viewed on 30 April 2021, https://accan.org.au/no-australian-left-offline

[6] Australian Government, 'Australia's National Digital Health Strategy and Framework for Action', in *The Australian Digital Health Agency*, Viewed on 22 April 2021, https://www.digitalhealth.gov.au/about-us/national-digital-health-strategy-and-framework-for-action

[7] Australian Government, 'Good things happening to support digital health literacy', in *The Australian Digital Health Agency*. 22 March 2021, viewed on 22 April 2021, https://www.digitalhealth.gov.au/newsroom/media-releases/recent-media-releases/good-things-happening-to-support-digital-health-literacy

[8] Good Things Foundation, 'Health My Way Resources'. Viewed on 22 April 2021, https://www.beconnectednetwork.org.au/training-resources/healthmyway-resources

[9] Good Things Foundation, 'Outcomes of Health My Way'. Viewed on 22 April 2021, https://www.goodthingsfoundation.org.au/what-we-do/our-projects/health-my-way/

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What is digital inclusion? Why is it important?

Access to digital services and the internet is becoming essential for daily life, just as other services and utilities such as electricity and water allow for participation in social and economic life. The Australian Digital Inclusion Index (ADII) is used to provide a snapshot of digital inclusion in Australia. The ADII defines digital inclusion as being influenced by three key factors: Access, affordability, and ability.

Within the Tasmanian context, Tasmanians with lower income, employment and education levels have lower levels of digital inclusion. Education, work opportunities, government services and social connections are increasingly accessed through digital technologies, but there is a digital divide where not all Tasmanians have the same access, and Tasmania is lagging the rest of the nation. The gap between Tasmanians who are digitally included and those who are excluded is widening.[10]

Tasmania ranks the lowest out of Australia's eight states and territories and some groups in Tasmania experience particularly low levels of digital inclusion. Tasmania has an average score of 59.6 compared to the Australian average of 63. The ACT leads the nation at 67.5. [11]
According to findings from the ADII:

- Access is particularly poor in Burnie and North-West Tasmania, where people also have the lowest quality of internet technology and the smallest data allowances.

- Affordability is also the lowest in North-West Tasmania, although southern Tasmania receives the lowest value for expenditure.

- Digital ability is where the biggest gap between Tasmania and the national average can be found, with a 4.9 point gap (47.1 versus 52).
    - In the North-West, this gap is 15.7 points.
    - For Tasmanians in the lowest income quintile, the gap is 18.1 points.
    - For Tasmanian seniors, the gap is 21.4 points.

Other groups at particular risk of exclusion include Tasmanians who are not in the labour force and less educated Tasmanians. Levels of digital exclusion are higher in areas of relative socioeconomic disadvantage. Statistical Area Level 2s (SA2s) are regions categorised by the Australian Bureau of Statistics. In Tasmania, there are 28 SA2s, and 25 of the 28 SA2s where more than 20 percent of the dwellings do not have internet access are in areas of highest socio-economic disadvantage.

[10] TasCOSS, 'Understanding digital inclusion in Tasmania: Report on research findings', in TasCOSS, November 2018, viewed 30 April 2021, https://tascoss.org.au/new-submission-to-the-tascoss-vault-11/

[11] J Thomas, J Barraket, CK Wilson, E Rennie, S Ewing, T MacDonald, 'Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2019 for RMIT University and Swinburne University of Technology, Melbourne, for Telstra'. 27 August 2019, viewed on 23 April 2021, https://digitalinclusionindex.org.au/wp-content/uploads/2019/10/TLS_ADII_Report-2019_Final_web_.pdf

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Low-income households recorded the lowest overall inclusion score in Tasmania. An obvious barrier for low-income households is affordability. TasCOSS reports that low-income households are forced regularly to make choices between things that many households consider as essential, such as paying rent and bills, buying food, and putting petrol in the car. The upfront and ongoing costs associated with digital access can be one of the first to go to make way for these more immediate needs.

> *"I choose some things over other things. Yeah, which makes it tough. Because it's just me and my two children and so it's only one wage coming in. But if it was cheaper, that'd be probably a big help for me."* [12]

What was the impact on community services?

COVID-19 has had varied impacts on the community services industry, revealing both challenges and opportunities. Challenges included obstacles to service delivery due to physical distancing requirements. This meant some service users did not receive the level of support they required, or it could not be offered in the form they preferred or had known. Many organisations had demand that simply could not be met.

Organisational budgets were also been impacted due to a loss of income from either social enterprise, traditional fundraising or where fee-for-service income had reduced. Additional expenses were incurred because of supporting staff to work remotely or implementing alternative methods of service delivery to assist clients, placing further strain on budgets into the future. Opportunities arose through new ways of doing business that will be beneficial if they can continue in the future.

Some of the barriers to service provision included:

- Clients having to navigate changes to models and platforms of service delivery. For example, there was a widespread loss of face-to-face services, and potential loss of online services due to staffing changes. This potentially resulted in insufficient supports for people disproportionately impacted by COVID-19 (e.g., fewer face-to-face services, less in-home services).

- Digital access is not always successful for service delivery due to barriers in online engagement (e.g., technology, access, impairment, digital literacy levels).

- People needing to access support for the first time and were unsure where to go for help, or hesitant to reach out. Some people made the choice not to access services, due to a perceived concern that they would get sick if they were to venture out.

- There were inconsistencies in the application of guidelines, such as the use of Personal Protective Equipment (PPE) and visits to Residential Aged Care Facilities (RACF).[13]

[12] TasCOSS consultation participant, TasCOSS, 'Submission to the Tasmanian Government's *Our Digital Future* Consultation Draft', in *TasCOSS*, November 2019, viewed 30 April 2021, http://www.dpac.tas.gov.au/__data/assets/pdf_file/0018/503307/Submission_8_-_TasCOSS_20191128.pdf

[13] *Ibid*.

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" … offering telehealth appointments however have not proven to be particularly successful for a number of reasons — clients don't have mobile phones or live in an area with poor phone service, don't have any credit, no internet, no wi-fi available, etc. When telehealth has been used, it has been reported by both clients and workers that it is not as satisfactory as face-to-face service provision — it's difficult to engage, build and maintain rapport, does not feel particularly authentic, IT platforms can be unreliable." [14]

How did the community services industry respond?

COVID-19 meant that many service providers and consumers had to adapt rapidly. Because face-to-face appointments were largely impacted, this meant that methods of service delivery had to change quickly. In response, the State Government Department of Communities provided $350,000 worth of small grant funding for service providers to purchase essential technology items. This funding was administered by TasCOSS, and applicants were awarded full or partial funding based on the criteria required. Each applicant organisation could apply for up to $10,000 each.

The results of the Essential Technology Fund (ETF) showed that:[15]

- Recipient organisations were able to fast-track important IT purchases and improvements that may have been delayed for several years due to cost. Many recipients reported examples of vital system upgrades, software procurement and expansion of telephony needs.
- Digital literacy confidence was increased in most organisations due to the swift adoption of technology. Both service workers and consumers worked in tandem to learn and test the technology together. Flow-on benefits meant that consumers were able to utilise these skills for personal use and with their families.
- Due to remote working, staff and clients remained safe and connected during COVID-19.
- The purchase of devices has continued to benefit organisations post-COVID as these devices and skills have been embraced and embedded in most organisations. Recipients reported that funding helped implement important software systems that will exist beyond COVID-19.

"We never would have thought that our workshops could be delivered in this way and many of the 'human books' did not believe they could learn the necessary IT skills, so it has shown us that innovation is possible. This has opened our minds to other possibilities!"

Another resource that was available to Tasmanians during the pandemic is the FindHelpTas directory. This resource assists the general public and service providers to access up-to-date information about local services. During COVID-19 there were 437 organisations and 937 program listings in total. Based on user feedback during COVID-19, new filters have allowed users to narrow down their searchers by region and Local Government Area (LGA). In 2020, analytics showed that over 20,000 users accessed FindHelpTas. This is an ongoing, self-funded initiative led by a partnership of Tasmanian community service organisations.[16]

[14] TasCOSS, 'Community services industry combined response: Premier's Economic and Social Recovery Advisory Council – Stage One Consultation', in TasCOSS, June 2020, viewed 30 April 2021.
[15] TasCOSS, 'Essential Technology Fund: Evaluation Report', in TasCOSS, 28 April 2021.
[16] TasCOSS, 'TasCOSS Half-Yearly Funding Report to Department of Communities Tasmania July-December 2020, in TasCOSS, January 2021.

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In undertaking this current research project, we engaged with a wide range of providers to learn about their experiences during COVID-19. This feedback helped us to learn what gaps and themes existed. This gave us a framework to design the focus group and survey questions.

Several organisations in Tasmania have produced reports and publications (grey literature) which discuss the impact of COVID-19 on Tasmanian communities.

These conversations and summaries of grey literature are included at Appendix 1.

What have we heard?

We spoke to service providers regarding their experiences of COVID-19 and how it relates to digital literacy. We knew that people needed support if they were accessing online services for the first time or were unsure or hesitant to engage. TasCOSS spoke to two programs, *Health My Way* and *Digital Ready for Daily Life*, to learn more about these innovative programs and how they have supported people to increase their digital literacy.

Health My Way program

Health My Way is a Federal government Australian Digital health Agency program delivered by Good Things Foundation, which partnered with 75 community organisations across Australia. The author interviewed a Program Manager at Good Things Foundation.[17] The program partnered mostly with neighbourhood centres (27%) and community training organisations (22%) and reached over 6,000 people nation-wide. Participants learned about My Health Record, how to find reliable health information online, how to use health and wellbeing apps, and other digital health topics.

The *Be Connected* program is for Australians over 50 years of age to help them learn basic digital literacy. This program has been running for three years, but similar models have been running in Britain for over 10 years so learnings have been adopted here. The *Health My Way* program is broader, and open to anyone over 18 years. It is designed to be a step-up from *Be Connected*.

The interviewee suggested that the success of the program lies in embedding skills into existing activities that people are doing so that it can be infused in everyday life. For example, during art classes students can learn how to search for art galleries online. It was also acknowledged that people will generally only go to the places that they know about. The *Health My Way* program in Tasmania was quite small with only a couple of community partners involved. When asked about emerging themes that are seen, the interviewee said that data consumption and overall cost is a common barrier, particularly for health appointments. National recommendations from *Health My Way* suggest that community-based digital literacy programs work and should be extended to more locations across Australia. Funding should be multi-year, as it takes time and commitment to engage participants and build relationships with community partners.[18]

[17] L. James, phone interview with the author, 03 June 2021.
[18] Good Things Foundation, 'Health My Way', in *Good Things Foundation*. May 2021, viewed on 03 June 2021.

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Digital Ready for Daily Life program

The Tasmanian Government aimed to implement a roadmap for digital transformation, the *Our Digital Future* strategy. One of the specific programs rolled out was *Digital Ready for Daily Life*, a program for digitally-disadvantaged groups, including low income households, older Tasmanians and people not in paid employment.[19] TasCOSS spoke to a Program Manager at Digital Ready, who shared that the biggest challenge was people not having the skills to know how to operate new devices (even if these were supplied to them).[20] The interviewee shared anecdotes that their hotline could receive 10 phone calls to set up an email account; or similarly, people were told to "Click on a link" and the response was "What is a link?" This again highlights the disparity between those who can utilise digital technology and those who cannot.

Methodology

Who did we talk to?

A total of 157 people directly participated in the action research project:

- 26 consumers participated in focus groups.
- 14 service provider workers participated in interviews.
- 53 consumers participated in the consumer survey.
- 64 service providers participated in the service provider survey.

Qualitative information was collected through focus groups and individual interviews with consumers, and interviews with service providers. Consumers who participated reported a wide range of service needs, including disability, health care, mental health, Cultural and Linguistically Diverse (CALD), homelessness, and LGBTQI+. Focus groups ran for 90 minutes, and participants were compensated $30 per hour for their time through the disbursement of pre-paid department store/supermarket gift cards. Four focus groups were conducted in South Tasmania, and one focus group was conducted in North-West Tasmania.

Quantitative information was collected through two surveys: One for consumers and one for service providers. The survey questions were designed based on some of the findings from the focus groups. One assumption of our project was that focus group participants may have been disproportionately affected by COVID-19, and as such, had a rich body of lived experience and knowledge to share. Designing the survey questions after the focus group data allowed us to compare what type of information was coming through and how the wider Tasmanian community was impacted by COVID-19.

What did we ask?

[19] Tasmanian Government, 'Our digital future: Tasmanian Government strategy for digital transformation', in *Department of Premier and Cabinet*. March 2020, viewed 22 March 2021, https://digital.tas.gov.au/__data/assets/pdf_file/0024/91068/Our-Digital-Future.PDF

[20] N. Gee, phone interview with the author, 22 March 2021.

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We wanted to find out what people want and need from digital and online models of service delivery, such as telehealth and video conferencing. We began conversations by exploring how people in Tasmania had navigated health and community service delivery during the COVID-19 pandemic.

The research questions we asked people in the focus groups were:

Area	Question
Service Experience	What were Tasmanians' experiences of community and health care service delivery during the COVID-19 pandemic. What did they need to access during COVID? How did they access these? Could they get support online for everyday tasks?
Barriers to Access	What were the barriers to accessing online/digital services?
Positives	What worked well? What did people appreciate the most? How did they prefer to engage?
Negatives	What didn't work so well? What frustrated people the most?
Improvements	How could we make improvements? What would an ideal system look like?

We expected people to share a wide range of barriers that prevented them from accessing the services they need. People appreciated the opportunity to share their story. Health and mental health[21] concerns were likely to be high, and low digital literacy levels and telephony/internet access[22] being barriers. The content of the focus groups confirmed this line of enquiry.

We also expected to find some "hacks" or pointed techniques for how consumers think online/digital service delivery should occur. However, what emerged from the themes of the focus groups were "principles" of digital service delivery. These were the elements of service design that providers can focus on to make themselves more health literate in an online/digital space.

Results: Focus Groups

Summary

People shared rich, qualitative feedback about their experiences of the system during COVID-19. People needed to access a range of services during COVID, spanning across health, community, utilities, food, housing and accommodation, government services, and banking.

For many consumers, the online/digital space worked well. This was particularly evident for things like repeat prescriptions or simple to assess appointments. Respondents shared that they enormously appreciated it when a clinician asked them to explain if they understand ('teach back').

[21] L. Lester, et al. 'Report for the Premier's Economic and Social Recovery Advisory Committee: The Tasmania Project Wellbeing Survey', in *Institute for Social Change, University of Tasmania*, March 2021, viewed 23 March 2021, https://www.utas.edu.au/tasmania-project

[22] Tasmanian Government, 'Premier's Economic and Social Recovery Advisory Council: Final Report', in *PESRAC Reports*. March 2021, viewed on 22 April 2021, https://www.pesrac.tas.gov.au/__data/assets/pdf_file/0011/283196/Final_Report_WCAG2.pdf

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Several themes emerged from the focus groups. These were the elements that consumers found to be most important to them:

Theme #1: Financial burden of access. People struggled with the cost of devices, smartphones, and telephony. This had a big impact on their cost of living, and balancing daily living expenses such as rent. Devices may have been out of stock, and for people who were homeless it was hard to keep these charged. Ultimately, the cost of technology prevented people from accessing services; people described having to choose between having phone data and rationing other services.

Theme #2: Data is essential. A consistent theme was that data is essential to attend appointments and engage with services during a pandemic. Simple appointments with clinicians could consume entire data budgets in one go. Some people received data vouchers from their providers, but this was scant. It was common for people to use public Wi-Fi, which was detrimental to personal privacy, particularly for confidential appointments.

Theme #3: Digital literacy skills. Low digital literacy skills were a strong barrier. People had trouble finding and sorting information online. People felt frustrated that content was designed without the end-user in mind. There were assumptions that people had the newest phones that could access content. This frustration had an impact on people's mental health overall. For consumers who were already feeling isolated, COVID was an accelerant for this. It made social connection for consumers difficult and negatively impacted their mental health. To meet their needs, people often found alternate ways to seek out information, knowledge, or support. Family and social media was used, although it was not always the most accurate or unbiased information.

Theme #4: Knowledge of services and how to navigate systems. During the COVID-19 pandemic, respondents reported that larger service providers were difficult to contact or get help through. They did not seem to understand (or have the resources to deal with) consumers who had low levels of digital literacy. This was particularly challenging in communities where English was not a first language. Some people avoided undertaking daily tasks, such as paying bills, because they simply couldn't access or navigate online services. Wait times for appointments also increased dramatically, although this was alleviated somewhat through offering telehealth (for those who could use it) which was seen as a welcome addition for people who had barriers to attending in-person.

Theme #5: Differences in the user experience between in-person and online. Digital delivery meant that people and their providers engaged differently. If people were attending an online appointment from home, if they were in a safe space they felt comfortable. Conversely, the removal of the sanctity and "four walls" of an office meant that some people did not feel safe nor private. However, despite these challenges, people greatly appreciated when local services communicated well with them. State Government messaging worked very well, and people appreciated the regular and stable updates.

What services did people need?

People needed to access a range of services during COVID, spanning across health, allied health, primary health, utilities, food, housing and accommodation, government services, and banking services (online banking). These included:

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Health Services

- COVID-19 support
- General Practice
- Emergency department
- Hospital services
- Pharmacy
- Mental health emergency
- Psychologist
- Psychiatrist
- Radiology
- Physiotherapist
- Rheumatologist
- Mental health support in the community

Essential Utilities

- Energy providers
- Internet providers
- Banking services
- Libraries
- Telecommunication providers
- Financial hardship

Government, Income & Housing

- Centrelink
- NDIA
- Service Tasmania
- Medicare
- MyGov
- Government agencies
- Public housing
- Private rental market
- Real estate agents

Community Providers

- COVID-19 support
- Disability support
- In-home help
- Support workers
- Family violence services
- Homelessness
- Alcohol, Tobacco and other Drugs
- Mental health services
- Telephone helplines

Everyday Activities

- Paying bills
- Online food shopping
- Veggie boxes
- Supermarkets
- Independent grocers
- Education courses
- Recreation
- Family and friends

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What did people like about online/digital delivery?

Online appointments were generally convenient and easier to access

For many consumers, the online/digital space worked well. They were giving "rave reviews" for telephone conversations and online video platforms. People are saying it is an "absolute imperative" that it should continue, with the caveat that having a choice (between online and in-person access) is crucial. There is potential for greater reach to rural and remote areas, where physical service delivery may be traditionally limited.

> *"All of the physical barriers that we talk about to get to an appointment, are taken out of the way."*

> *"It was so much easier to access primary health services during COVID. I had more access to my GP than ever before."*

People also considered the impact of poor health on being both a barrier and an enabler to service access:

> *"If I'm unwell I'm not likely to get to the doctor, but I'm much more likely to make it to the computer."*

For simple things, online appointments worked well

Respondents reported that GP phone consults were a welcome change for simple repeat prescriptions. Conversely, for appointments requiring a greater sense of connection or immediacy, it was noted that phone and video conferencing with psychologists were maybe not as effective as in-person consults. This correlated with some feedback from General Practitioners that the two most important changes to their systems were electronic prescribing and having access to more appropriate MBS telehealth items.

For telephone-based service providers who would traditionally reach their consumers through telephone, they reported that it became easier to communicate via video and have a 'normal' appointment rather than on the phone. However, for some of these users, online appointments were not possible due to financial restrictions or lower digital literacy skills. This created significant barriers and required time to support consumers in using those options.

Respondents shared that they enormously appreciated it when a clinician asked them to explain their understanding of what was said. Most people did not know that this was a technique called 'Teachback', but they were keenly aware when it was used by clinicians. Some people reported that they see teachback happening more often with specialists. They said it doesn't happen as much in GP clinics, possibly due to time constraints.

What were the barriers?

People experienced system-level barriers across a range of mediums, ranging from physical barriers, online access barriers, service design and access barriers, and technology barriers.

Some people had a very negative experience of the system overall and felt that their wrap-around services were not adequate: "*My service stopped. I lost my doctor, psychologist, social worker, and home help. I ended up in the psych ward.*"

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Privacy was an issue of concern during COVID, particularly in shared environments (e.g., home, public). Sensitive information was hard to keep private in an open setting (such as a reception area) and this was made harder by the physical separation of Perspex glass. Some respondents reported that the experience of security guards meant they felt controlled, and people were apprehensive about others not practicing good hygiene. This particularly impacted participants who used public transport.

