

Caregiver Perceptions on Telehealth-Based Audiological Services Offered Within a Mobile-Health Clinic for Infants

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Abstract

Purpose: Telehealth audiological services offered within a mobile clinic can expand the range of hearing healthcare services to rural and remote areas where many patients, in particular infants with hearing loss, go undetected due to limited access to specialist care. This study describes caregiver perceptions on the use of synchronous telehealth-based auditory brainstem response (ABR) services.

Method: Forty caregivers rated their perceptions of the mobile telehealth-based service through a self-administered questionnaire comprised of 15 questions.

Results: Caregivers were satisfied (76.8%) with mobile telehealth-based services on aspects of access, satisfaction with the mobile health clinic, privacy, comfort, technical and non-technical experiences, distance, quality of care, travel costs and time; and noted they would use telehealth in the future. Interestingly, 17.5% of the participants agreed that using computer technology to receive health services is not culturally appropriate and 15% agreed that it felt *unnatural* to them. There was a strong association ($p = 0.04$) between the participants that earned below the minimum wage and the choice to use telehealth in the future.

Conclusion: The findings of the study are a positive indicator for the use of synchronous telehealth-based ABR services through a mobile clinic as a service delivery model for infants. This service is particularly beneficial to those residing within rural and remote areas with limited access to specialized services. However, consideration of how telehealth services may influence cultural practices and beliefs is important.

Keywords: mobile-health clinic, telehealth-based ABR, caregiver perceptions, audiological care, infant ABR

Acronyms: ABR = auditory brainstem response; PHC = primary healthcare

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Telehealth-based audiological services are defined as the use of technology-based virtual platforms to offer a variety of assessments stretching across hearing screening, follow-up auditory brainstem response (ABR) examinations, behavioral audiometry, cochlear implants programming and intervention (Hatton et al., 2019; Molini-Avejonas et al., 2015). In this article, mobile health services is defined as delivery of health services through a mobile clinic. The use of telehealth-based audiological services offered within a mobile clinic could potentially improve early detection and intervention services for

infants with hearing loss. Mobile audiological services ensure that infants receive hearing healthcare services within close proximity to their homes. Caregivers are often faced with cost challenges and long travel times, as well as limited access to audiologists, which can deter caregivers from taking their infants for audiology care visits at hospitals. Furthermore, the COVID-19 pandemic created delays and disruption in the auditory healthcare setting with many caregivers being discharged with their infants before infants received hearing screening (Ben-David et al., 2021; D’Onofrio & Zeng, 2022; Jenks et al., 2022;

Panahi et al., 2023). In the South African context, due to the socio-economic challenges, caregivers are unlikely to come back for a routine hearing test. It is also likely that the COVID-19 outbreak had psychological impacts on the population (Naidu, 2020) and caregivers may fear taking their infants back to the hospital for hearing assessments due to the risk of exposing their infant's vulnerable immune system to sick patients at the hospital. Telehealth-based audiological services may help alleviate some of these concerns especially if such services are brought into close proximity of the patient.

There has been a rapid growth in technological advances and telehealth technology, coupled with an increase in the use of telehealth-based services, particularly since the COVID-19 pandemic (Bhamjee et al., 2022; D'Onofrio & Zeng, 2022; Hoi et al., 2021; Manchaiah et al., 2022; Saunders & Roughley, 2021; Talbott et al., 2022). Bhamjee and colleagues (2022) found that telehealth-based services for hearing loss in South Africa's public healthcare system increased during the COVID-19 pandemic. Prior to the pandemic, only 7.2% reported using hearing healthcare via telehealth, but nearly 19.6% used it during the COVID-19 pandemic. It is therefore plausible to assume that the use of telehealth technology provides an opportunity for increasing the provision of audiology services (Fernandes et al., 2020; Kim et al., 2021). However, it is important that end-users of a service are consulted in terms of their perceptions and experience with the services to ensure compliance and sustainability of health programs. Caregivers are key stakeholders in the provision of newborn audiological services. Ongoing consultation of their experiences, opinions, suggestions, and perceptions must occur so that the derived information can be assimilated into the development and refinement of health service delivery programs.