> *"When services stopped, it showed us what didn't work well."*

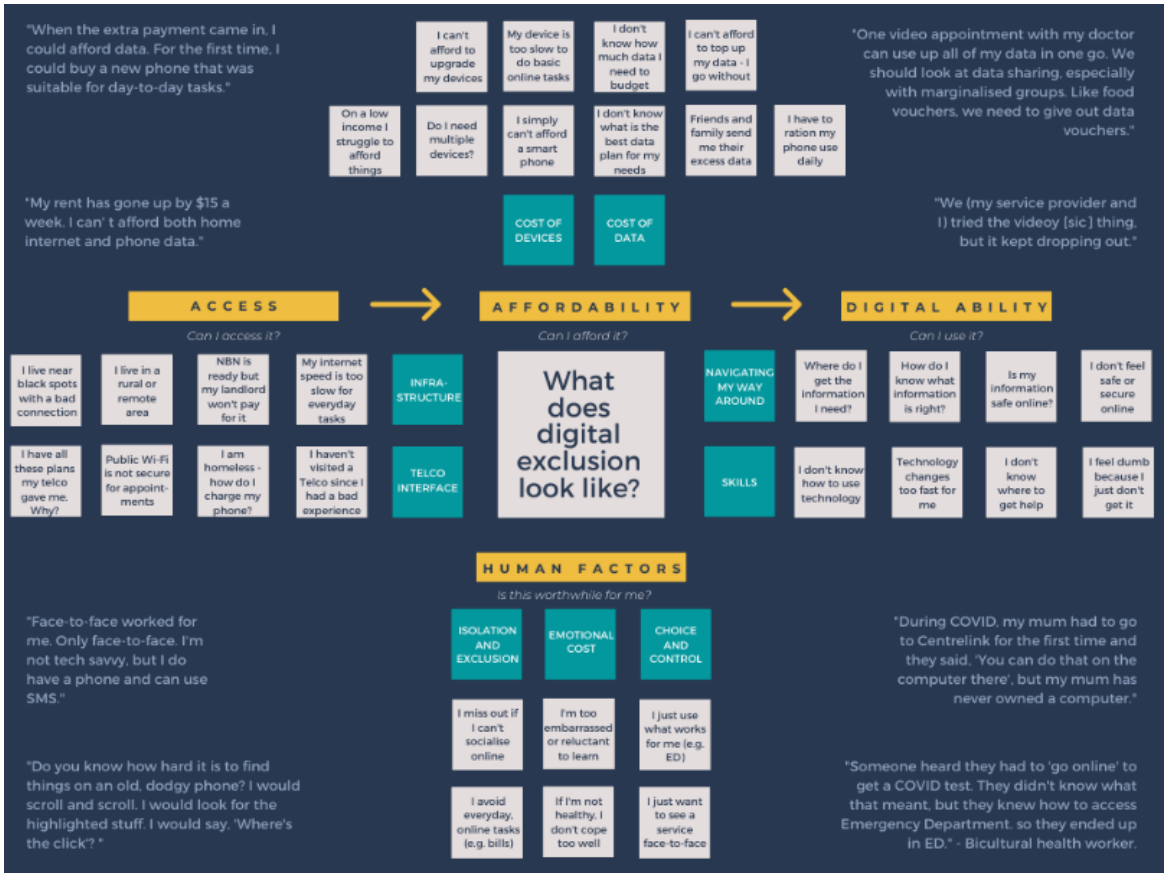
Conversely, some respondents in the mental health space stated that their normal experience was moved to the background in a COVID context. This provided a sense of relief:

> *"People stopped questioning if I cancelled stuff during COVID (usually there's pressure for me to attend an appointment)."*

For people who were accessing existing services when COVID happened, this had implications for continuity of care: "*I was sick two weeks before COVID, then everything stopped.*"

However, for the most part, focus group participants experienced a wide range of barriers that existed before COVID, or were compounded by the experience.

TasCOSS has mapped out what barriers people face when dealing with digital exclusion. The below includes anecdotes and sentiments from the focus groups. This map is included as Appendix 2. Below is a low-resolution copy.



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Theme #1: Financial burden of access

A consistent theme was the financial burden of accessing a digital service. This included the cost of devices, data and telephony, and ongoing struggles balancing this against daily living expenses.

Balancing the overall cost of living during a pandemic

The introduction of JobSeeker and JobKeeper was a welcome addition to many people who live on low incomes. One respondent summarised the sentiment:

> *"When the extra payment came in, I could afford data. This meant that I could – for the first time – buy a new phone that was suitable for day-to-day tasks. I could access online services that I couldn't access before."*

Once the rent moratorium was lifted in Tasmania, one consumer representative shared that they consistently heard of instant rent increases of $70 to $100 per week.

> *"Access to more income was just what people needed. The withdraw of that will be more catastrophic than before."*

Due to increases in the cost of living, some respondents reported having to choose between having data and rationing other services. This was made evident:

> *"My rent has now gone up (by $15 per week) but I can't afford both internet and data. [The group then discussed hot spotting/tethering, which this respondent was not aware of.]"*

Devices were not always available to purchase or were impractical for others

This appeared to be compounded by the cost of living in general, and limited access to home office equipment. Office supplies and telephony was in short supply during COVID, so some respondents had to wait months to receive item such as office chairs and headphones.

It was highlighted that in order to access a service online you need a device, and it needs to be charged. This was of particular concern for respondents experiencing homelessness.

> *"For people who were homeless, phones were constantly flat. In other cities there are public access points – but (during COVID) everything was closed in town."*

Inversely, the cost of attending physical appointments was seen as an enabler of access:

> *"When you factor in lunch, transport, it can be a $20 trip. If it's at the end of pay week, sometimes there just isn't that money there."*

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Theme #2: Data is essential and both a barrier and enabler of access

A consistent and standalone theme from the consultations, is that data – and access to affordable data – is both a barrier and enabler of digital access during a pandemic. Data was simply seen as an expensive requirement and people had to ration their budget very closely.

Online appointments can consume a high amount of data

Regarding the digital cost of appointments, it was reported that a simple Facetime appointment with a clinician could consume all of someone's data in one call. It was suggested that more work could be done at the digital service provider level and data should be considered as an essential service alongside utilities. Some respondents even went as far as to consider it a "human rights issue" that internet and data access be affordable for all.

In some instances, consumers could only access data in public places, and therefore, did not have adequate privacy to conduct their consultations.

> *"My service provider gave me data, and that's what got me through COVID. But when Easter came, they ran out, so I went to public places. But then my favourite space changed their reach [Wi-Fi signal] so I had to stand at the door."*

"If we couldn't get the technology to work, everything would grind to a halt."

Access to data or connection points was limited

Not everyone knew about tips to use data effectively and efficiently. For example, *hotspotting* a phone means that people can use data from their mobile phone to use on their home computer. At times, the digital literacy skills required to understand data, and load data to a device caused some frustrations to escalate:

> *"My provider gave me gift cards to access Telstra data, but the cards weren't accepted by Telstra … Now I'm not allowed to go back to Telstra."*

Regarding possible solutions to access to data, data banking was proposed. *Data banking* is where organisations and service users will "pool" their unused data which can be used by individuals who need it. This appears to be used in mainland Australia, one example being Belong.

> *"We should look at data sharing, especially with marginalised groups. Like food vouchers, we need to give out data vouchers."*

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Theme #3: Digital literacy skills and difficulties engaging with digital services

It emerged in the consultations that low digital literacy was a strong barrier, and this impacted on people's ability to engage with services offered in the online space.

Finding information online was difficult or hard-to-access

When asked about their experience of filtering information online, it was noted that there can be half a dozen ways to access information online but only one method is required. The multiple pathways can be confusing and overwhelming for people.

> *"There are half a dozen ways to do anything on the internet. When you are starting out, you just need one way to do it. Just one."*

Another respondent remarked that service providers can make assumptions that hosting information online is sufficient, and people will have the skills to find what they need:

> *"Don't assume everyone has access to technology. There was an overload of toolkits and resources (online)."*

For people who used mobile devices to search, curate and access services, some of their frustrations came from the limitations placed on content either being not user-friendly (poor design) or being not mobile-friendly.

> *"[When accessing online services on a phone] Online is great to use when you have a laptop or a big screen, but if you're constantly on a dodgy phone, it's such a battle to read it. Give it 3 minutes, and I've given up. I would scroll down, and keep scrolling. I would look for the highlighted stuff. It would get to the point where I would say 'Where's the click?' "*

Connectivity issues appeared to cause frustration for respondents who attempted to use this medium:

> *"We [my service provider and I] tried the videoy [sic] thing, but the connection kept dropping out."*

Impact on mental health

It was acknowledged by most that people who are digitally literate still struggle, and this had an impact on people's mental health overall:

> *"I can sum up COVID-19 in one word: Fear."*

People reported feeling anxious about not knowing where or how to access services. People said they would greatly appreciate a central source of information about all services in their local area (e.g., health, mental health). When asked why, they said "Otherwise it's too hard to work out."

> *"We need more information about telephone helplines."*

> *"The information (about after hours services) isn't out there enough."*

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For consumers who were already feeling isolated, COVID was an accelerant for this. It made social connection for consumers difficult and negatively impacted their mental health. This was spoken about in CALD communities because a sense of community is important to them and COVID stopped them from gathering. Sometimes consumers withdrew from support because online appointments did not work for them, and it was difficult for providers to re-establish contact.

One regional group reported that there were a lot of free activities available, but no one could find them. This was descried as having to "clear the path to find the gold."

A small percentage of people made a clear choice not to engage with services because they found the process too difficult as it impacted poorly on their mental health. Similarly, they found 'workarounds' to have their needs met:

> *"Face to face worked for me. Only face to face. I'm not tech savvy, but I do have a phone and I can use SMS and data."*
>
> *"Getting my meds was like, they would leave it in a bag outside. It worked, but it was a pain in the a--."*
>
> *"It was just really hard to work out what I could do, and what I couldn't do."*

<u>People found alternate ways of finding what they needed</u>

Respondents reported that they would also find alternate ways to seek out information, knowledge, or support. People would reach out to relatives or friends to find information, but it was acknowledged that it was not always the most accurate information. Social media appeared to be one method of connecting in, when they could not get the help from providers that they needed.

Facebook Messenger appeared to be a common social media platform that many respondents participated through. There was a benefit to being in contact but not always in direct contact: "Spending time without spending time with someone." One respondent reported they used this to communicate if their health is in decline. They opted not to contact the health services direct.

> *"I would message my friends on Facebook Messenger for help with practical things. I would let them know if I'm crashing. I survived by Facebook friends."*

One innovative idea was to provide people with a cost-effective tablet that is pre-loaded with all the services they need:

> *"[On social prescribing] "People need a plain English tablet with all the services on it. Training should be provided."*

Theme #4: Knowledge of services and how to navigate systems

Overall, there was a sentiment that larger service providers appeared to be inflexible in their delivery and didn't seem to understand the nuances of populations disproportionately impacted by COVID-19.

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Engaging with larger service providers was difficult

During the COVID-19 pandemic, respondents reported that larger Government services (housing, Centrelink) were very difficult to contact or get help through. This also extended to other industry providers such as telephone companies and banks. Some people avoided undertaking daily tasks, such as paying bills, because they simply couldn't access or navigate online services.

There was a sentiment that larger Government services did not understand (or have the resources to deal with) consumers who had low levels of digital literacy. For example, there were some people who were accessing Centrelink for the first time. When they spoke to the customer representative, the consultant said, 'You can just do that on the computer', but the customer was not digitally literate:

> *"My mum had to go to Centrelink for the first time and they said, 'You can just do that on the computer over there', but my mum has never owned a computer."*

If people were used to visiting a branch in person, they would only do it this way. Some people generalised services based on previous bad experiences. For example, some people had a negative experience with telephone companies trying to sell them unnecessary phone contracts. This led their experienced to become generalised to "all things online." This meant that often friends or family would help them pay their bills.

Calling telephone helplines was very difficult without adequate phone credit

During COVID-19 there was a high reliance of telephone helplines for support and information. Due to the cost and access to devices and data, it was not uncommon to hear of people contacting a service using a payphone. It was suggested that call back/ring back services are crucial.

> *"If I'm on a pay phone, I can't hold when they're asking me to. They need to use ring back."*

Regarding the COVID hotline, one participant shared a story where his elderly neighbour reached out to him because he thought he may need a COVID test. The participant rang the hotline on his behalf. After a brief call-back period, they asked what he was calling for. He said that he was seeking advice for his elderly neighbour (who does not use computers) who wanted to know how to get a COVID test. The participant was informed that they could not tell him anything (about the process) because he didn't have his neighbour's consent to ask.

In the CALD space, language was seen as a huge barrier. There is a reliance on bi-cultural workers to fill these gaps. This is complicated by COVID restrictions, social distance, and privacy concerns. Due to this gap, some staff may receive calls on their days off because they are connected to their communities on a personal level.

Due to language barriers, children would usually step in on behalf of their elder family members when accessing services, or a community member would accompany them. This can be awkward when sharing confidential medical information. There was a general sentiment that people will give up easily unless the process is easy. If there is someone to help them, then they can get support. One anecdote highlighted this:

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"People ended up in Emergency Department (ED) because someone said to 'Go online' to get a COVID test. They didn't know what that meant, but they did *[emphasis] know how to access the ED. So, they ended up in the ED." – Bicultural health worker*

There was a general sentiment that in Tasmania peer networks and knowledge-sharing takes place through word-of-mouth. During the pandemic, there were barriers that prevented this. One person summarised it:

"Everything relies on word-of-mouth. Generally, it's okay, but in a pandemic it doesn't work. People struggled to know where to go. So, people came to me more for support during COVID. We would ask ourselves, 'Who's job is it to do this?' "

Wait times increased dramatically during COVID-19 but digital access helped relieve this

A prevalent issue raised regarding service access in general, was waiting times. During the COVID-19 pandemic, capacity for mental health services stopped, which in turn meant that wait times increased drastically – in some cases up to six months. Once the backlog was deal with, people responded with scepticism: "If we call (your service), you're just going to tell me nothing's available."

Wait times for appointments were, however, largely reduced using digital access. This was particularly beneficial for people experiencing acute health stressors. Because telehealth was generally easier to access (in terms of barriers), people were more likely to go to an appointment if they were unwell.

"Clinicians don't understand the impact of sitting in a waiting room. If people need to attend (an appointment) during work time, then they will be late when they get back (due to wait times), and they're freaking out."

Theme #5: Differences in the user experience between in-person and online

Respondents shared what their experiences felt like, and the focus group environment allowed for an opportunity to make these feelings known regarding their experiences during COVID.

Hybrid/mixed models of service delivery didn't work so well

When asked about the main differences that consumers observed between delivery models, some feedback was that the most radical thing people noticed was the difference in setting. This was explained as: If you are at home, you are (generally) in a safe space. However, sometimes this is not the case. One suggestion was for clinicians to have a short video meeting with everyone in the household to let them know that information may be shared about them, but that the focus is on the recipient of that service.

Regarding a hybrid model of delivery for group service delivery (e.g., both in-person and online), respondents resoundingly reported that it did not work well. This was because people felt isolated if there were uneven numbers on one side:

"[On the hybrid model] If I was online but others were in the room, I didn't have a voice."

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Interacting with the physical environment while online

One of the enablers of digital delivery was the physical environment. This was reflected in a comment about being at home meant that they have access to self-soothing mechanisms: "I can turn the camera off or go and lay down on my bed and still have a conversation with my doctor." When asked about whether clinicians can assist clients in this process, some feedback was that clinicians can use this to their advantage through grounding techniques brought into the house environment.

> *[Examples of grounding techniques that a clinician could use] "That's a nice poster on your wall, can you tell me about it? Is it OK if you can show me around your house? You've said something a bit distressing there, how about we go get a glass of water together?"*

Feedback from clinicians is that they generally would prefer to be face-to-face for the first initial consultation, or at a minimum, ask that a support person or carer attends for the first online session. This is so that they can get a sense of the supports available. For initial assessments, both clinicians and consumers reported that they found the experience slightly harder to undertake during a video call. The rationale for this was because there are small traits and nuances that you would get from sitting with someone face-to-face.

This approach was supported from a consumer perspective as well. Online services were seen as important so that clinician do not see a "false sense of me" in a clinical setting, but rather, they can see people in their own home or living environment. ("For people in physical or mental disability, we spend a lot of time here.") Respondents reported that they "very much" want the new options (e.g., telehealth) to remain.

One person reported that being on the receiving end of a video may have an impact on self-perception as this is something not experienced previously with face-to-face consultations:

> *[Commenting that having video on isn't always the best] "We do online contact with school (training). I consider myself 'ugly face', so I don't like seeing myself on screen."*

Localised service delivery was appreciated

State Government messaging worked well, and people seemed to appreciate the daily updates and stability afforded by the State Government. This was reflected strongly in CALD communities. The Government would send key information to bicultural workers daily. The workers would translate these messages and would use Facebook Messenger to record and send it to their community members. This was important because they could interpret language nuances and unpack the context of key messages. These messages would also be played to community members who weren't on social media. One of the drawbacks was that it required workers to be friends with consumers on Facebook. The group proposed a solution whereby a third-party app could host these audio messages.

Local and small facilities (e.g., small GP practices, local IGA stores) maintained a connection to people it serviced, which was a sentiment not shared when considering larger facilities or services. ("*Some local stores who 'know' you can really make you feel at home.*")

Whilst online models mean that many of the physical service navigation issues were minimised, some work needs to be done in terms of applying health literacy principles of website navigation.

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"If we had to convince clinicians to roll out Zoom en masse, it would have taken us years. Covid gave us the opportunity to accelerate this."

When considering service design in some non-clinical settings, it was interesting to note that supermarkets introduced 'quiet hours' for people. The dimming of lights was "very useful" for people with anxiety. This anecdote was included because physical environment and space impacts on user experience in a health literacy context.

When asked about their experience of what would happen if they had a service need that was declined by a service provider, one person stated: "Ask yourself why not before saying no."

[If you are a service provider about to say no]
"Ask yourself why not before saying no."'"

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Case study:

Mosaic Disability Services and a music group adapting during COVID to connect together

A music group comprising people with disabilities was impacted during COVID. All of a sudden, they were faced with physical isolation, social isolation, and fear regarding getting sick.

As a disability service provider, Mosaic was considered an essential service and staff either worked on-site or were able to take leave. However, the music program was operating with a small crew, and the disability support workers within this program were able to work from home. Both participants and staff had varying levels of digital literacy. When asked what steps they took to begin to overcome this, they said they embarked on a process of co-design where they taught each other:

"We created a private Facebook group. Everyone could share, including our families. We shared what we were doing at home. We couldn't do this previously due to social media policies."

The group tried different technologies, and through trial-and-error, ended up interacting heavily over Zoom. They used Messenger to teach other how to use video conferencing facilities. They had lunch together and asked each other what they were eating. To overcome social isolation, they kept going by doing individual or group projects "*to keep our spirits up*."

When faced with barriers, they used their individual and collective resilience to get through it: "We were also concerned about privacy and etiquette. We were not sure exactly how to communicate, but we did. Our slogan became 'Adapt or die'."

One participant at Mosaic – who is good friends with the music group – used his digital knowledge to help the group upskill. "Computers are my connection to the world," he said, which he used to help the group refine their online service delivery.

Prior to COVID, the group was heavily involved in radio production. When the pandemic arrived, they could not access the recording studios. The group used their newly-developed model and began recording from home. When asked about the success of this, they said: "We ended up winning an award!"

The group acknowledged that there was a lot of anxiety and a lot of stress, but they "dug in deeper" and found very creative ways to deal with their circumstances.

When asked what advice they could give to services looking to migrate to a digital service delivery, the group offered these pearls of wisdom:
"There is no right or wrong. You will need to adapt as we (our service) had to adapt."
"Give it your best shot."
"Be an open and friendly service. Don't look at it as a business, look at it as client managed. Most businesses fail because their client isn't in the middle."
"Services need to listen more. See (and observe), don't just wait for someone to suggest it."

"Innovation doesn't come from only management. Listen to your staff, listen to your consumers."

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Where there any unintended benefits that arose?

Despite the many barriers discussed in the focus groups and interviews, respondents reported that there were some unintended benefits. During a pandemic, there was an increased desire to connect with local communities and a sense of optimism when reflecting on this topic.

When asked what worked well, people commented:

- *"People caring about each other."*
- *"Some things got better! People waved a lot more – it was more friendly."*
- *"Even in Melbourne everyone said hello!"*
- *"The community got through it together. ANZAC Day was great."*
- *'I found a use for COVID' in that more people are talking about anxiety – it's become a more common experience.*

Many people reported that they felt grateful and overall "lucky." They shared that service providers generally had good communication, were flexible, and empathetic towards their needs. It also meant that more appointments slots opened and there was more flexibility.

Regarding how the public perceived "teething problems" with telehealth rollout: "There was no time to think about the unintended consequences and no time to consult. There's a general forgiveness for any things that have gone wrong."

"I felt like I was a COVID winner. It meant less barriers for me. For us, financial barriers and access barriers are the big ones. When COVID happened, I didn't have to justify myself.'"

Pre-COVID, one group of participants had an already established face-to-face (F2F) peer network which would meet on a regular basis.

When asked what worked well during the migration to digital service delivery, respondents reported that peer networks seemed to be a wonderful opportunity that was previously unavailable.

"Group Zoom meetings were very beneficial to reduce feelings of isolation."

Moving online increased member engagement, and the online space was team-driven. Peer networks allowed members to up-skill other members in a peer environment. Of note, Zoom appeared to be preferable over Microsoft Teams.

"Despite all of it, we were in such a lucky position."

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What were some of the solutions discussed?

There were some innovative ideas that arose from the focus groups.

- Plain language websites.
  Some people suggested that organisations such as the Tasmanian Health Service could have two websites. One with large buttons, icons, and plain language. At the start, you can elect to click on an "EASY" option which would accommodate those who have limited data, poor connectivity, older phones or overall are seeking a plain language interface.

- Bigger devices.
  People spoke about the importance of 'surface area' on a device. Some discussed a scheme to allow for access to an iPad or iPad Mini, based on their surface area. One person summarised it as: "I can't tell you *how many people* can't type on small phones."

- Data rebates.
  Discussions also focused on government concessions. Many people felt that data rebates could be applied for those who are eligible for Centrelink concessions. This qualification could allow for cheaper devices and plans, with the freedom to choose an appropriate device in the free market.

- Telecommunication provider involvement.
  Another suggestion was for telecommunication providers to play a larger role. One idea was for these businesses to fund a new Advisory Board to assist with digital literacy mentoring and skills development for people who need it the most.

- Learning together.
  The focus groups demonstrated that local providers and consumers can learn together. This was particularly highlighted for a group of young NDIS participants who worked closely with their support workers during the pandemic. Through trial-and-error they tested online models and, importantly, the participants were the ones who taught the providers. This was also seen in the CALD community who used their strong relationships to share information and learnings on a very regular basis.

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Results: Consumer Survey

Quantitative information was collected through two surveys: One for consumers and one for service providers. The consumer survey was distributed widely through online networks, provider meetings, and focus group partners.

The survey instrument was distributed and completed online. It is fair to assume that this may have limited the potential pool of respondents. We attempted outreach to individual participants through partner organisations, but due to time and demand constraints they couldn't commit. Therefore, we decided that our focus groups would be the instrument to listen to and understand the voices of those people who were most disproportionately impacted by COVID-19.

Summary

Strong support for primary health providers. 53 consumers participated in the survey and were represented across South, North and North-West Tasmania. During COVID, most people needed primary health care support (92%) and had mostly positive experiences with GPs. People shared that their GP appointments were a good experience.

> *"Made a GP appointment and the GP called at the appointment time, all seamless."*

Convenience of digital service delivery. Online appointments worked well for simple procedures, such as reviewing medical results or writing scripts, and saved on travel and parking costs. Most people felt confident and comfortable engaging with their provider online. Most people used telephone (87%) to contact their provider and felt confident and comfortable engaging with their provider using a phone or computer.

Barriers for consumers. People said they wanted choice over the type of appointment, and that they had difficulty navigating some systems. Poor digital literacy and low data were also barriers for respondents, albeit less of a concern. Device cost was of least concern. Consumers were asked what they believed were the most important things that providers should be aware of: These were (in order) digital literacy, navigation, device cost and capability and data.

Difficulty navigating systems. There was a theme that people sometimes felt "bounced around" between systems and services, particularly when trying to find the right information online. Some people reported that messages are not always passed on, and it can be difficult to know who the correct person is to contact.

Support and training for providers. People felt that it was important that providers involve their consumers when designing their online services. Providers should understand that people have diverse needs and communicate clearly with their consumers. Information should be accurate and easy-to-navigate, and training should be provided to consumers if necessary to help them use an online service.

> *"I believe all service providers should provide digital solutions that work effectively for people of all abilities. Digital health services must be accessible and usable for the widest audience possible. Telephone should always be an option."*

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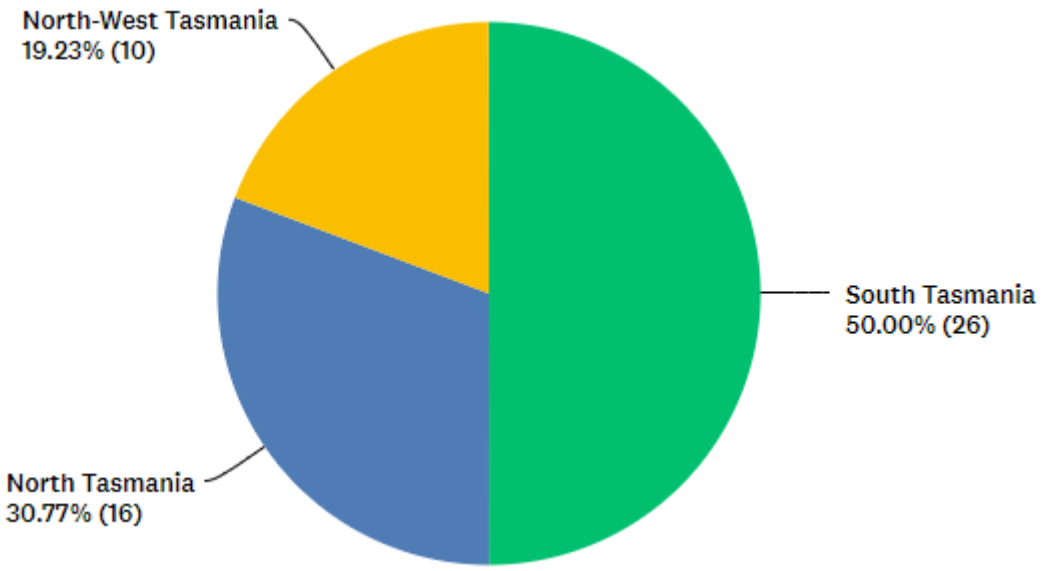
Demographics

A total number of 53 people participated in the consumer survey. Most survey respondents live in South Tasmania (50%), followed by North Tasmania (31%) and North-West Tasmania (19%).

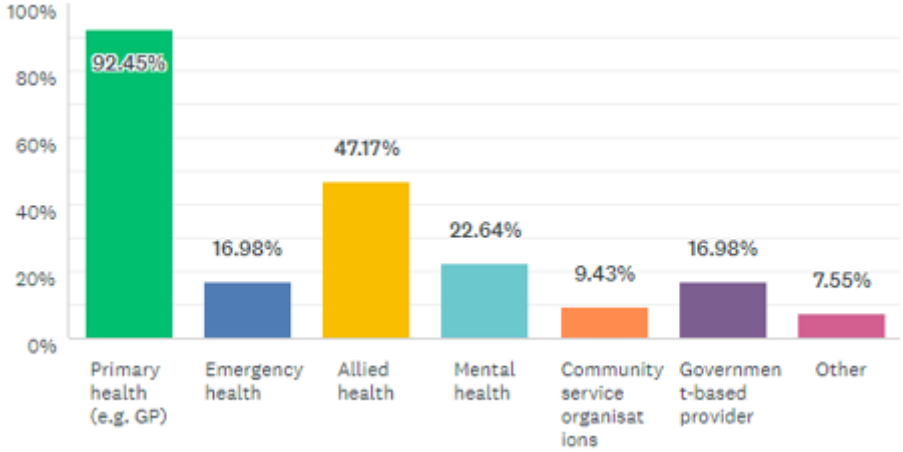


What did people need support with?

What did people need support with during the COVID-19 pandemic?

The most frequently required services were for primary health (92%). These included General Practice, hospital, and pharmacies.

The second most frequently required services were allied health (47%), such as physiotherapy, podiatry, or allied health specialists. This was followed by mental health (23%).
The remaining categories were emergency health (17%), government-based providers such as Centrelink (17%), community service providers (9%) and other (8%).



How did people contact the services that they needed?

The most common way that people contacted a health, community or government provider was by telephone (87%). This was followed by in-person contact (32%), and other (11%), online video

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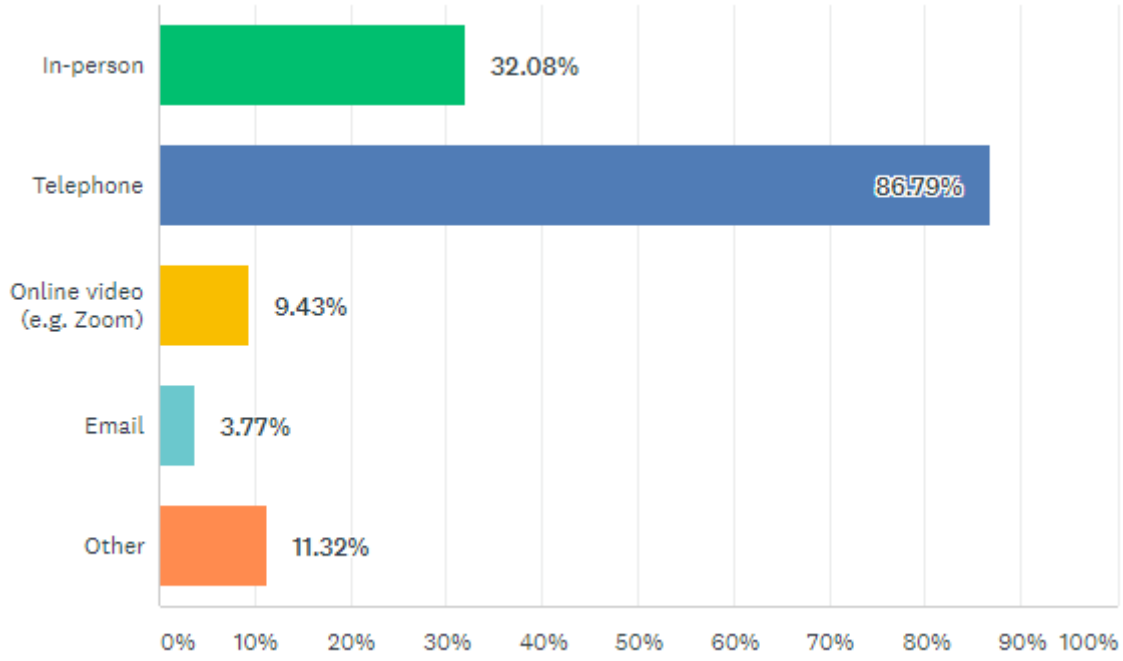
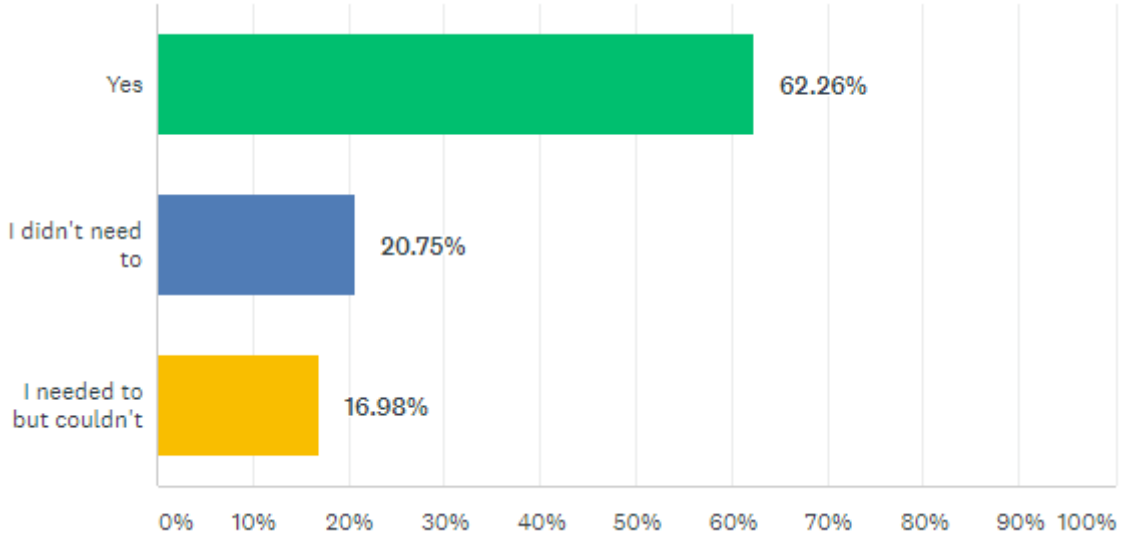
(9%) and email (4%). The free-text responses for 'Other' included text messages and Facebook Messenger.



Did people engage with service providers using computers or smartphones?

Most respondents accessed a service provider using a computer or smartphone (62%). A fifth (21%) said they didn't need to, and 17 percent said they needed to but weren't able to. When asked why they couldn't, comments ranged from:

- Unsure how to use the computer.
- Easiest option for me.
- Prefer personal contact.



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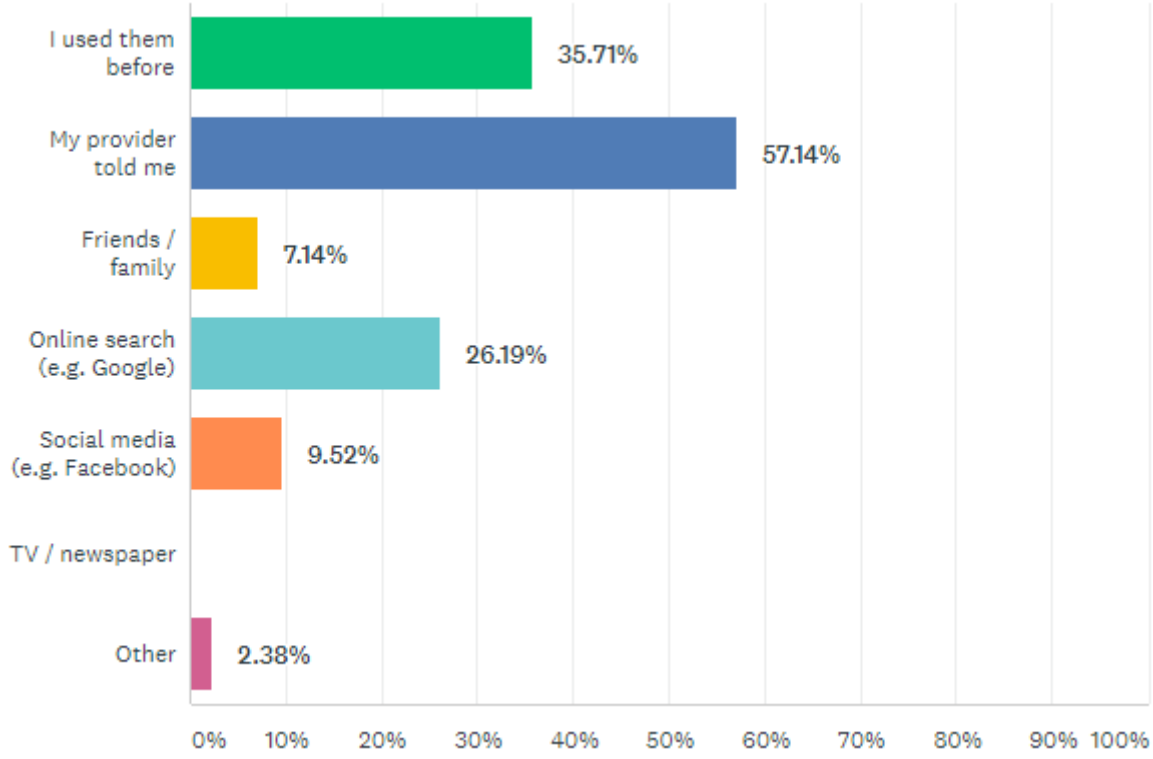
How did people find out about digital or online services?

For people who used a digital or online service during COVID, most people learned about it because their service provider told them (57%), or they had used a digital or online service before (36%). A quarter (26%) of people used online search engines such as Google, and smaller percentages used social media such as Facebook (10%), family and friends (7%) and other (2%). No respondents said they found out by TV, newspaper or print media.



What barriers did people face?

What barriers did people face when using digital or online services?

People reported that the biggest barrier was that they wanted to have a **choice** between online, phone or face-to-face appointments (55%). The second biggest concern was **navigation** (50%), not knowing where to go or who to contact for information.

The '**Other**' category (26%) included comments such as limited skills, accessibility (phone and internet connection drop-outs), privacy of accessing mental health services at home, trouble with COVIDSafe and medical apps not being disability-friendly, and the issue of receiving incorrect information about where people can attend COVID appointments.

Privacy and preferring face-to-face was identified as a concern (18%), as well as the **capability** of a phone or computer to handle online appointments (18%).

Other concerns included:

- Skills (16%) – Not knowing how to adequately use digital services.
- Data (16%) – Data ran out too quickly or it was too expensive.
- Person-centered care (13%) – People had negative experiences with service providers.
- Device cost (3%) – People felt that devices were too expensive.

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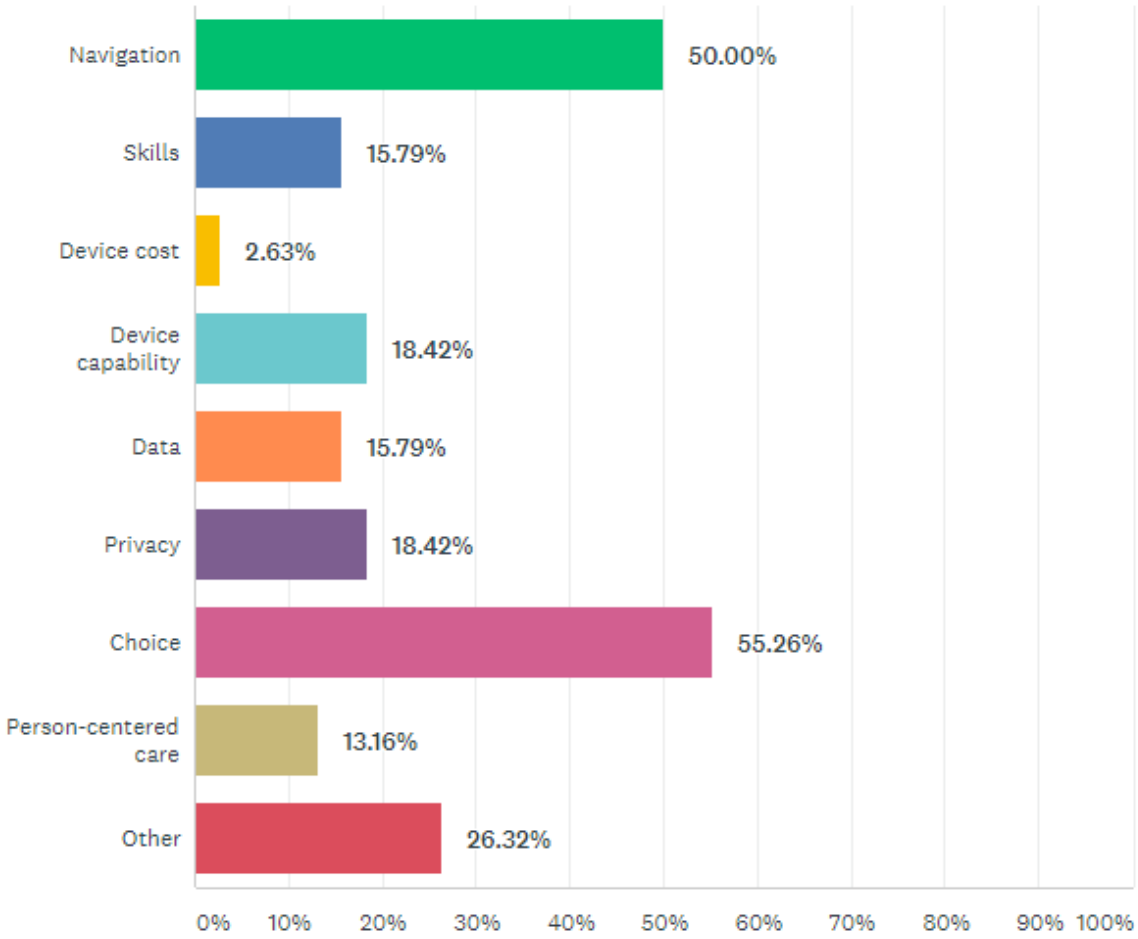

What barriers did people face when using digital or online services?	
Category	Example
Navigation	I had trouble finding information about where to go or who to contact.
Skills	I didn't have the knowledge or skills to use a digital/online service.
Device cost	Devices (e.g., computer, phone, tablet) were too expensive.
Device capability	My device was too old to handle digital/online services and websites.
Data	Data ran out too fast, and it was expensive to buy more.
Privacy	I didn't like online. I was more comfortable in a face-to-face appointment.
Choice	I wanted the option to choose between online, phone or face-to-face.
Person-centred care	I had some negative experiences talking to service providers during COVID, they had poor customer service.
Other	

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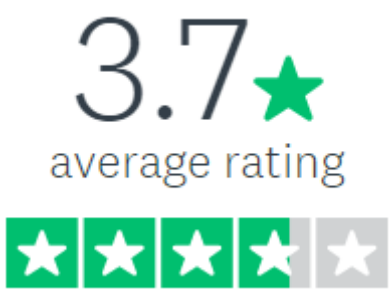
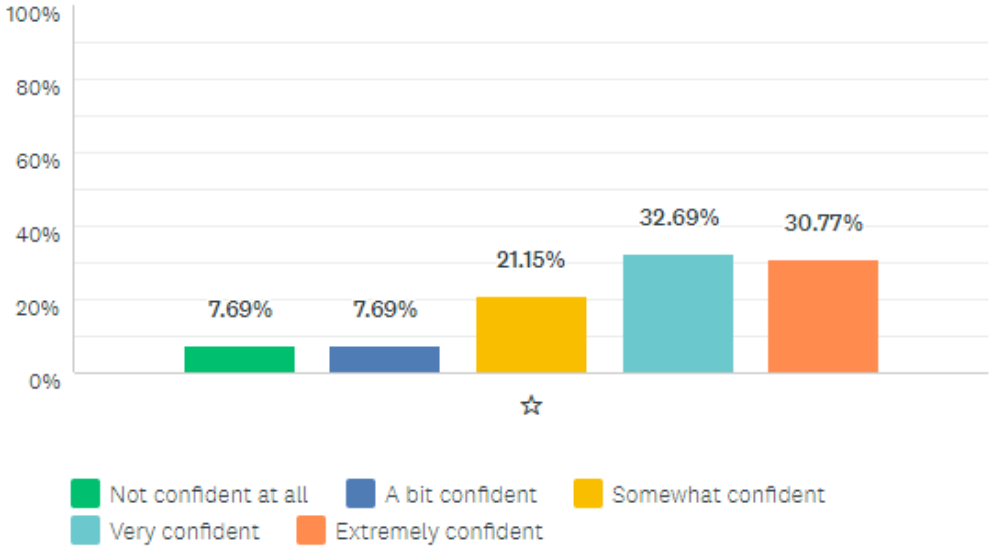
How did people feel using online services?