The overall feedback from caregivers regarding telehealth-based services reflected in the literature has been positive (Hatton et al., 2019; Talbott et al., 2022). The main benefits pointed out by caregivers are related to the overall increased accessibility to health services offered by synchronous telehealth services and the associated reduction in travel time (Hatton et al., 2019; Talbott et al., 2022). Additionally, they felt that their privacy was respected, and they felt comfortable in the area where the sessions were being conducted (Hatton et al., 2019). Furthermore, they indicated that they would use telehealth-based services in the future (Hatton et al., 2019). A study conducted by Dharmar and colleagues (2016) on reducing loss to follow-up with tele-audiology diagnostic evaluations reported that all caregivers rated the importance of tele-based hearing healthcare services *extremely important*. It is therefore plausible that continued development and validation of the telehealth-based programs will help improve audiological services and expand the reach to patients located in remote areas (Talbott et al., 2022). A scoping review of telehealth services to facilitate audiological management for children concluded that further telehealth research must be focused on technology

assessment, protocol design, cost-effectiveness, and stakeholder perception to bridge the gap between knowledge and action (Govender & Mars, 2017).

Although there are known advantages to offering auditory care services via telehealth, there are currently few studies describing caregiver perceptions of the use of mobile telehealth-based ABR services, especially for caregivers accessing care at primary healthcare (PHC) clinics. Caregiver perceptions are useful when designing and developing ABR service delivery programs. For instance, ABR services can be used for both screening and diagnostic objective hearing testing in the pediatric population who are unable to be tested by conventional hearing testing. Thus, understanding caregiver perceptions is valuable to the sustainability of the program. Caregivers as key stakeholders can provide valuable insight into the service delivery model.

The current study aimed to describe caregiver perceptions of the use of mobile telehealth-based ABR services offered to their infants when accessing care at primary healthcare clinics (PHC) within the Winterveldt district/region of Pretoria North, South Africa.

Method

Study Design

A questionnaire on perceptions of telehealth was used to measure the effectiveness of the ABR telehealth service that was offered within a mobile clinic. Questions were adapted from Weaver and colleagues (2020) and worded to suit the current research study that is based on caregiver perceptions of telehealth-based audiology services. A self-administered questionnaire comprising 15 questions in the form of a Likert scale (*strongly disagree* to *strongly agree*) was used. The tool was translated into Setswana by a professional Setswana translator to ensure its validity. The questionnaire was back-translated to ensure that it was accurate.

Setting

The research study was conducted in three PHC facilities situated in the rural areas of Winterveldt, situated in the northwest of Pretoria, and falling under the City of Tshwane Metropolitan Municipality of the Gauteng Province, South Africa. Selection of the PHC facilities was based on permission obtained from the various sites. These sites were also selected as they do not provide audiology services.

Study Population and Sampling Strategy

The sample included caregivers visiting Winterveldt PHC clinics during the data collection period who volunteered to have their infants' hearing evaluated through an ABR assessment. The three participating PHC clinics in this study have a total number of 51,100 infants receiving post-natal care services on an annual basis. Of these, an average of 358 infants require follow-up audiological

testing. Approximately 10% of caregivers seeking service (40 caregivers taking care of 40 infants) were asked to complete the questionnaire regarding their experience with audiological care in a mobile-based telehealth setting. Participants were included in the study if they were seeking postnatal care for their infants who ranged from 3 days to 6 months old. Caregivers were invited to participate in the study, regardless of whether their infants had risk factors for hearing loss, such as being born prematurely or being born with low or very low birth weight. All participants were residents of Winterveldt. The sample consisted of caregivers of infants ($n = 40$) who were residing in rural areas and who were accessing health services at the PHC clinics. Purposive and convenient sampling strategies were employed to recruit caregivers for the study. The caregivers could converse in either English or Setswana. The researchers explained the aim of the study to the caregivers and invited them to participate. Only caregivers who met the inclusion criteria and who provided consent were included in the study.

Data Collection

Data Collection Tools

Caregivers were asked to complete a questionnaire adapted from a survey by Weaver and colleagues on perceptions of telehealth (Weaver et al. 2020). The questionnaire collected information about the effectiveness of telehealth-based hearing healthcare services. The questionnaire was designed in the form of a Likert scale (*strongly disagree to strongly agree*) and was available in English and was translated to Setswana. The questionnaire had fifteen questions about the perceptions of the caregivers regarding tele-diagnostic ABR testing. The first section of the questionnaire elicited demographic information (educational levels, minimum wage range, and linguistic profile). The second section explored participants' experience with the ABR telehealth service that was offered in the mobile clinic (quality of the care received, videoconferencing experience, comfort, privacy, and cultural considerations). A copy of the questionnaire is included as Appendix A.