How confident did people feel using a phone or computer to access an online service?

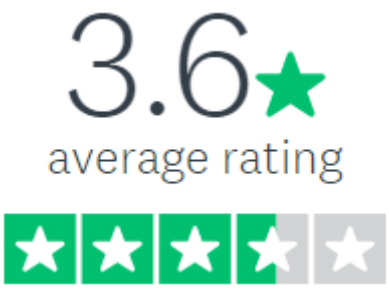


On average most people (74%) reported a high level of confidence using a phone or computer to access an online service.

People felt either Very Confident (33%) or Extremely Confident (21%). A smaller number said they felt Somewhat Confident (21%), and eight percent reported feeling A Bit Confident or Not Confident At All.



How comfortable did people feel using a phone or computer to speak to their service provider?



On average most people (72%) reported a high level of comfort using a phone or computer to speak to their service provider.

Over a third of people said they felt Very Comfortable (33%) using a phone or computer to speak to their service provider. Almost a third of people said they felt Somewhat Comfortable (27%), under a quarter said they felt Extremely Comfortable (22%), and a smaller percentage said they felt A Bit Comfortable (14%) or Not Comfortable At All (4%).

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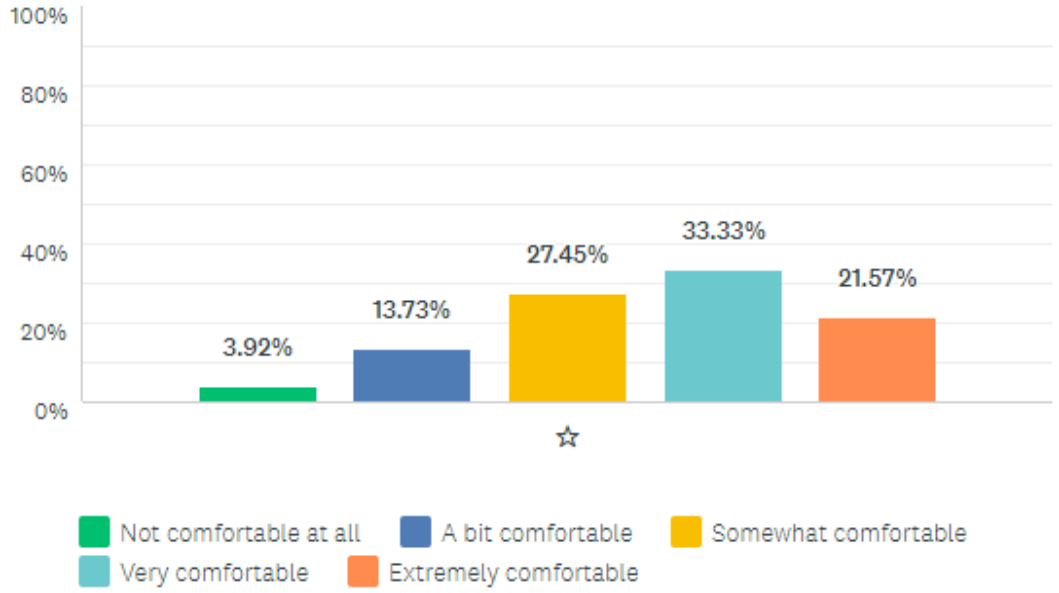
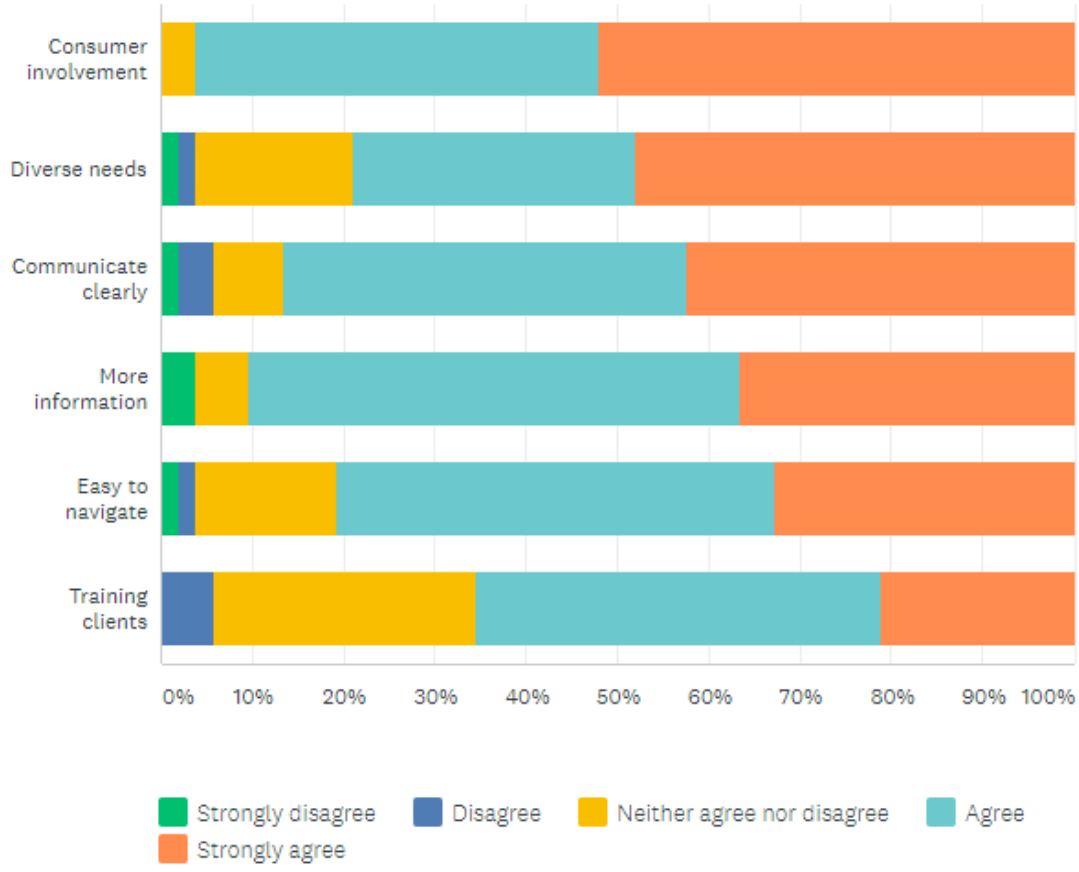


What things did people think that providers should focus on?

What domains of health literacy did people think organisations should focus on?

Survey participants were asked to respond how much they Agree or Disagree with some statements. These statements reflect categories in the HeLLOTas! Toolkit as well as some emerging themes that arose from the consumer focus groups.



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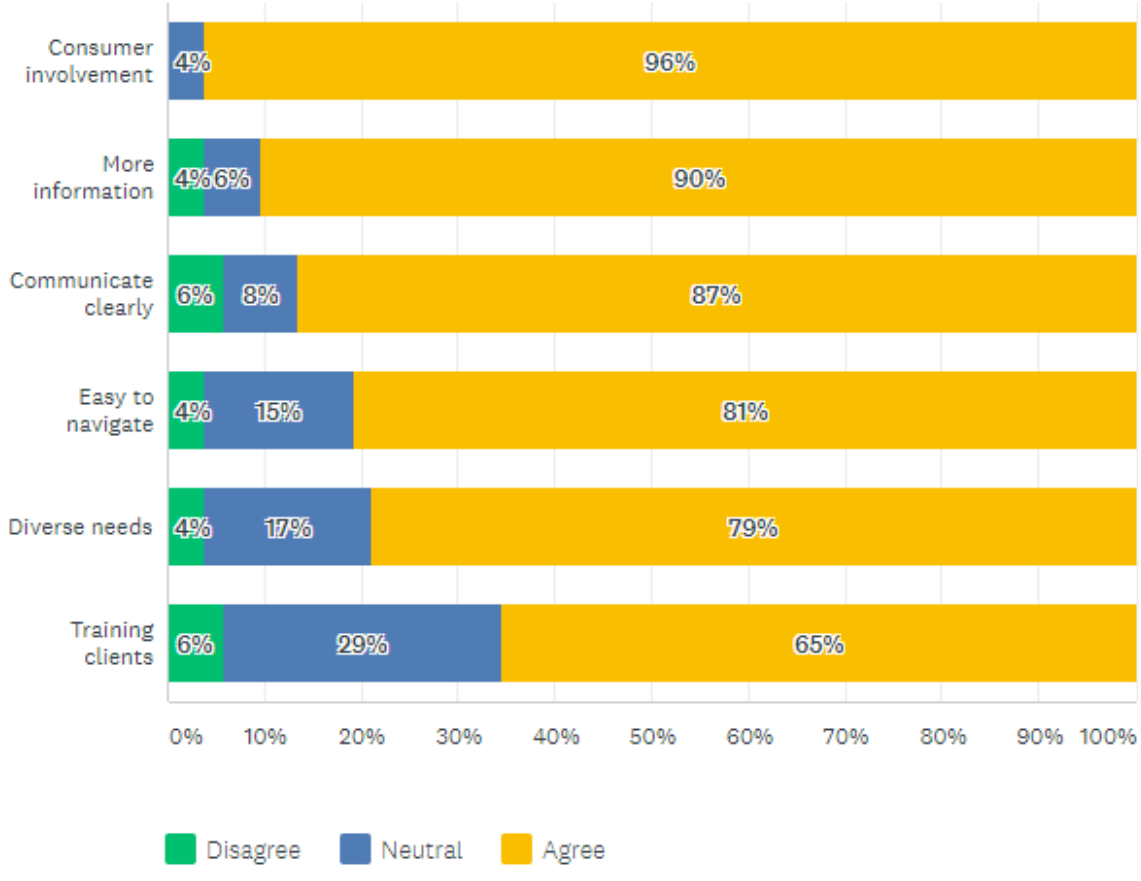
Statement	Category	Weighted Average
Providers should involve their consumers when designing/improving digital/online services	Consumer Involvement	4.48
Providers should have a better understanding of the diverse needs of their consumers and communities	Diverse Needs	4.21
Providers should take the time to explain things so that people understand better	Communication	4.21
Consumers need more information about what services are available	Information	4.19
Digital/online services should be easier to navigate, understand and use	Navigation	4.08
Providers should offer more training/support for me when accessing a digital/online service	Training	3.81

Some free-text comments included:

> *"I believe all service providers should provide digital solutions that work effectively for people of all abilities. Digital health services must be accessible and usable for the widest audience possible. Telephone should always be an option. Use simple plain language."*

> *"The expectation that anyone over the age of 55 knows anything about computers and how to use them is not often taken into consideration everyone assumes oldies can use computers and they often don't!"*

When the data categories are combined to reflect Agree versus Disagree, the data shows a strong preference for training/support opportunities across all domains.



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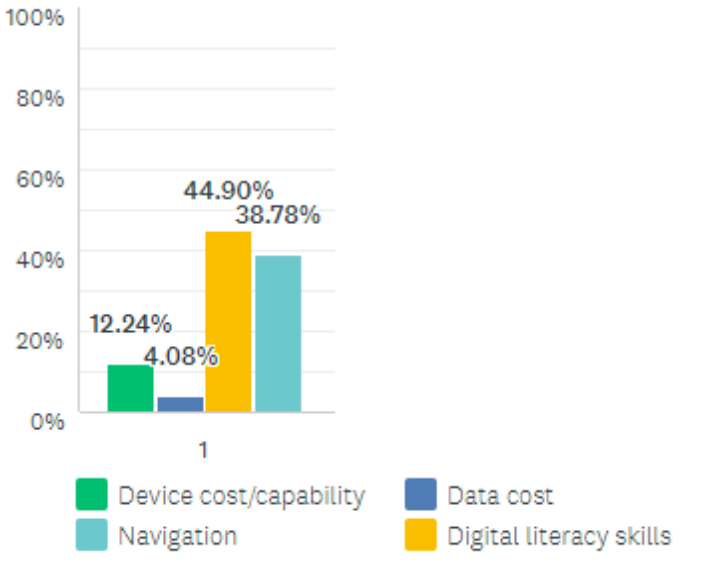
What did people want service providers to be aware of?

Survey participants were asked what they want service providers to be aware of. They were asked to rank four key issues in order of importance. These issues were the emerging themes from the focus groups. Including this question in the survey would show us which issues were most important to the wider community.

The rank from highest to lowest was:

- **Digital literacy skills** and varying knowledge of how to use digital/online platforms.
- **Navigation** and difficulties not knowing where to go or who to contact.
- **Device cost** including age of device, and the capability of the device to perform.
- **Data** including its cost, using too much data too fast, and assuming everyone has data.

Statement	Focus Group Theme	Rank | Percentage
People don't always have the knowledge/skills to use a phone or computer.	**Digital Literacy Skills**	1 (44.90 %)
People can't always find information about where to go or who to contact. The system should be less confusing.	**Navigation**	2 (38.78 %)
Computers/smartphones can be too expensive, or too old to handle online appointments or websites.	**Device Cost/Capability**	3 (12.24 %)
Data can be expensive for people, or data can run out too quickly. Don't assume that everyone has data available.	**Data**	4 (4.08 %)



How else could we improve things?

What other ideas did respondents have about making the system better?

Survey participants were asked if they have any other ideas about what people want and need from an online service.

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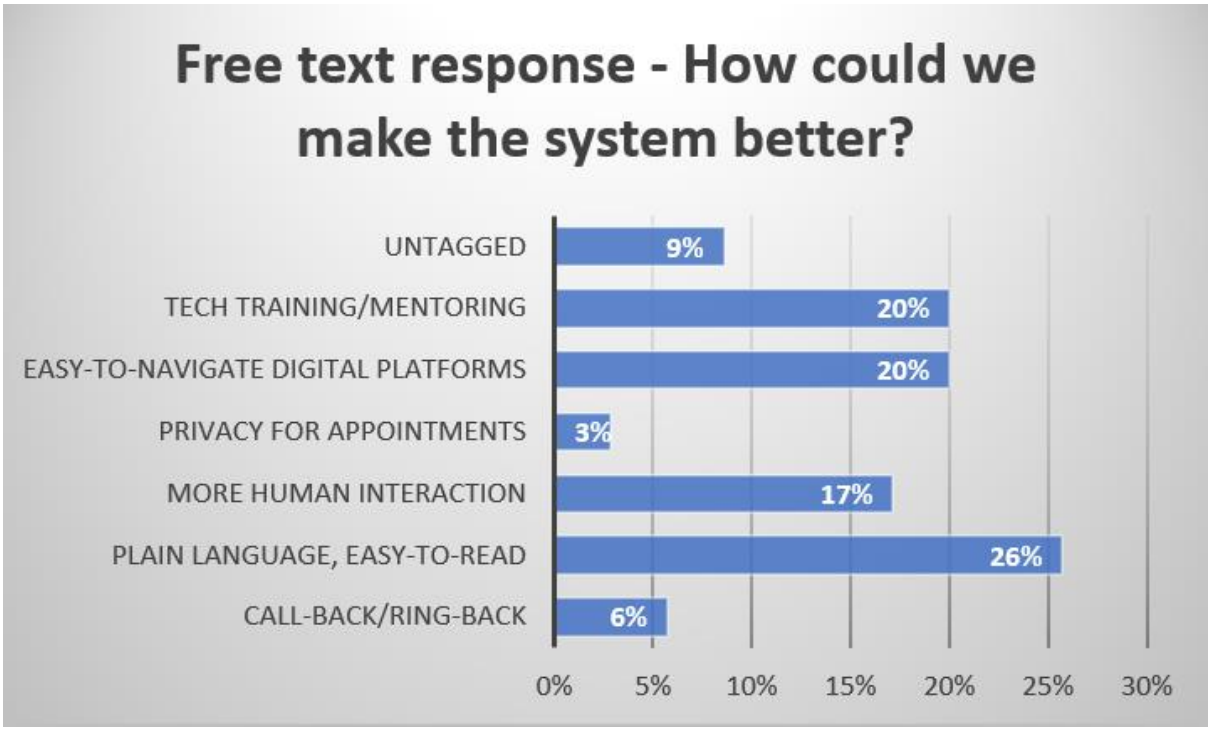
The three most recuring comments that were proposed were:

- Plain language. Making sure websites and digital platforms are written in plain language, and are easy to read (26%)
- Training/mentoring. Having digital skills training or mentoring available in the community (20%).
- Digital platforms. Making sure that digital platforms are easy-to-navigate (25%).



What examples did people share about their online experiences?

Survey participants were asked to share examples of when they used a telephone or smartphone to access a service provider online. The below themes were shared:

Limitations of phone/online services

Some conditions couldn't be seen over the phone (e.g., chest infection, sinus) and it was a negative experience. Sometimes the call or Zoom call would drop out or the call quality would be poor. Some people reported that their GP used only telephone, but they prefer Zoom, Teams or Facetime.

> *"I tried unsuccessfully to use zoom on my phone for a consult with my GP. Great I was bulk billed but couldn't get a visual image which was extremely important for me to show my GP what I was dealing with."*

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Another respondent reported that the COVIDSafe app and many other apps are not disability-friendly. They are not accessible with screen readers and haven't been designed according to the WCAG 2.1 requirements.

> *"Telephone is less personal/makes you feel less connected. If I had been offered it, I would have preferred teleconference (zoom). So essentially providers should always ask what is the user's preference: phone, teleconference, etc."*

Poor communication from providers

There was a theme that providers sometimes lacked in their communication. This had an impact when people were feeling unwell. On person reported that this was often about the system itself.

> *"I have had many interactions with my GP, up to weekly, over the past year. I have been so grateful for this service. I have interacted with a group of specialists in another state. Often, I will receive a call at 8pm of the appointment day and have no advice about when to expect a call. The call will then be rushed, and I have to fight to get some time to ask questions and gain an understanding of the information I am being provided. Often the call ends before I have reached an understanding and I am in the dark until the next follow up. As a health care provider, I am health literate and able to advocate for myself but also have this issue; I worry for those who are not able to do so."*

Generally, very positive experiences with GPs

Overall, people reported positive experiences engaging with their providers (mostly GPs) over the telephone. 37 percent of all text responses were regarding positive experiences with a GP. It was noted that telephone appointments saved on travel and parking costs. For simple procedures, such as reviewing medical results, this worked well. It was quite beneficial for scripts.

> *"Made a GP appointment and the GP called at the appointment time, all seamless."*
> *"Phone appointment with GP, worked perfectly and couldn't have done better."*
> *"Take time to listen."*

Excessive wait times and demand on the health system

There was a theme that people felt wait times were excessive and this was most likely due to the demand on the health system. Some people reported that messages are not always passed on, and it can be difficult to know who the correct person is to contact.

> *"Waiting on the phone being told how much your call matters, and how they are experiencing heavier than usual demands every time you ring is very, very stressful. And that is before you even start to explain your situation. On hold for so long, hung up in frustration. Over an hour that is. Very negative about bothering again."*

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Often people were not aware of new processes, particularly when engaging with services through an online system:

> *"I had a telehealth appointment, so I rang in at the time of my appointment to be told the GP would contact me when they were free. I was not advised of this at time of appointment. Minor problem but something to be aware of lack of communication which could be confusing."*

If people were waiting on hold, they said that having some information or resources available to read at the same time would be useful (e.g., a Frequently Asked Questions section on their website).

Difficult to navigate online information and use digital systems

There was a theme that people sometimes felt "bounced around" between systems and services, particularly when trying to find the right information online.

> *"I need to get a home support for myself and my husband. Every time we rang, we were put on hold and had to wait for a long period of time and then they didn't understand when they told me to go online, and I didn't know how?"*

> *"Recently I used the computer to make an online physio appointment. I had to fill out a form that was a picture, not a PDF doc. I couldn't get it to work. Things like this should be easy."*

> *"I didn't access online, but I did search for GPs offering vaccination to the over-50s. Someone has gone to a lot of trouble to produce a useless website (that I see the premier promotes). Out of interest I followed all the links and none of the GPs in Launceston offered online booking (only by phone). They might as well have just listed the phone numbers at the outset rather than waste people's time with a website which appears to offer online booking only for each GP to end up saying 'no appointments available online' or 'call'. "*

Results: Provider Survey

Quantitative information was collected through two surveys: One for consumers and one for service providers.

Summary

Health and community industry engaged. Health care and community service providers were well represented in the survey, with 64 respondents. Almost half of the respondents from community service organisations (49%) and a similar number from health care providers (41%). Most respondents serviced South Tasmania (38%), North-West Tasmania (24%), Statewide (29%) and North Tasmania (13%).

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Benefits of digital service delivery. The benefits of online appointments meant that staff improved their digital skills, more consumers could be reached, and consumers who were unwell or who had transport issues could now attend.

Results could be delivered to patients more effectively, and news could be shared over social media. Online appointments allowed for flexibility, and consumers could attend from the comfort of their own home. For providers who delivered education, they could reach larger groups than usual when in person.

Support for consumers to help them engage with technology. Providers said that almost all (95%) of their consumers had accessed their services during COVID. Providers stayed in contact with their consumers often, and mostly through phone (84%). Providers shared that their consumers faced challenges with the cost of devices and data, and poor digital literacy skills. There was a sentiment that online worked well for people who knew how to use it, but it caused a divide for people who were fearful of technology.

Digital inclusion is still an issue for people disproportionately affected by COVID-19. Providers believed that digital affordability, digital literacy, and data were the biggest barriers that consumers faced. The biggest impacts that providers faced for their organisation were poor consumer digital literacy, inadequate in-house technology, and low digital skills for staff. Fundamental challenges were noted in poor internet/mobile coverage across Tasmania, compounded by low digital literacy rates.

Face-to-face was still seen as preferred. Digital service delivery was seen as not a complete replacement, but as a tool that can be used where needed. The overall sentiment was that face-to-face appointments are better to see body language, cues, and one's full physical health and allows for more personal attention. Before COVID, in-person and telephone appointments were very common. COVID saw an increase in telephone use and online video use increased but only for occasional use.

Support and training for providers. Most providers were highly confident using online or phone to engage with their consumers, however, they indicated they would like more training to help their consumers use technology, how to make their services easier to navigate, and how to involve consumers in co-design.

Demographics

A total number of 63 service provider workers participated in the provider survey. Most respondents serviced South Tasmania (38%), North West Tasmania (24%), Statewide (29%) and North Tasmania (13%).

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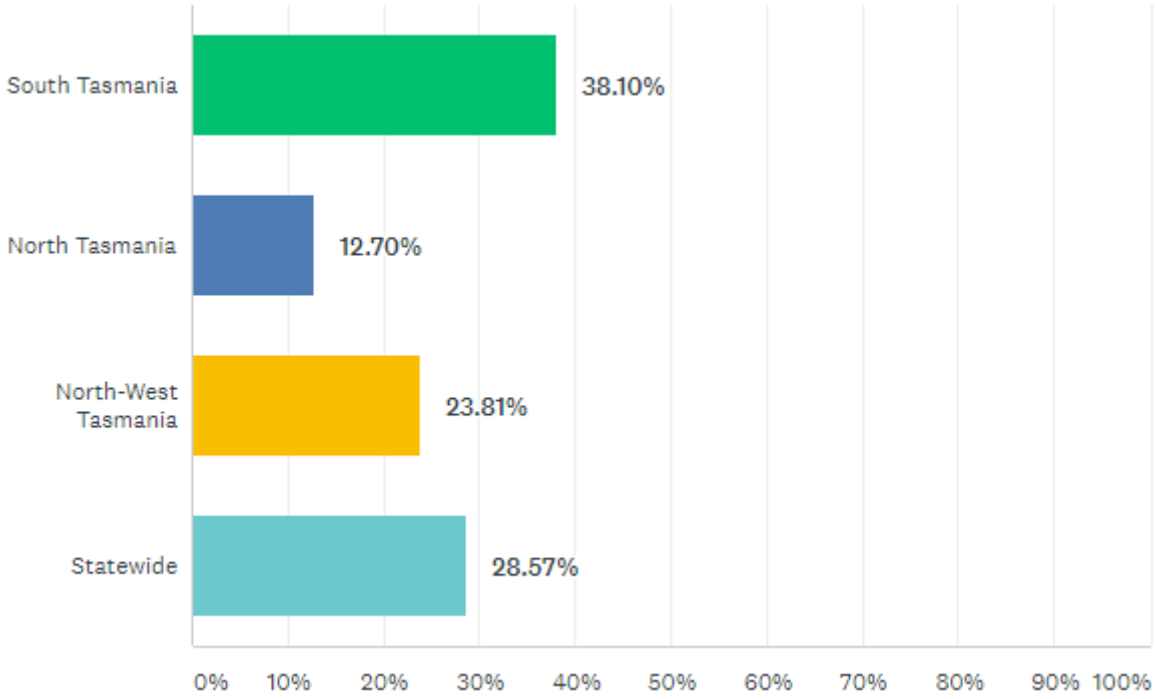
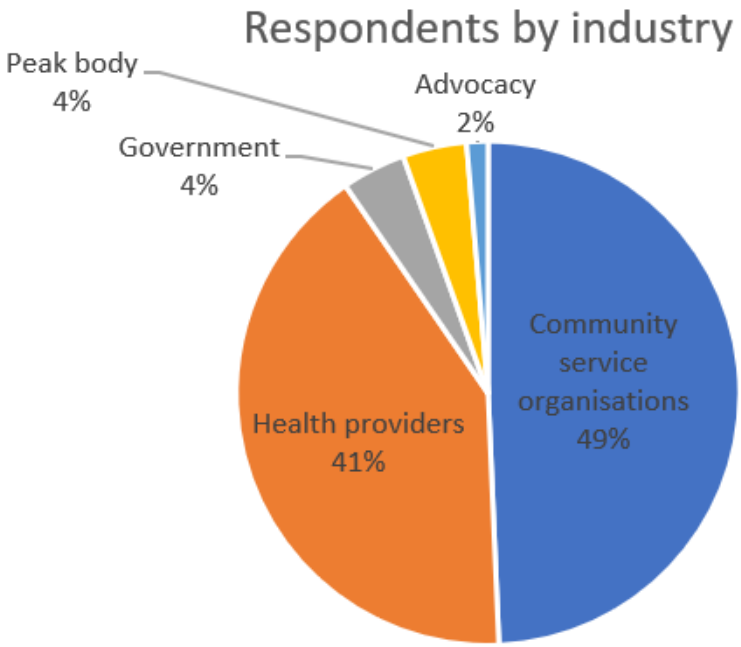


Respondents were asked which category best describes their service. The highest response was community service organisations (54%). General Practice services accounted for six percent (4 respondents), with allied health (14%) and other health (14%) being the two largest categories.

When grouped in aggregate, there was a relatively even split between health providers (41%) and community service organisations (49%).



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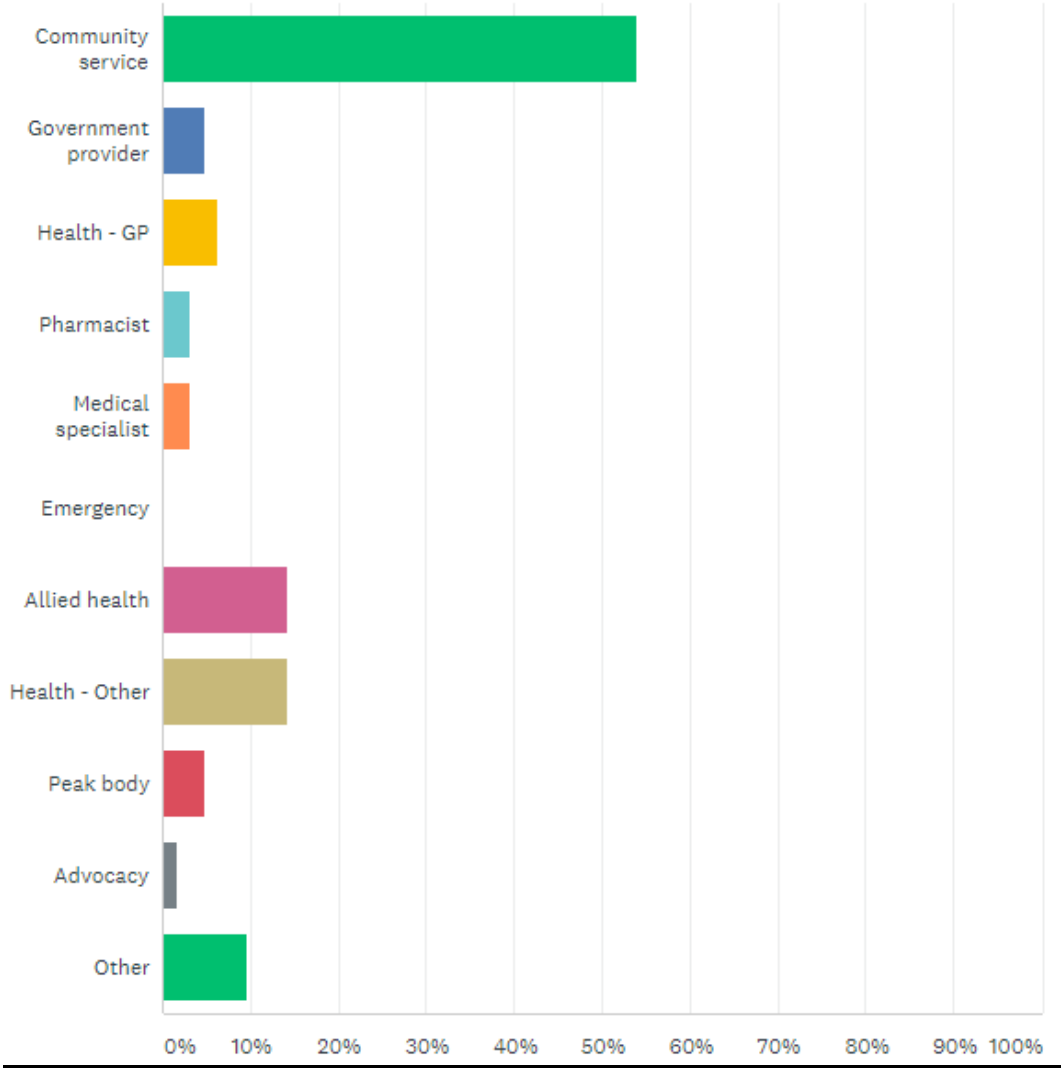
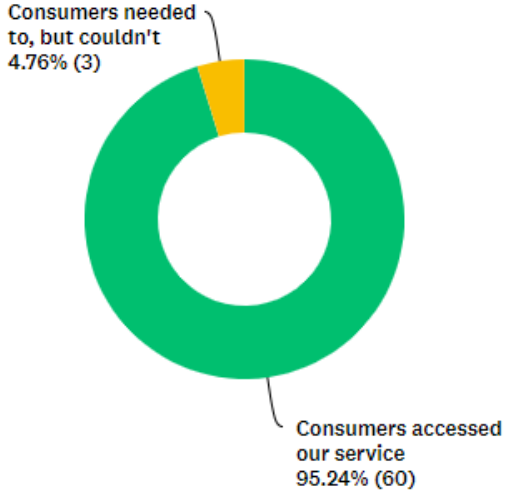


What services did people need?

Did people need to use a service provider during COVID-19?

Respondents were asked if consumers (or patients) accessed their service during COVID-19. A large majority (95%) percent said that they did access their service, and 5 percent said that their consumers needed to access their service during COVID-19 but weren't able to. No respondents said that their consumers didn't need to access their service.



When asked why not, three respondents reported that their state-based service was moved online (national service only continued); elective surgery was limited and therefore their service couldn't continue in the same capacity; and one respondent reported that their service was very cautious due to working with aged people.

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What did services do if their consumers had difficulty accessing them?

70 percent of respondents said that they contacted their consumers by telephone or text if their consumers had difficulty accessing them.

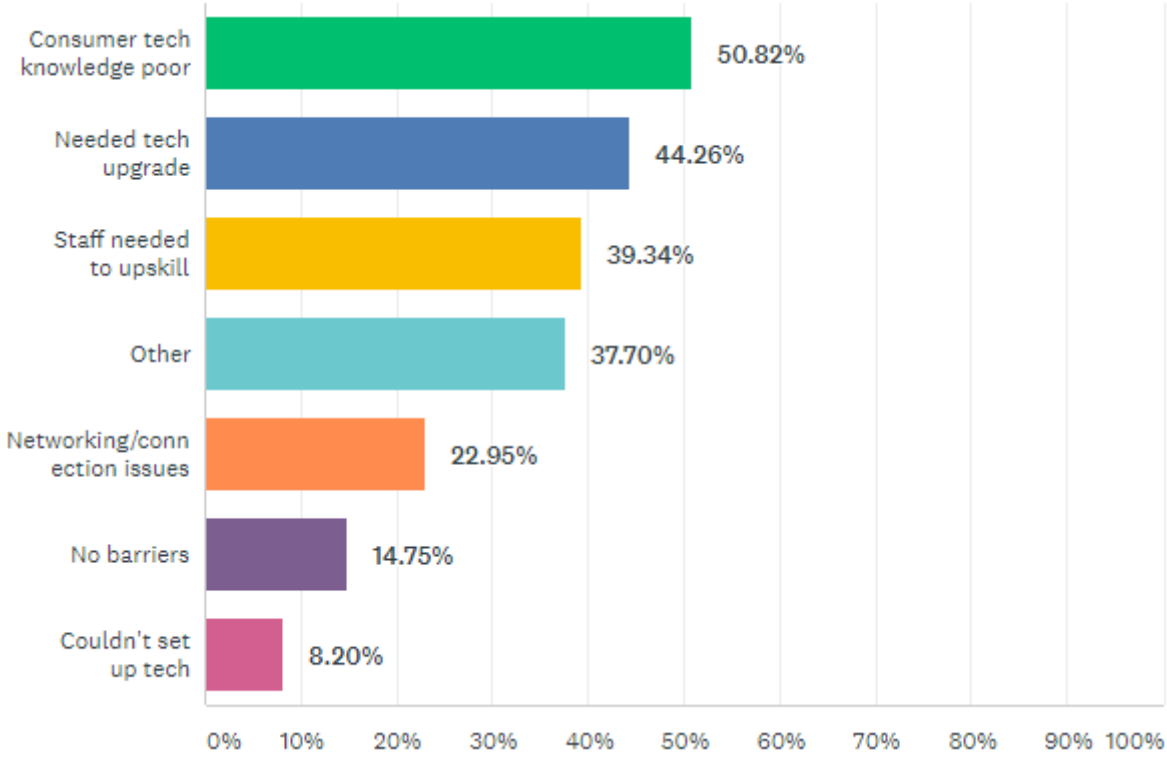
Some respondents shared that their consumers may have missed appointments due to reasons such as:

- Late to appointments as people were unaware of the screening processes at reception which could take an additional 10-15 minutes.
- Could not access buildings for face-to-face appointments.
- Low or nil attendance because of fear of contracting COVID-19 and fear of leaving the home or using public transport.
- Some people were reluctant to allow assessors into their homes to conduct comprehensive assessments.
- Many consumers postponed face-to-face appointments and opted for a digital service where available.

What were the barriers that impacted services?

The biggest barrier reported by providers was that consumers didn't know how to access digital/online services offered by a provider (51%).

The second biggest barrier was that providers needed to upgrade their technology 44%). Thirdly, providers needed to upskill and learn how to use digital/online systems (39%). However, only eight percent of providers reported that they weren't sure how to set up their digital/online systems.



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The ‘Other’ response field (38%) comprised a range of interesting feedback:

- Need to purchase video conferencing software.
- Some direct services were not suited to digital delivery.
- Many consumers didn't have access to devices and/or internet or couldn't afford the data or phone calls.
- Some consumers were isolated and without family to support them (e.g., elderly).
- Poor digital literacy.
- Clinic rooms meant that carers were often left out.
- Waiting lists blew out due to clinic closures.
- Black spots (particularly in North West Tasmania) where internet is not accessible.
- Consumers were fearful of engaging.
- Service had to purchase electronic devices to keep clients connected so they didn't miss out.
- Having enough equipment to allow staff to work from home (in-office most staff shared equipment).

“While we attempted to do assessments by phone, this didn’t get a true assessment of a client’s needs and wants for their care. Elderly people are less likely to be digitally literate and have more difficulties with health literacy. Face to face assessments are important, one of the biggest barriers was ensuring clients it was ok.”

“For ourselves as workers, working-from-home tech was clunky and at times non-operational, while the processes brought in to substitute supervision and ensure productivity felt punitive and sceptical of workers. Greater tech might have allowed more intuitive/less labour-intensive record keeping.”

How did consumers know about digital/online services on offer?

Providers were asked about what they did to let their consumers know whether they were offering digital or online services. Most respondents had used telephone (84%) to let their consumers know they were offering digital or online services during COVID-19.

This was followed by social media (55%), word-of-mouth (54%), email (46%), websites (30%) and other (24%).

Less commonly used communication methods were print media (7%) and Google advertising (4%). Some responses in the ‘Other’ category included communication through:

- Service provider network meetings.
- Social media messaging (e.g., WhatsApp).
- Posted letters.
- Communication with phone interpreters or bilingual workers.

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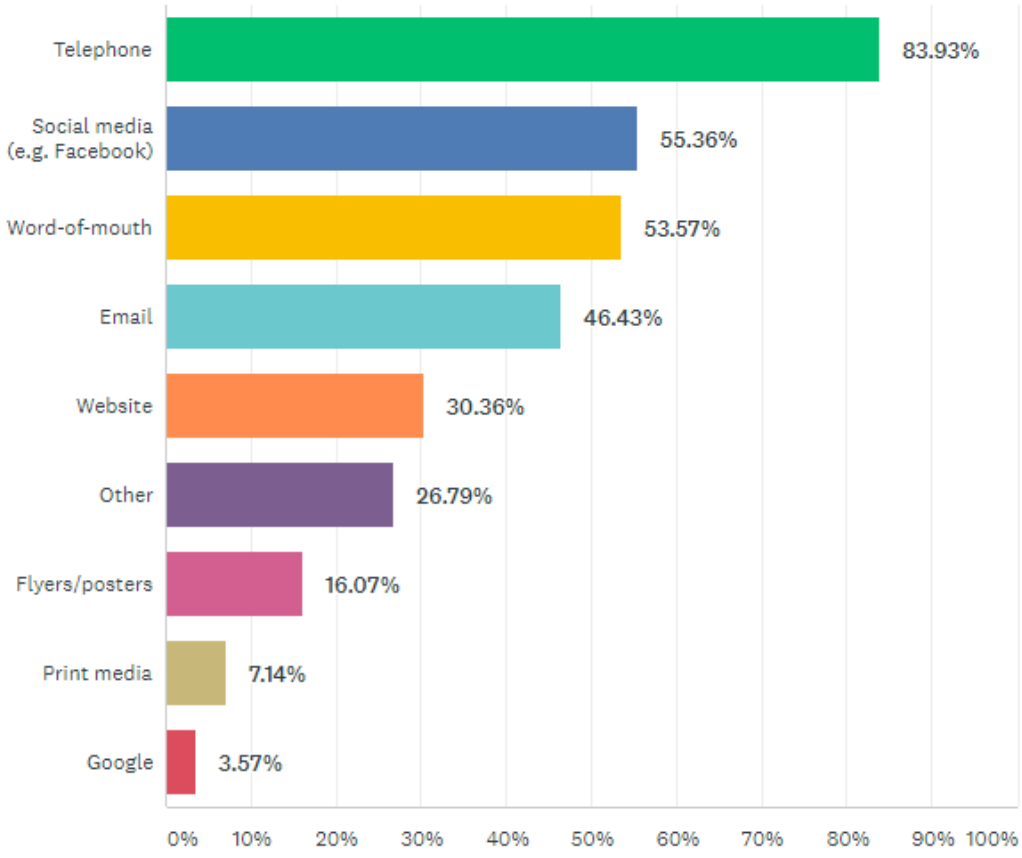

What worked well for providers?