Data Collection Procedure

Caregivers observed their infants undergo a mobile telehealth-based ABR assessment using a synchronous telehealth model with the assistance of a community healthcare worker. Caregivers were then asked to complete a questionnaire to evaluate their perceptions about telehealth-based services.

Each of the 40 infants underwent a face-to-face and synchronous telehealth ABR assessment. All infants were aged six months or less with 90% of the infants aged between 1 and 2 months old. The face-to-face ABR assessment was conducted in a sound controlled environment within the nearest hospital and the telehealth assessment was conducted in a mobile clinic that was stationed just outside PHC facilities. The researchers

conducted testing in a counter-balanced manner in that the researcher started with in-person testing for the first patient, followed by tele-diagnostic testing. The reverse of this process occurred for the next patient. This pattern continued for the entire sample. Mobile tele-diagnostic ABR testing was conducted by the audiologist (researcher) and required the assistance of a community healthcare worker in the mobile clinic to prepare the infants for testing. Two laptops were used: the laptop in the mobile clinic (used by a community healthcare worker and a caregiver) formed part of the PATH Medical Sentiero Advanced (ABR or ASSR) system and used videoconferencing (TeamViewer installed) for the audiologist to test the infants remotely, monitoring and providing guidance to the community healthcare worker. This laptop was charged with a portable power supply. The second laptop was with the audiologist who was situated in the nearest hospital to test the infants as it mirrored (duplicated) the laptop in the mobile clinic van. Caregivers were seated next to the bed where their infant underwent the ABR assessment. After both assessments (face-to-face and telehealth-based ABR), caregivers were given a questionnaire to complete.

Data Analysis

Descriptive and inferential statistical analysis was used to summarize and analyze results of caregivers' responses obtained through self-administered questionnaires. Caregivers' responses were collected and captured in a Microsoft Excel spreadsheet. Participant numbers were used to ensure anonymity. Microsoft Excel was also used to organize and format the data. Both researchers checked the accuracy of the recorded data to ensure reliability of the data capturing process. Data were analyzed using the SPSS software v28.0.18. This software was used for both descriptive and inferential statistics. The results of the study have been presented as frequency, and percentages for categorical variables, and mean $\pm SD$ for continuous variables. To compare groups, Fisher's exact test was used for categorical variables, while an independent student *t*-test was performed for continuous variables. A *p* value of less than 0.05 was considered statistically significant. A statistician assisted with data interpretation and verification, result analysis, and confirmation of the reliability of the analysis.

Results

Demographics

A total of 40 participants completed the questionnaire. All participants were black females residing in the Winterveldt region of Pretoria who volunteered to bring their infants for a face-to-face and synchronous telehealth ABR assessment in a mobile clinic. The majority of participants (67.5%, $n = 27$) had matriculated while 7.5% ($n = 3$) attended College and 7.5% ($n = 3$) attended University. One of the 40 participants left school after grade 11. Six (15%) participants' did not report education level. All of the participants reported they could read and write, and regarded their literacy as good. The majority of participants

(80%) earned less than the minimum wage (under ZAR25.42 per hour) while 20% ($n = 8$) earned above the minimum wage. The majority of the participants (92.5%, $n = 37$) were Setswana speaking and 7.5% ($n = 3$) were Shona speaking. Of the Setswana speaking participants, only 8.1% ($n = 3$) requested to complete the questionnaire translated to Setswana with the rest preferring the English questionnaire. The average age of the participants was 26.25 years, ranging between 17 and 44 years. The demographic information is summarized in Table 1.

Table 1
Demographical Information of Participants

Variable	Description	Frequency	Percentage
Education level	College	3	7.5
	Grade 11	1	2.5
	Matric	27	67.5
	University	3	7.5
	Missing	6	15
Minimum wage	Less	32	80
	More	8	20
Linguistic profile	Setswana	37	92.5
	Shona	3	7.5

Questionnaire Results

Participants were requested to rate their perceptions of the telehealth ABR services that they received from a mobile clinic using a five-point Likert scale questionnaire. The options included two extremes (*strongly disagree* and *strongly agree*), two intermediate (*disagree* and *agree*) and one *neutral* opinion. Participants rated their perceptions in terms of access to the mobile services, satisfaction with the tele-diagnostic ABR services, privacy, comfort, and comparison of services to in-hospital care, as well as various other aspects detailed in the Method section.