Respondents were asked what worked well for them if they offered online/telephone appointments.

The most common responses were that staff improved their digital skills and knowledge (57%), providers could reach more consumers (55%), and online appointments meant that consumers with transport barriers or who were unwell were more likely to engage with their service (54%). Only 11 percent of respondents reported that they did not see any benefits. 25 percent reported benefits in the 'Other' category. Free text responses included:

- Remuneration for work which was already being done.
- Ability to send and receive text messages, which helps people who are reluctant to make phone calls.
- Higher turnout rate and fewer cancellations.
- More consumers taking advantage of online/digital appointments as they became more accepted as a service option.

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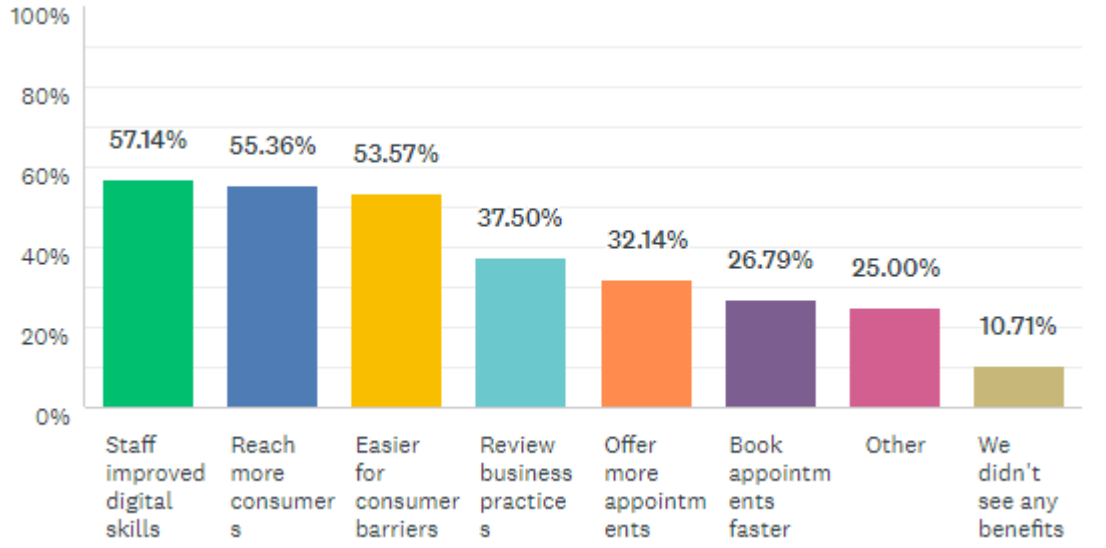

Answer Choice	Percentage
Our staff improved their digital skills and knowledge	57.14%
We were able to reach more consumers by having online/telephone appointments	55.36%
People who were unwell or who had transport barriers were more likely to reach us by using online/telephone appointments	53.57%
It was an opportunity to review our business practices and offer new solutions (e.g., online booking system, call-back)	37.50%
We were able to offer more appointments by having online/telephone appointments	32.14%
Our consumers were able to get appointments faster by having online/telephone appointments	26.79%
Other	25.00%
We didn't see any benefits	10.71%

How did providers engage with consumers before and after COVID?

Respondents were asked how often they engaged with their consumers before COVID-19. The categories were for in-person appointment, telephone, online video (e.g., Zoom), email, and other.

The results from this question found that:

- In-person was the most common way providers engaged pre-COVID, with 33% engaging Often and 62% engaging Always.
- Telephone was the second most common way providers engaged pre-COVID, with 34% engaging Sometimes, 36% engaging Often and 27% engaging through telephone Always.
- Online video (e.g., Zoom) was never used 64% of the time, and only used Often 7% and Always 2%.
- Email was used 44% of the time rarely and used 30% sometimes.
- The Other category included free text responses overwhelmingly suggesting social media and text messaging.

In summary the data suggests that before COVID-19, in-person and telephone appointments were used far more often than email and online video appointments.

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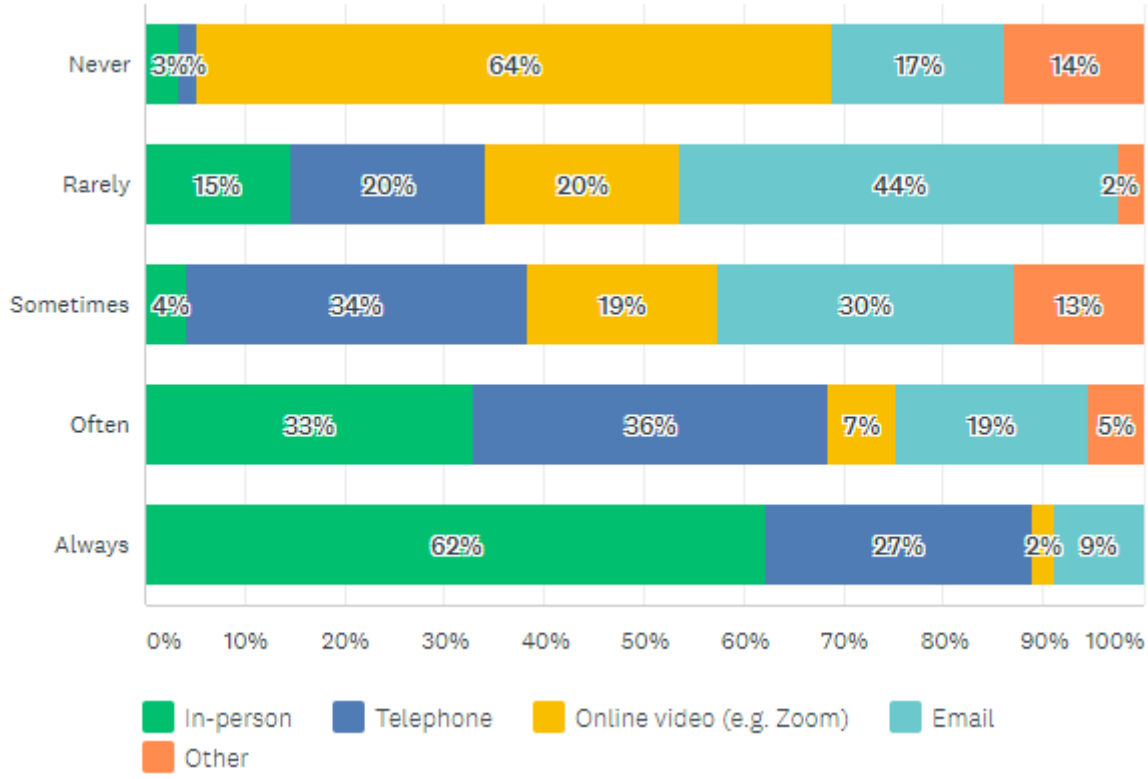

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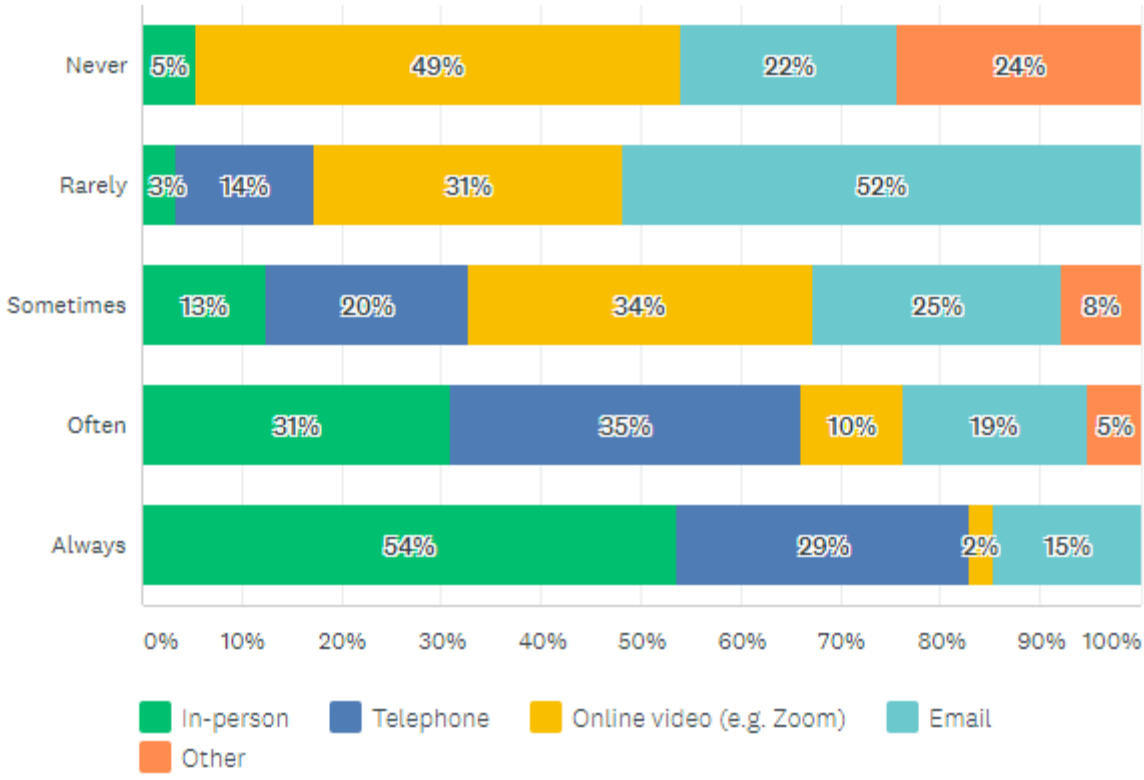
Respondents were asked how often they engage with their consumers now (after COVID-19). The categories were for in-person appointment, telephone, online video (e.g., Zoom), email, and other.

The results from this question found that:

- In-person is the most common way providers engage with their consumers, with 31% engaging Often and 54% engaging Always.
- Telephone is the second most common way providers engage with their consumers, with 35% engaging Often and 29% engaging Always.
- Email is the third most common way providers engage with their consumers, with 25% using it Sometimes, 19% using it Often, and 15% using it Always.
- Online video (e.g., Zoom) was used Sometimes (34%), Rarely (31%) and was Never used 49% of the time.
- The Other category included free-text responses overwhelmingly suggesting social media and text messaging.

In summary the data suggests that in-person and telephone appointments are still used more heavily than online appointments and email.



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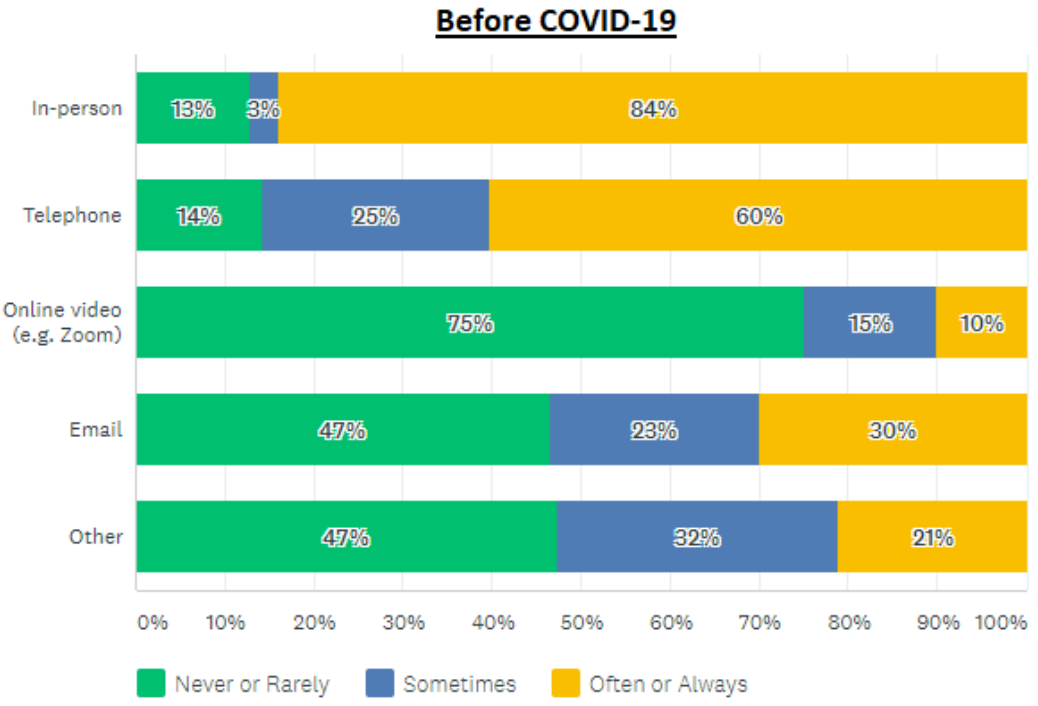
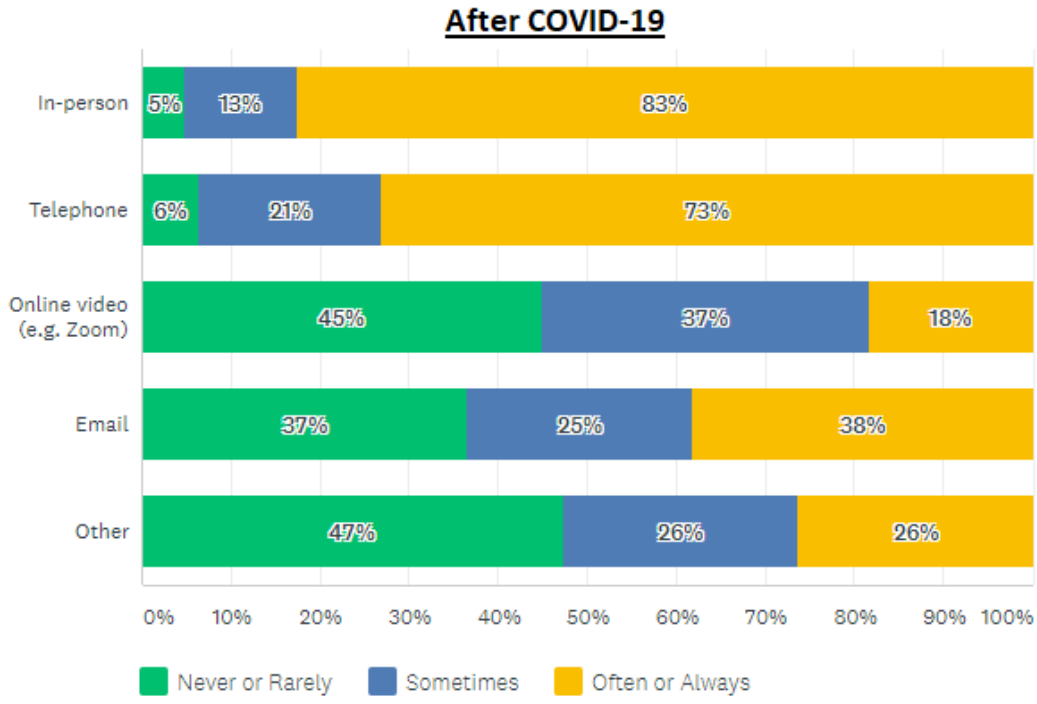
Analysed side by side, the data suggests that:

- Before COVID, in-person (84%) and telephone (60%) were the most often used methods. Only 10 percent of the time was online video used often.
- After COVID, uptake of online video increased, but not by a large margin. The percentage of providers not using online video decreased from 75 percent to 45 percent, and more providers used it sometimes. Telephone use also increased from 60 percent to 73 percent.





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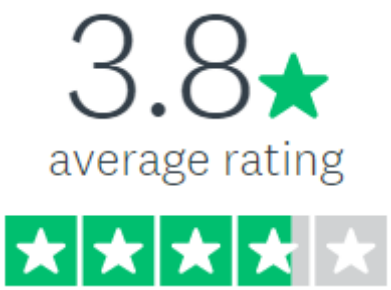
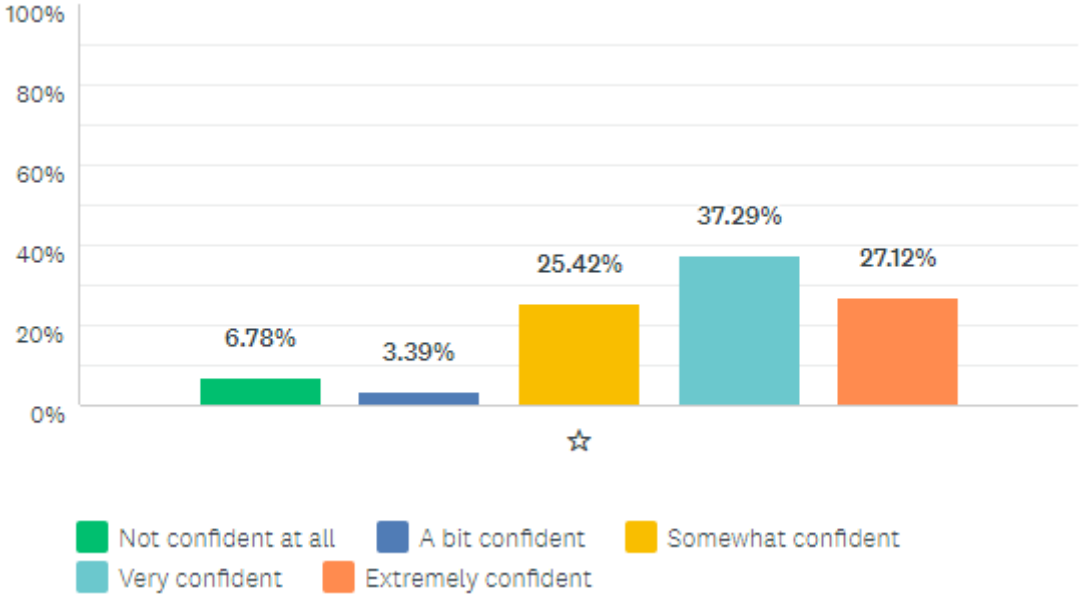
How did providers feel about engaging online?

How confident did service providers feel using an online or telephone appointments to engage with their consumers?



On average most service providers (64%) reported a high level of confidence using an online or telephone appointment to engage with their consumers.
People felt either Very Confident (37%) or Extremely Confident (27%). A smaller number said they felt Somewhat Confident (25%), and 10 percent reported feeling A Bit Confident or Not Confident At All.



What do providers think are the biggest issues consumers face?

Service providers were asked what they think are the biggest barriers that consumers face when using online/telephone appointments. They were asked to rank four key issues in order of importance. These issues were the emerging themes from the focus groups and including these questions would tell us which issues were seen as most important by service providers.

The rank from highest to lowest was:

- **Device cost** including age of device, and the capability of the device to perform.
- **Digital literacy skills** and varying knowledge of how to use digital/online platforms.
- **Data** including its cost, using too much data too fast, and assuming everyone has data.
- **Navigation** and difficulties not knowing where to go or who to contact.

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Statement	Focus Group Theme	Rank | Percentage
Computers/smartphones can be too expensive, or too old to handle online appointments or websites.	**Device Cost/Capability**	1 (32.79 %)
People don't always have the necessary knowledge/skills to use a phone or computer.	**Digital Literacy Skills**	2 (31.15 %)
Data can be expensive for people, or data can run out too quickly. Not everyone has data available.	**Data**	3 (24.59 %)
People can't always find information about where to go or who to contact. The system should be less confusing.	**Navigation**	4 (11.48 %)

What training or support would providers like?

Service providers were asked what training or support opportunities would support service providers in the digital or online space. These statements reflect categories in the HeLLOTas! Toolkit as well as some emerging themes that arose from the consumer focus groups. Consumers were also asked a similar question in the consumer survey, asking respondents to nominate what they think are the most important things that service providers should focus on.

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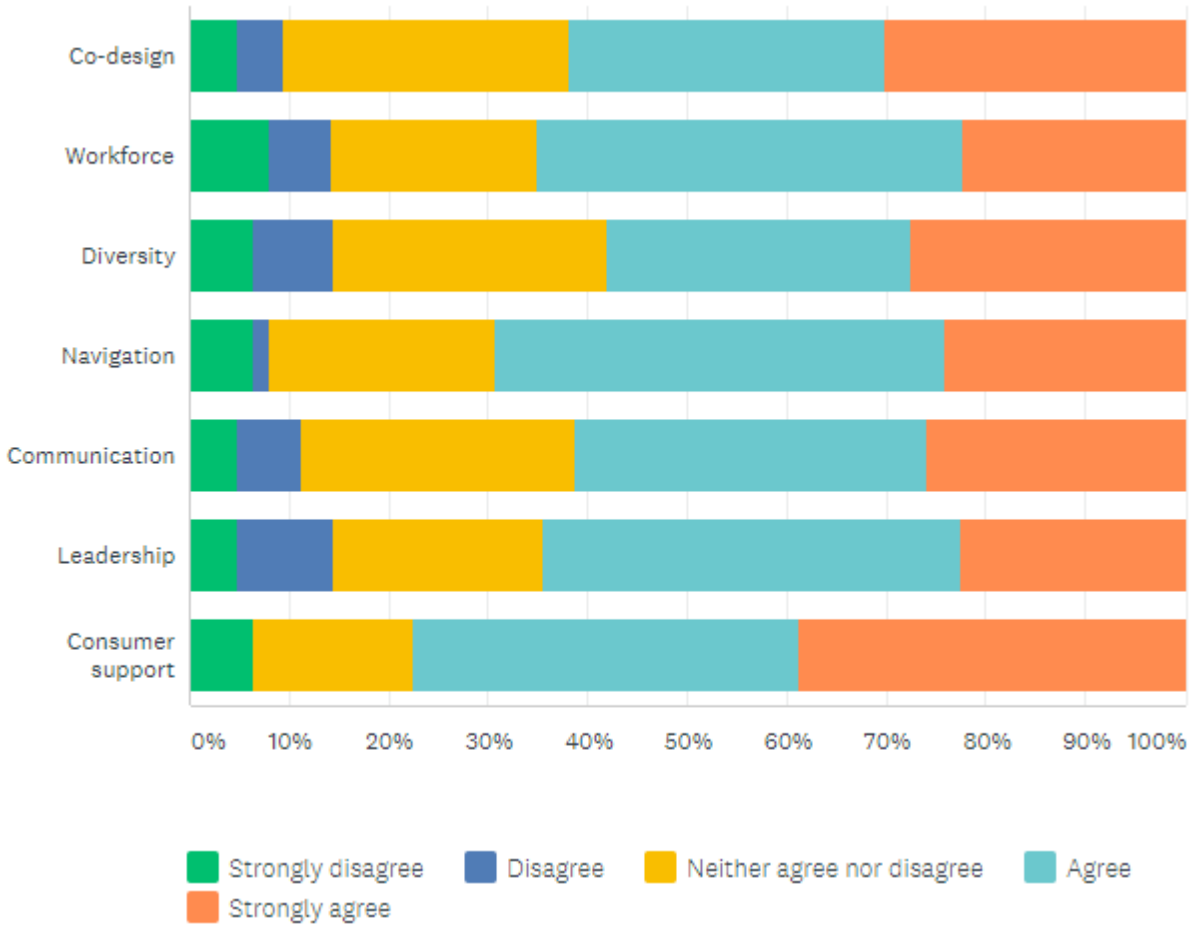

Statement	Category	Weighted Average
How to help our consumers use digital/online technology from home (e.g., practical tips/support for our consumers)	Consumer Involvement	4.03
How to make our digital/online services easier to navigate, understand and use (e.g., website)	Navigation	3.79
Involving consumers to design/improve our digital/online services (e.g., consumer needs)	Co-design	3.78
How to communicate more clearly with our consumers in the digital/online space (e.g., plain language, brochures)	Communication	3.71
How to improve our organisational policies/goals to be more health literate in the digital/online space (e.g., management/culture)	Leadership	3.68
Improving our staff's health literacy skills in the digital/online space (e.g., knowledge)	Workforce	3.65
Improving our digital/online services to reflect the diversity of our consumers	Diversity	3.65

When the data categories are combined to reflect Agree versus Disagree, the data shows a strong preference for training/support opportunities across all domains.

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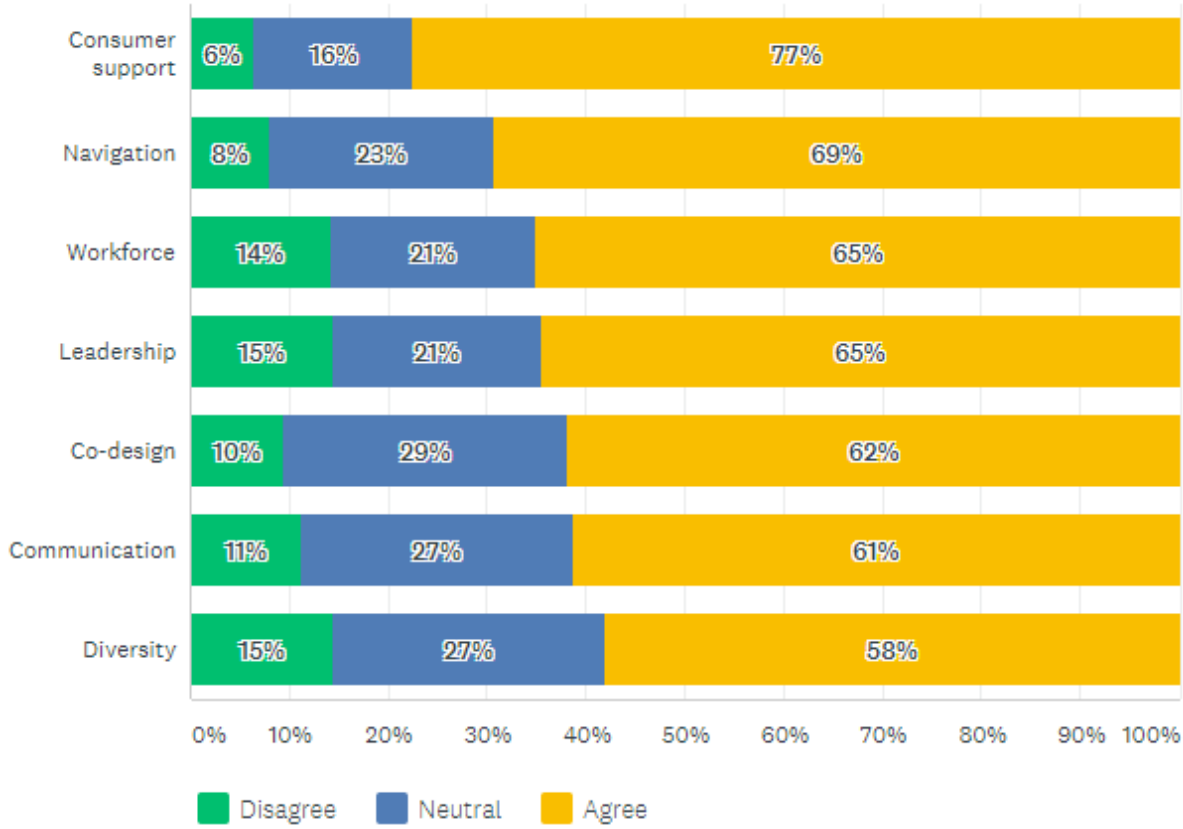

What stories did providers share?

Survey participants were asked if they have any other ideas about what people want and need from an online service. They were invited to share stories about things that worked or didn't work when they engaged with their consumers. Several themes stood out:

<u>Digital service delivery allowed for more flexible arrangements</u>

Video conferencing allowed providers to engage in more flexible ways.

One health service shared that they were able to provide private, individual counselling sessions to mothers experiencing breastfeeding difficulties. This was achieved using break-out rooms with a breastfeeding counsellor and the mother and baby. This allowed for private conversation and allowed for detailed observations if necessary. The service reported that this also meant that others in the discussion could keep on talking whilst this happens.

> *"The inclusion of telehealth (both phone and video) as a mode of delivery for our clinical services has been a positive one overall. Patients are able to be seen in a timely fashion, wherever they live, and a reduction in travel means more clients can be seen each day."*

Digital service delivery meant that providers were not able to travel to see clients. This created an unintended benefit where service workers were able to increase their work capacity in some cases:

> *"During the lockdown in Tassie we worked fully on the phone or online. What worked was that we had time (usually travel to them) to offer more sessions per week if they wanted them.*

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What we found was often we as workers were more keen to engage more frequently than the clients were!"

The overall sentiment is that offering multiple streams of contact is preferred:

"Hybrid models, with lots of flexibility are best. Allow phone, online, text and face-to-face service options wherever possible."

Digital service delivery could be more efficient (when it worked)

Digital service delivery supported providers in several ways. These included getting results to patients in a way that was quick and easy, it was more cost effective as people were attending appointments from the comfort of their home, and online appointments also helped with staff safety and risk of contagion.

Digital service delivery such as social media, phone and online video suited a lot of families. This included patients who experience social anxiety, phobias, and have limited transport. Digital service delivery meant that consumers could attend appointments "literally in their PJs [pyjamas]" at home. This method of delivery made consumers more comfortable. However, if video connectivity dropped out during medical or mental health appointments, this caused frustration and interruptions to the flow of conversations.

Online education also reached a far wider consumer base (e.g., state-wide) compared to more traditional face-to-face local sessions within the community.

"We changed our day program to be online and supported clients to access digital services through client training."

For providers that delivered community-based education, training, and professional development during COVID, they also found a similar experience to frontline service providers:

"We developed one of our training programs to be delivered virtually, via video conferencing and accompanied by a PowerPoint presentation. We supplemented this with a folder of resources posted to attendees. We were able to deliver training sessions to people who otherwise wouldn't have been able to access it and with groups larger than usual. However, it was more difficult to deliver without the rapport and engagements that occur during in-person training, and harder to respond to non-verbal communication that would otherwise be more obvious."

Digital service delivery is not a replacement for face-to-face appointments

Digital service delivery was seen as not a complete replacement, but as a tool that can be used where needed. Respondents said they would not like to see it replace all aspects of appointments (such as initial assessments), but it can be very useful for the "in between" visits. The overall sentiment is that face-to-face appointments are better to see body language, cues, and one's full physical health and allows for more personal attention:

"Regardless of how much access to digital technology can be improved, it cannot compare to face-to-face engagement for our service. Most of our services are activity-based and are about reducing social isolation and these needs cannot be met effectively through digital platforms."

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This was acknowledged particularly in mental health service delivery. It was reported that connectivity/network issues were problematic and psychotherapy through telehealth is not as effective as face-to-face. It was noted that there are distinct benefits however, such as increased reach and engagement of clients. In some cases, the act of engagement itself was incredibly powerful:

> *"Clients were desperately wanting contact during COVID and being able to hear a voice on the end of the telephone or see a face on video was in some situations lifesaving."*

> *"We offer telehealth and find it perfectly adequate but not a replacement for in person consults."*

During COVID-19 some local services reduced or removed their coverage, which was rolled-up into national or centralised roles. One example was given where a service tried to help an individual navigate their way back into their program:

> *"The method was designed nationally and was not person-centred. Navigating the individual to undertake this was so complex that they gave up. Person centred care is lost when processes are designed on a population level that do not consider real world application."*

<u>Support for providers to help their consumers/clients engage with technology</u>

Providers shared that they would appreciate additional support to help their consumers and clients use technology. Examples were information sheets in plain language, and greater access to subsidised internet/devices would make a difference. Some providers reflected that there should be support for participants to attend telehealth appointments (e.g., a support person). This view was reinforced by feedback that some providers engage with their client's carers to help them navigate websites and services. During lockdown this was particularly difficult, as the digital literacy of a carer plays a strong role.

Not surprisingly, providers also experienced challenges managing the switch in technology. These challenges included staff working from home, conversations about how to support consumers who were reluctant to switch to telehealth, and the perception from clinicians that clinical care via telehealth was sub-optimal compared to face-to-face delivery.

One provider shared their experience using telehealth during the North-West Coast lockdown. They reported that initially, their consumers didn't adopt telehealth, but it worked well when they did:

> *"We do a lot of home visits and gain a lot of information (environment) when we do them - so a computer screen was limiting in this situation. However, having contact with clients and being able to walk them through issues was great and worked well for staff and we had positive feedback from clients as well."*

Sometimes providers would be able to support consumers "off the side of their desk" through small tasks. One provider shared that they gave assistance to a client to set up an email account, and that client now receives their monthly activity calendar via email. Some providers had the capacity to support their consumers in a larger way:

> *"We were able to have consumers who were isolated during lockdown call or email us with problems, and we could make adjustments to their devices remotely, or organise home visit support."*

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One provider made a philosophical comment that highlights both 'sides of the same coin':

> *"Those clients who used digital technology prior to COVID continue to use and increase their usage. Those clients who did not use digital technology prior to COVID, very rarely increased their usage. The latter continue to be fearful of the use of technology."*

Accessibility, affordability, and device capability issues for people who were disproportionately affected by COVID-19

Providers shared many reminders that some of their consumer groups are disproportionately affected by COVID-19 and offered some solutions. Accessibility and digital literacy were identified as issues impacting on consumers. Fundamental challenges were noted in poor internet/mobile coverage across Tasmania, compounded by low digital literacy rates.

Affordability was an issue for people who were disproportionately affected by COVID-19, such as people experiencing homelessness. Some consumers did not have data or a safe place to access services. One service reported that all their consumers were provided with support through phone and text messages:

> *"Due to working with young people who are experiencing homelessness or at risk of experiencing homelessness, utilising any other form of technology were generally out of their reach financially."*

> *"Some consumers did not have data or a safe place to access services (i.e., away from children or perpetrators of family violence)."*

One youth service reported that counselling sessions online worked well when children went back to school, however it did not work well when they were at home due to a lack of sufficient devices, connectivity issues, or no access to Wi-Fi at home.

Several comments referred to older populations and reminded us that elderly people may be affected by hearing or vision loss, which makes it difficult to engage with phone or online appointments:

> *"Elderly people are often hearing impaired so their ability to communicate effectively over the phone is challenging and can lead to mistaken understanding."*

One comment stood out regarding the importance of consumer involvement when considering how services are designed and implemented:

> *"PLEASE do not let bigwigs at the top make a decision of efficiency of on-line services without really considering how many mental health clients live. Extreme poverty, extreme suspicion of technology, extreme difficulty concentrating to learn new skills - and that's when they have reliable internet access."*

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Discussion

What were the main observations?

Digital service delivery models have many benefits

Digital service delivery models generally improve service delivery and access for providers and consumers alike. For providers, online appointments meant that staff improved their digital skills, more consumers could be reached, and consumers who were unwell or who had transport issues could now attend. For providers who delivered education, they could reach larger groups than usual when in person.

For consumers in the pandemic, online appointments were a welcome change for simple consultations (e.g., repeat prescriptions from GPs). Some physical barriers, such as transport and parking, are removed when people engage online. This also improves service delivery for outreach services who can spend more time engaging with consumers instead of travel. Consumers can also attend appointments from the comfort of their own home. The physical environment can be used as a tool between consumer and clinician to interact in the consumer's home environment.

Digital service delivery models have some limitations

A limitation of digital service delivery models is that they are not accessible to all. Tasmania ranks the lowest out of Australia's eight states and territories in digital inclusion and some groups in Tasmania experience particularly high levels of digital inclusion. Access, affordability, and digital ability issues were demonstrated in the focus groups and surveys, and levels of digital exclusion are higher in areas of relative socioeconomic disadvantage.

One limitation of digital service delivery models is privacy. Whilst arguably more convenient, the safety of a clinical or off-site room is removed if you are accessing an online appointment from a place that is not safe. Feedback from clinicians suggested that they prefer face-to-face for initial appointments due to information being more available (e.g., behaviour, expressions, communication) to fully understand the presenting needs. Hybrid models (e.g., mixed face-to-face and online) don't seem to work well. People preferred one or the other.

Digital literacy is a key concern for Tasmanians

Low digital literacy is a key concern for people in Tasmania. People shared stories that they would "give up" after trying to find information online, particularly on older devices that were slower. In a health context, this is important because if someone is feeling unwell, they may have a reduced capacity to find what they need. There is a sentiment that providers should not assume that it is "enough" simply for information to be hosted online. More work needs to be done to educate and inform consumers to improve their digital literacy skills. A large component of this lies at the organisational level of health literacy.

It was acknowledged by most people that poor digital literacy had an impact on people's mental health overall. For consumers who were already feeling isolated, COVID was an accelerant for this. It made social connection for consumers difficult and negatively impacted their mental health. In the consumer survey, respondents said that the most important issue for service providers to be aware of is digital literacy skills.

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People need support navigating systems

People reported feeling anxious about not knowing where or how to access services. People said they would greatly appreciate a central source of information about all services in their local area. This prompted discussion regarding the FindHelpTas online service directory. Interestingly, during the focus group discussions no participants had heard of FindHelpTas nor the *Digital Ready for Daily Life* or *Health My Way* programs but were positive to hear that these services existed.

During the pandemic, local services maintained a connection to their consumers. In the focus groups, there was a sentiment that larger organisations were difficult to contact, and they did not understand (or have the resources to deal with) people with low digital literacy. For example, there were some people who were accessing Centrelink for the first time. When they spoke to the customer representative, the consultant said, 'You can just do that on the computer', but that person had never owned a computer before and was not digitally literate. Localised service delivery was appreciated (e.g., small GP practice, local IGA store).

If people couldn't find they help they needed, they would generally seek out known supports from relatives or friends. It was recognised that this was not always accurate, especially when seeking clarification around key messages during the pandemic. Within the Culturally and Linguistically Diverse (CALD) context, communication and messaging was crucial and local communities developed innovative ways to address this.

Cost of living for people disproportionately impacted by COVID-19

The data clearly indicates that there can be a high cost to accessing a digital service. This includes the cost of devices, data, and telephony, and balancing this in line with everyday living expenses. Both focus group participants and service providers reported this. The high cost disproportionately impacts those people who are on low incomes. In addition, some devices are too old to sufficiently handle websites and appointments. One of the biggest barriers that people on low incomes face is the high cost of data. Simple appointments can consume large amounts, and this leads people to ration their data budget. In lieu of this, public Wi-Fi places are used but they aren't practical for private appointments.

Similarly, during the pandemic people needed to call telephone helplines to access information and services. This was problematic if you did not have credit. People were obliged to use public payphones, and this was not practical if people were on hold for long periods of time.

Changing patterns in service delivery before and after the pandemic

Due to the rapid deployment of online services during COVID, we expected to see an increase in telephone and online video use. However, the results from the provider survey suggested some interesting findings.

In-person and telephone appointments were the most common ways to engage before COVID (84%, 60%), but telephone engagement increased to 73 percent after COVID. In-person appointments dropped marginally by one percent.

Before COVID, online video was used only 10 percent of the time often or always. After COVID, this increased to 18 percent often or always. The largest increase was seen in occasional use – occasional use of online video increased by 15 percent to 37 percent (22% uptake).

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Greater support and training for service providers

Both providers and consumers suggested that service providers would benefit from greater support and training opportunities. Consumers felt that providers should involve their consumers more when designing online services, understand the importance of diversity, and communicate clearly. Information should be accurate and easy to navigate, and training should be provided to consumers if necessary to help them use an online service.

Consumers suggested that information should be written in plain language, training and mentoring for consumers should be available in the community, and digital platforms should be easy-to-navigate. For consumers, mentoring and training appeared to be of a higher need than as perceived by providers.

Assumptions and limitations

As with any scientific line of enquiry, there are assumptions and limitations that we can make regarding the findings. These can lead to opportunity to refine and improve methodology for further research.

Differences in what people and providers felt were important

Survey respondents (consumers and providers) were asked to rank four key issues that they thought were most important for service providers to be aware of. (Note that this was different to a question which asked them to report their own barriers.)

Key Themes from Focus Groups (Consumers)	Key Issues Ranked by Consumers (Survey)	Key Issues Ranked by Providers (Survey)
Financial cost	Digital literacy skills	Device cost
Data	Navigation	Digital literacy skills
Digital literacy skills	Device cost	Data
Navigation	Data	Navigation
In-person vs online		

Within the focus groups, financial cost and data was most important, whereas in the consumer surveys, these were ranked as being lower importance. There is no demographic data to distinguish between the two groups, however one potential explanation for the difference between the groups is self-selection based on consultation type which may have seen people on lower incomes more strongly represented in focus groups as compared to an online survey. Because survey participants responded online, it is also more likely that survey participants had access to devices and sufficient data.

Differences in what barriers people faced

One of the interesting findings was some differences in the results from the consumer focus groups and the consumer survey. Within the focus groups, the most prevalent themes were the cost of devices, and data. Having a choice over the type of appointment was mentioned, but people didn't have a strong preference for this.