Participants were asked whether the telehealth service they received improved their access to hearing healthcare services. Thirty-nine participants (98%) either *strongly agreed* or *agreed* and one participant was *neutral*. Thirty-eight (95%) participants *agreed* that they were satisfied by the telehealth service being delivered in a mobile health clinic and 5% ($n = 2$) *disagreed* as they did not find the service satisfactory.

All participants *agreed* that their privacy and the privacy of their infant was respected. A majority of participants (87.5%, $n = 5$) *agreed* or *strongly agreed* that receiving services in the mobile clinic was comfortable, however 7.5% ($n = 3$) experienced some discomfort whilst receiving services within the mobile clinic which largely related to space. Participants were asked if they thought that using computer technology to receive health services was culturally inappropriate. Interestingly, 15% ($n = 6$) *strongly agreed* with this statement whilst 52.5% ($n = 21$) *strongly disagreed*.

All participants (100%, $n = 40$) agreed that they would access telehealth services again. Participants were asked whether it was easier for them to attend the mobile health service than to attend a face-to-face service at the local hospital and 85% ($n = 34$) either *agreed* or *strongly agreed* whilst 10% ($n = 4$) *disagreed*. Regarding the distance, 80% ($n = 32$) of participants *agreed* that the mobile service reduced their overall travel distance whilst 20% ($n = 8$) did not feel that the mobile health service impacted their travel time to the local hospital.

Regarding the technical experience, a total of 32 (80%) participants *strongly agreed* that they had observed the audiologist communicate clearly through videoconferencing during testing, 12.5% ($n = 5$) *agreed* with the statement, 5% ($n = 2$) either *disagreed* or *strongly disagreed* with the statement. Caregivers were given feedback through videoconferencing, and 90% ($n = 36$) indicated that they could hear the audiologist clearly during the feedback session after testing their infants, and 5% ($n = 2$) did not agree with the statement.

Regarding the quality of care, 77.5% ($n = 31$) *strongly agreed* or *agreed* that the quality of care over the telehealth model is the same as in-person visits, however, 20% ($n = 8$) *disagreed* with this statement. A total of 39 participants (97.5%) indicated that telehealth is an acceptable way to receive hearing healthcare services, and 2.5% ($n = 1$) *strongly disagreed* with the statement. The majority of the participants (97.5%, $n = 39$) indicated that they would use telehealth again for their infants' hearing healthcare services in the future, and 2.5% ($n = 1$) neither *agreed* nor *disagreed*. Lastly, 97.5% ($n = 39$) of the caregivers indicated that telehealth saved them and their family time and/or money, and 2.5% *disagreed* ($n = 1$).

Table 2 provides detailed findings of participants' responses from the questionnaire. As shown in Table 3, there was a statistically significant difference (p -value < 0.0001) between participants that agreed (76.8%) and those that disagreed (18.4%) on aspects of access, satisfaction with the tele-diagnostic service, privacy, comfort, using telehealth again, experience, distance, videoconferencing experience, and feedback from the audiologist.

Table 4 shows a strong association ($p = 0.04$) between the participants earning below minimum wage and the choice to use telehealth in the future suggesting that participants earning below minimum wage would access telehealth services in the future due to saving costs and less traveling time.

Discussion

This study investigated caregiver perceptions on the use of mobile telehealth-based ABR services and found that a majority of caregivers are positive about this model of hearing healthcare service delivery. The findings of the study indicated that the majority of participants strongly agreed that the telehealth mobile service was easy to access, was comfortable, and that their privacy was respected. Participants indicated that they would use the

Table 2*Participants' Responses on the Questionnaire*

	Strongly disagree	%	Disagree	%	Neutral	%	Agree	%	Strongly agree	%	Total	%
Q 1: Access	0	0.0%	0	0.0%	1	2.5%	12	30.0%	27	67.5%	40	100%
Q2: Satisfaction	0	0.0%	2	5.0%	0	0.0%	10	25.0%	28	70.0%	40	100%
Q 3: Privacy	0	0.0%	0	0.0%	0	0.0%	7	17.5%	33	82.5%	40	100%
Q 4: Comfort	0	0.0%	3	7.5%	2	5.0%	7	17.5%	28	70.0%	40	100%
Q 5: Computer tech for culture	21	52.5%	11	27.5%	1	2.5%	1	2.5%	6	15.0%	40	100%
Q 6: Natural or not	19	47.5%	14	35.0%	1	2.5%	1	2.5%	5	12.5%	40	100%
Q 7: Use telehealth again	0	0.0%	0	0.0%	0	0.0%	7	17.5%	33	82.5%	40	100%
Q 8: Experience	1	2.5%	3	7.5%	2	5.0%	9	22.5%	25	62.5%	40	100%
Q 9: Distance	1	2.5%	2	5.0%	5	12.5%	9	22.5%	23	57.5%	40	100%
Q 10: Videoconferencing experience	1	2.5%	1	2.5%	1	2.5%	5	12.5%	32	80.0%	40	100%
Q 11: Feedback	1	2.5%	1	2.5%	2	5.0%	8	20.0%	28	70.0%	40	100%
Q 12: Quality of care	0	0.0%	8	20.0%	1	2.5%	9	22.5%	22	55.0%	40	100%
Q 13: Telehealth	1	2.5%	0	0.0%	0	0.0%	12	30.0%	27	67.5%	40	100%
Q 14: Use of telehealth in future	0	0.0%	0	0.0%	1	2.5%	8	20.0%	31	77.5%	40	100%
Q 15: Travel costs and time	0	0.0%	1	2.5%	0	0.0%	0	0.0%	39	97.5%	40	100%
Average	3	7.5%	3	7.7%	1	2.8%	7	17.5%	26	64.5%	40	100%

Table 3*Analysis of Variance Between Caregivers that Agreed and Disagreed*

Summary

Groups	Count	Sum	Average	Variance
Disagree	16	2.95	0.184375	0.086823
Neutral	16	0.75	0.046875	0.00649
Agree	16	12.3	0.76875	0.113125

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	4.701354	2	2.350677	34.16061	<0.0001	3.204317
Within Groups	3.096563	45	0.068813			
Total	7.797917	47				

Table 4*Minimum Wage*

Variable	Description	Less	%	More	%	Total	%	Chi square	df	p-value
Q 15: Will use telehealth in future	Neutral	0	0.0%	1	12.5%	1	2.5%	6.129a	2	0.0467
	Agree	8	25.0%	0	0.0%	8	20.0%			
	Strongly agree	24	75.0%	7	87.5%	31	77.5%			
	Total	32	100.0%	8	100.0%	40	100.0%			

telehealth mobile service again because they had a good experience, and did not have to travel a long distance for these services. They reported that the videoconferencing experience was good, they could hear the audiologist well during testing, and the feedback session and overall quality of care via telehealth was comparable to the in-person visit. Participants' answers indicated that mobile telehealth services is an acceptable and easy way to receive hearing healthcare services.

Our study indicated that the telehealth model has the potential to expand access to audiological care. Studies conducted by both Hatton et al. (2019) and Dharmar et al. (2016) found many of the same benefits of telehealth for participants including: spacing in the mobile clinic was comfortable, their privacy was respected, and they were satisfied with the technical experience for videoconferencing throughout the session. Liu and colleagues (2021) found that telehealth visits had a higher frequency of visits than other modes of consultation and care due to easy accessibility. Our study builds on these findings by showing the potential to expand access to audiological care through the telehealth model.

However, in this study, a minority of participants did not agree that the mobile telehealth-based service was culturally appropriate, and noted that it did not feel *natural* compared to the traditional in-hospital care approach. None of the existing studies included cultural appropriation matters in their survey questionnaires which adds to the relevance of the present study findings. The findings of the study are similar to that of Ncube and colleagues (2023) who found cultural and traditional beliefs were identified as inhibitors to telehealth services. Therefore it is important that cultural factors and beliefs be considered in the development of telehealth programs as culturally-appropriate services will ensure sustainable uptake (Caffery et al., 2018).

Caregivers indicated that the quality of care during telehealth-based care services is the same as in-person visits. These findings are similar to that of Bilimoria et al. (2021), Slightam et al. (2020), and Street et al. (2022) where patient experiences using telehealth resulted in similar rates of patient experiences between face-to-face and telehealth-based services. Participants in the present study indicated that they would access mobile telehealth services in the future and the findings were in agreement with those of Atreya et al. (2020) and Hatton et al. (2019).