This is contrasted in the consumer survey. The most prevalent barrier reported was that consumers want greater choice and control over the type of appointment (55%). Data was a lower

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barrier (16%), as was digital literacy skills (16%), and the lowest barrier for respondents was device cost (3%). However, when asked what they think is the most important issue that service providers should be aware of, they stated digital literacy skills. This indicates that while digital literacy skills weren't a barrier personally, most people who completed the consumer survey felt it was an incredibly important consideration, nonetheless.

We may be able to assume from the samples that the focus group participants were disproportionately affected during the pandemic and may have experienced a higher degree of hardship. If someone was not in financial hardship, then it would be reasonable to assume that device cost and data would be of comparatively low concern. It can be assumed that there is a relationship between low socioeconomic status and low digital literacy skills, as levels of digital exclusion are higher in areas of relative socioeconomic disadvantage.[23]

Distribution and sample size

There was strong representation from service providers who engaged through the provider survey, with 64 respondents across Tasmania. Anecdotally in our conversations with providers we heard that services were experiencing "consultation fatigue." Therefore, we were pleased with the uptake rate of respondents given the constraints that providers are commonly under when balancing workload priorities.

Seeking representation in the community for the consumer focus groups was somewhat more challenging. More resources went into establishing a focus group, and some lines of enquiry ended up failing. Even after extensive communication there were times when provider workload simply exceeded their ability to support a focus group. Individual interviews were undertaken where the opportunity arose, but there was limited uptake for individual interviews with people who were disproportionately affected by the pandemic. Whilst we would have appreciated a wider sample size, we believe the data is highly rich and thematic saturation was reached.

Regarding the consumer survey, as mentioned in the Results section of this report, the survey instrument was distributed and completed online. It is fair to assume that this may have limited the potential pool of respondents. Due to time constraints our partner organisations weren't able to connect us with individuals who could participate, however, further research may wish to explore this with specific community subsets.

Recommendations

What are our key recommendations?

- Develop a set of actions with our partners based on this report.
- Continue to engage with service providers to promote organisational health literacy.
- Build the findings of this report into the HeLLOTas! Toolkit so that digital health literacy is embedded into the domains of organisational health literacy.

[23] J Thomas, J Barraket, CK Wilson, E Rennie, S Ewing, T MacDonald, 'Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2019 for RMIT University and Swinburne University of Technology, Melbourne, for Telstra'. 27 August 2019, viewed on 23 April 2021, https://digitalinclusionindex.org.au/wp-content/uploads/2019/10/TLS_ADII_Report-2019_Final_web_.pdf

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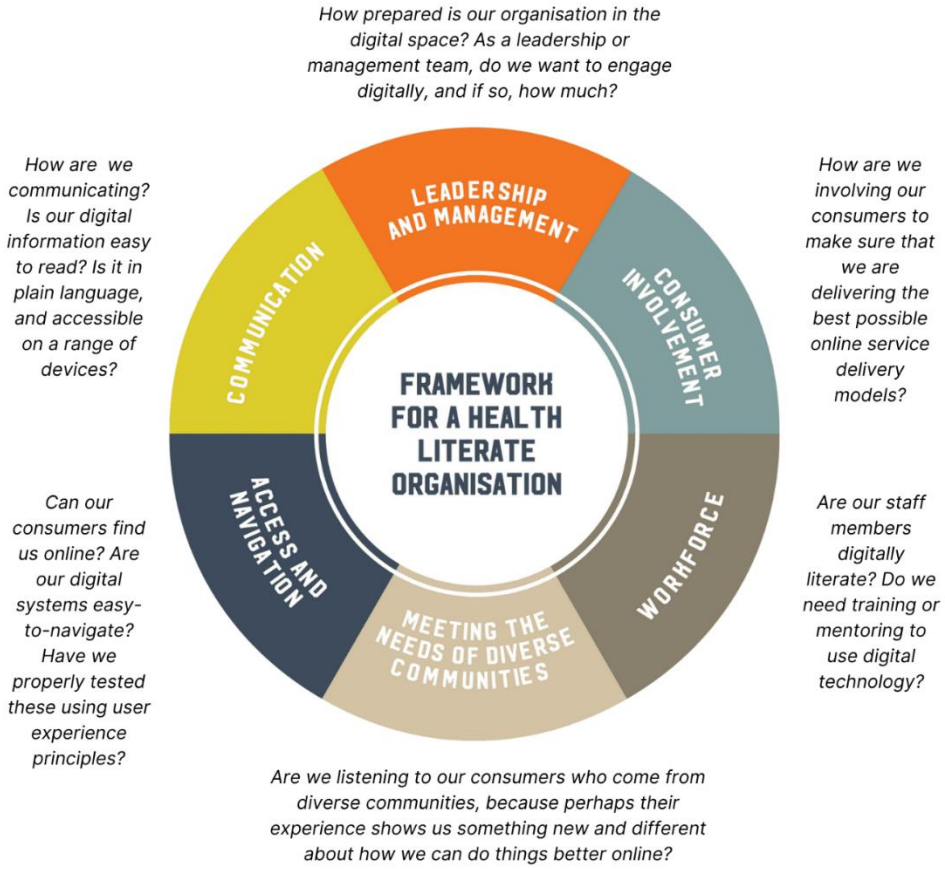
- Explore training and mentoring opportunities with service providers – including opportunities for "digital literacy audits" – either within the existing project or by connecting to existing training providers.
- Consider whether business partnerships can be explored for data sharing and/or equitable distribution of excess data to the areas of greatest need.
- Core funding be made available for rapid mobilisation of essential technology to areas of greatest need.

What do the findings suggest?

Health literacy is a core component of service delivery across health and community services industries. There is substantial evidence to suggest that digital service delivery models improve service delivery and access for providers and consumers alike. Affordability and accessibility are key determinants of whether people can receive the care that they need; when COVID-19 happened, the industry was largely unprepared, and we think it would be beneficial to have core funding available for rapid mobilisation to distribute to the areas of greatest need.

The findings of this report suggest that we cannot think about digital health literacy in isolation. It sits in the broader health literacy context, and we need to make it a key part of health literacy conversations. The HeLLOTas! Toolkit was developed before the COVID-19, and we intend to update the toolkit to reflect digital health literacy and the changes that have been observed since the pandemic.



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How can we support service providers?

More work needs to be done to support providers to help them become more health literate to enable digital-friendly services. We need to consider our language and narrative and how we look at digital inclusion. This means having conversations about becoming a "digital-friendly service." We also need to increase community awareness of existing digital literacy programs (e.g., Health My Way) as our consultations suggested there was limited awareness of these services.

We acknowledge that digital health literacy is a relatively new concept within the health and community service arenas, due to rapid mobilisation spurred by a pandemic. Based on our consultations, we need to listen to consumers and providers about what works best for them and always consider the end-user in mind.

The following principles of digital health literacy have been distilled based on feedback from the focus groups, surveys, and interviews.

These principles can be embedded into the HeLLOTas! Toolkit and used as talking points and teaching tools for service providers to consider how to improve their organisation's digital health literacy.

Principles of Digital Health Literacy

Principle of Digital Health Literacy	How do we have these conversations with service providers?
Digital Literacy Skills *Ask: "Do you know how to do this?"*	Everyone has varying levels of digital literacy. This causes stress. Not everyone knows how to use devices. Remember that sometimes technology can fail. Have a back-up plan like a phone number they can call.
Affordability of Technology and Data & Accessibility of Internet Ask: *"Do you have a device? Do you have internet? Do you have enough data?"*	Devices and data are expensive. Not everyone can get the internet. Data runs out easily. People need to budget their data. This causes stress. Be considerate of accessibility, technological and data costs. Online can be just as expensive compared to in-person for some people.
Consumer Training and Co-Design *Ask: "How can we make things better for you? Do you need help reaching us online?"*	Provide support to your consumers where you can. Offer mentoring or training where possible. If your consumer gave up, explore why and where. Give people opportunities to share feedback and insights. They are their own experts. They know what works best for them.
Privacy and Choice *Ask: "Are you comfortable online? Is in-person better? Are you safe and secure where you are right now?"*	Online appointments are different. Be aware of privacy in shared spaces within someone's home or living environment. In-person works for some people. Online works for others. We have different needs. People appreciate having a choice. Don't assume what people need. Ask them.

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What else could we explore?

The consultations demonstrated a willingness and enthusiasm for people in Tasmania to share their views, feedback, and ideas about how to create a better, more connected digital State. There were several unique ideas presented in the consultations that can be explored such as:

- Data banking or data sharing, to enable unused data to be more equitably distributed to people who need it the most.
- Opportunities to engage directly with service providers to consider how digital health literacy can be understood, potentially beginning with “digital literacy audits” to see where areas for improvement lie.
- Exploring relationships with providers and businesses and having greater involvement from businesses that provide telecommunication infrastructure and services.
- Facilitating wider discussions regarding digital literacy in the community and using these findings to improve the service delivery of health and community services industries.

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Appendix 1: Community provider research

Alcohol, Tobacco, and other Drugs Council Tasmania

The author interviewed a COVID-19 Impact Project Officer for a discussion[24] regarding findings from the COVID-19 Impact on Tasmanian ATOD Services report[25] and sector-specific anecdotal feedback. Based on the findings, the ATOD workforce reported three key themes: An increase in drug use, increased mental health concerns, and wait times to access government services increased. During COVID-19, demand for support increased for a large portion of ATOD service providers, including increased waiting lists. The majority of Tasmanians waiting the longest were attempting to access counselling support.

In terms of the digital experience, the digital transition has been patchy and dependent upon the individual client as to whether they find it beneficial. This is because it depends on factors such as the connection, internet, service, digital understanding, and that each individual client has a unique experience and their own response as to whether they find digital services helpful/useful or not. "It was unique to the individual client and their setting. Some clients spoke positively of phone/online services, others did not find them beneficial."

Some participants from a lived experience perspective stated: "Telehealth has been great during COVID, it has been so good." Similarly, from a provider standpoint: "The increased flexibility has been positive (of working from home)." The report also highlighted some of the challenged that consumers faced regarding the changing nature of health conditions: "Moving to zoom calls for my counselling sucked … it felt like all the rapport had left. But also, some days I didn't feel like talking … that made it hard."

An ongoing issue is the ability to fund much needed services with reduced resources. One provider reported: "Due to the increase in demand for the service, we are finding it difficult to meet demand with current funding levels for counselling staff." Lastly, regarding some emerging trends, the interviewee shared anecdotally that there seems to be a greater increase in co-morbidities of presentations and counselling staff are reporting that they are needing to understand multiple co-morbidities. In conjunction with the COVID-19 Impact on Tasmanian ATOD Services report, ATDC continues to survey its members and collect monthly data for the Tasmanian Government which provides ongoing and highly important information.

Carers Tasmania

Carers Tasmania ran a survey specific to the experiences of carers and COVID-19. Findings from Carers Tasmania[26] found that 40 percent of carers had begun spending more time in their caring

[24] A. Parisella, phone conversation with the author, 28 April 2021.
[25] Alcohol, Tobacco and other Drugs Council Tasmania, 'COVID-19 impact on Tasmanian ATOD services', in *ATDC*, 19 February 2021, viewed 19 April 2021, https://www.atdc.org.au/covid-19-impact-on-atod-services-report-1-july-november-2020/
[26] Carers Tasmania, 'Road to recovery: COVID-19 survey results', in *Carers Tas*. 19 June 2020, viewed 17 February 2021, https://www.carerstas.org/ctas-road-to-recovery-survey-report/

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role following COVID-19 restrictions, and 75 percent had used technology to connect with family or friends. A third of carers had recently contacted their GP for support, while 60 percent said they had used telehealth appointments through the pandemic. Some of the barriers that stopped people using technology was that they didn't have the necessary equipment or connection to the internet.

Council of The Ageing Tasmania (COTA)

The author hosted an interview with the COTA management team.[27] Digital literacy and digital inclusion are issues for older Tasmanians and ones that have been long-standing. This has been identified heavily in the *Finding Out* report, which found that people in older age groups are more likely to rely on a landline phone and have less access to mobile and internet use. Compounding this are issues of poor network coverage, and the cost of new technology and services. In turn this increases social exclusion, which was identified as of great concern.[28]

Regarding COVID-19 and the digital switch, COTA undertook some work in the digital access realm and produced a range of instruction sheets. These resources were targeting how to use Zoom, Messenger, and IT help sessions. In addition, COTA developed a Peer Mentor IT program to support participants.

Health Consumers Tasmania

Health Consumers Tasmania (HCT) ran a set of surveys specific to the experiences of health consumers and COVID-19. Findings from Health Consumers Tasmania[29] show that most Tasmanians had heard of telehealth (90%) but only 68 percent of respondents knew how to use telehealth. People using telehealth were either very satisfied (40%) or satisfied (46%) with their experiences of telehealth. Almost a quarter did not know how to use telehealth at all. People who did not know or were not sure about telehealth were more likely to be older (over 75) or were twice as likely to have finished schooling at year 11 or below.

> *"Telehealth is appropriate in some settings and for some people but should never completely replace face-to-face care. The potential is there, but currently it's not used as well as it could be." (HCT Forum participant)*

Hobart City Mission

The author hosted an interview with the Volunteer Engagement Coordinator at Hobart City Mission.[30] Hobart City Mission received grant funding for emergency relief and received 400 meals per week delivered by Hamlet, a social enterprise support people with disabilities in hospitality.

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[27] COTA, management team, in-person interview with the author, 13 April 2021.

[28] COTA, 'Finding out: Supporting older people to access the right information at the right time', in *Tasmanian Government's Inclusive Ageing: Tasmania 2012-2014 Strategy*. 29 April 2015, viewed 19 April 2021, https://www.cotatas.org.au/wp-content/uploads/sites/3/2019/09/FINAL-web-version-FINDING-OUT-REPORT-2015.pdf

[29] Health Consumers Tasmania, 'Concerns and queries regarding COVID-19 Survey 4', *Health Consumers Tasmania*. 28 July 2020, viewed 08 March 2021, https://healthconsumerstas.org.au/wp-content/uploads/2020/07/Health-Consumers-Tasmania-Stakeholder-Release-28-July-2020.pdf

[30] S. Shepherd, phone conversation with the author, 07 April 2021.

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Overall, the need for emergency relief did not increase much, possibly due to there already being a high demand of the service. However, some people engaged with the system who had not accessed the system in over 12 years (e.g., due to JobSeeker).

When COVID happened, all volunteers were shifted to the online environment. Being classed as essential services, however, meant that staff could attend the warehouses.
In terms of how volunteers were supported, they were first contacted by phone and asked about their support networks. Volunteers were engaged through weekly newsletters and a Facebook page was started. 150 participants engaged through social media. Morning teas were hosted online through Zoom, and the oldest participant was a 92-year-old volunteer. When asked about digital literacy and accessibility, approximately 30 people did not have access or skills to engage digitally. This was not a barrier, however, as this group engaged in the same way pre-COVID through phone calls and printed newsletters.

Palliative Care Tasmania

Palliative Care Tasmania adapted all their face-to-face education to online versions. For the workforce, this was an enormous and resource-intense activity. PCT reported that some agencies and organisations (particularly those in the aged care field) were disadvantaged due to a lack of technology. For PCT, however, they did attract a wider population base due to the shift online.[31]

Women's Health Tasmania

Women's Health Tasmania conducted interviews[32] with 10 women about their experience of homelessness during COVID-19. The Tasmanian state government introduced a Housing and Homelessness Support Package to assist people in housing stress and at risk of homelessness in response to COVID-19. However, the research found that the stigma and shame of homelessness meant that women were unable to access services and mental health services. The cost of primary health care was an issue that stopped women from visiting a GP. Women that were experiencing homelessness were also displaced from their normal communities, which meant trying to connect with new services. Increased bulk-billing during COVID had immediate benefits and enabled treatment previously unaffordable.

Women said that applying for government support meant that forms had to be filled out and submitted online. This was extremely difficult to do from a mobile phone. Telephony and hardware such as a computer or printer are often necessary when dealing with government agencies but are difficult to access when homeless. Their experiences were compounded by issues of grief, trauma, and violence, with an overarching theme that being homeless meant that were was no safe, stable place for processing or healing. Respondents reported that their relationships

[31] G Cunningham, email conversation with the author, 13 April 2021.
[32] L. Shannon & J. Van-Achteren, 'Talking to women about homelessness, Tasmania 2020', in *Women's Health Tasmania*. 2020, viewed 23 March 2021, https://www.womenshealthtas.org.au/sites/default/files/resources/talking-women-about-homelessness-tasmania-2020-report/talking-women-about-homelessness-tasmania-2020-report.pdf

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with key support workers was crucial in their ability to access help and support, both in terms of health care and homelessness and family support.

Working It Out

Working It Out (WIO) provided anecdotal feedback that their biggest barrier would be people being nervous to engage in particular ways (e.g., online), and not having access to privacy (e.g., young people living at home). Lockdown meant that people could no longer access public spaces such as community spaces, bars, and clubs where gender and sexuality can be safely embodied.[33]

One participant reported that they had difficulty attending online appointments because they had to hope their housemates would be out during the pandemic so they could safely connect in an LGBTIQ+ online space. Conversely, digital access meant that there was potentially greater access to peer support across Tasmania, particularly for those in the North and North-West. For those who could participate through the comfort of their own home, they were able to participate in the group in gender-affirming clothing. Our interviewee reported that all these anecdotes were likely unique to LGBTIQ+ people.

For those who had supportive homes and families, accessing the digital space was easier. For one person who was attending pop-in Fridays, they person phones in from their car or from a park. They give their reason as being that they are not out/are on the cusp of coming out and do not want their family to over-hear their conversations as part of a group. This would have been a potential barrier for younger participants who often have capped data.

Appendix 2: Digital exclusion map

TasCOSS has mapped out what barriers people face when dealing with digital exclusion.

The rest of this page is left intentionally blank. Please turn over to see the digital exclusion map.

[33] R. Grant, A. Gorman-Murray, & B. Briohny Walker, 'The spatial impacts of COVID-19 restrictions on LGBTIQ wellbeing, visibility, and belonging in Tasmania, Australia'. *Journal of Homosexuality*, vol. 10, January 2021, pp. 1-14.

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"When the extra payment came in, I could afford data. For the first time, I could buy a new phone that was suitable for day-to-day tasks."

I can't afford to upgrade my devices

My device is too slow to do basic online tasks

I don't know how much data I need to budget

I can't afford to top up my data - I go without

On a low income I struggle to afford things

Do I need multiple devices?

I simply can't afford a smart phone

I don't know what is the best data plan for my needs

Friends and family send me their excess data

I have to ration my phone use daily

"One video appointment with my doctor can use up all of my data in one go. We should look at data sharing, especially with marginalised groups. Like food vouchers, we need to give out data vouchers."

"My rent has gone up by $15 a week. I can' t afford both home internet and phone data."

COST OF DEVICES

COST OF DATA

"We (my service provider and I) tried the videoy [sic] thing, but it kept dropping out."

ACCESS

Can I access it?

I live near black spots with a bad connection

I live in a rural or remote area

NBN is ready but my landlord won't pay for it

My internet speed is too slow for everyday tasks

INFRA-STRUCTURE

I have all these plans my telco gave me. Why?

Public Wi-Fi is not secure for appoint-ments

I am homeless - how do I charge my phone?

I haven't visited a Telco since I had a bad experience

TELCO INTERFACE

AFFORDABILITY

Can I afford it?

What does digital exclusion look like?

DIGITAL ABILITY

Can I use it?

NAVIGATING MY WAY AROUND

Where do I get the information I need?

How do I know what information is right?

Is my information safe online?

I don't feel safe or secure online

SKILLS

I don't know how to use technology

Technology changes too fast for me

I don't know where to get help

I feel dumb because I just don't get it

HUMAN FACTORS

Is this worthwhile for me?

ISOLATION AND EXCLUSION

EMOTIONAL COST

CHOICE AND CONTROL

I miss out if I can't socialise online

I'm too embarrassed or reluctant to learn

I just use what works for me (e.g. ED)

I avoid everyday, online tasks (e.g. bills)

If I'm not healthy, I don't cope too well

I just want to see a service face-to-face

"Face-to-face worked for me. Only face-to-face. I'm not tech savvy, but I do have a phone and can use SMS."

"During COVID, my mum had to go to Centrelink for the first time and they said, 'You can do that on the computer there', but my mum has never owned a computer."

"Do you know how hard it is to find things on an old, dodgy phone? I would scroll and scroll. I would look for the highlighted stuff. I would say, 'Where's the click'? "

"Someone heard they had to 'go online' to get a COVID test. They didn't know what that meant, but they knew how to access Emergency Department. so they ended up in ED." - Bicultural health worker.

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