The study findings revealed a statistically significant difference between those working below and those working at or above minimum wage and the choice to access telehealth services in the future. There are socio-economic inequalities in South Africa where a significant percentage of the population earn below minimum wage (Anwar and Brukwe, 2023). This suggests that those working below minimum wage may not have the necessary finances to access healthcare. It is well known that the majority of the population earning below the minimum wage reside in rural and remote geographical areas

(Anwar & Brukwe, 2023). Because of this, they may face barriers to accessing specialized healthcare. This includes long travel distances to hospitals and high transportation costs (Harris et al., 2011; Rural Health Information Hub, 2023). Mobile telehealth-based ABR services through the use of a synchronous modality could bridge the service gap, allowing infants to receive services remotely at an early age, and, thereby, mitigating the negative impact of unidentified or late identified hearing loss.

The study findings show that a mobile telehealth ABR service for infants can be offered within rural community contexts as it appears that caregivers are accepting of this service. This means that it has the potential to reduce loss to follow-up as patients do not always visit hospitals due to various circumstances. This also contributes positively to the initiative of early detection and intervention of hearing loss among infants, thus, reducing the high prevalence and effects of infant and childhood hearing loss which according to the literature have been suggested to have a negative impact on development and on quality of life (Butcher et al., 2019; Mostafa et al., 2022; Neumann et al., 2022). A telehealth screening and/or diagnostic ABR service offered within a mobile clinic could improve access to audiological services and reduce the impact of hearing loss on the pediatric population. A mobile health service with screening programs that offer immediate access to diagnostic services could reduce loss to follow-up.

Strengths and Limitations

This research project was carried out in a mobile clinic located at the clinic, parked in an area that is accessible for patients who were visiting the facilities for postnatal care services. This implies that early detection and intervention programs using synchronous, telehealth services delivered from a mobile clinic can be used to make services more accessible to communities.

Although this study used several PHC facilities, the sample consisted of 40 participants. The small number of participants limits the extent to which the description of caregiver perceptions can be considered fully representative and the extent to which it can be generalized to a larger region. Additionally, the sites were relatively homogenous (all within the Winterveldt), the data collection period was only 8 weeks (which is relatively short), and the infants ranged in age from 3 days to 6 months. These variables affect generalization of results in terms of demographics.

Recommendations

Future studies should repeat the study with a larger sample size to increase the applicability of the results to a larger population. It would also be valuable to replicate the study across different populations to explore possible effects of age, populations, and geographical locations. Furthermore, future studies should evaluate cultural dynamics using the mobile telehealth-based model to deliver hearing healthcare services in South African rural

communities. Lastly, a cost-benefit analysis for infant telehealth-based ABR through a mobile clinic in a South African public health setting would be beneficial.

Conclusion

The majority of caregivers responded positively and were satisfied with the mode of hearing healthcare service delivery. Although offering telehealth-based services comes with some challenges such as the need to ensure culturally-appropriate services, the model of care provides an opportunity to improve audiological services to rural and remote communities. This research project was carried out in a mobile clinic located close to PHC facilities, parked in an area that is accessible for caregivers and their infants who were visiting the facilities for postnatal care services. The findings suggest there may be multiple benefits for *at home* (direct-to-patient) telehealth services that could save costs and improve access to audiological services.

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Appendix
Questionnaire Used in Study

Participant No. _____

Dear Caregiver:

In order for us to gather good information about our study, we require your assistance in identifying your experiences with the use of mobile auditory brainstem response (ABR) service using telehealth that was conducted on your child.

Please answer the following questions and please be assured that your information will remain confidential.

Please tick (√) in the most appropriate box

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
1. Telehealth improves my access to hearing health services.					
2. I am satisfied with the telehealth visit.					
3. I felt my privacy was respected.					
4. I felt comfortable in the mobile clinic van.					
5. I do not think that computer technology to receive health services is culturally appropriate.					
6. I think that receiving health services through telehealth feels unnatural to me.					
7. I would use telehealth again.					
8. It was easier for me to attend using telehealth rather than in person.					
9. If telehealth was not available, I would have travelled a long distance for my visit.					
10. I have observed the Audiologist communicate clearly through videoconferencing during testing.					
11. I could hear the Audiologist clearly during the feedback session after testing my child.					
12. I think quality of care over telehealth system is same as in-person visits.					
13. Telehealth is an acceptable way to receive hearing health services.					
14. I would use telehealth again for my child's hearing health services again in the future.					
15. Telehealth saved me and my family time/or money.					