PR Network Meeting May 2020 Agenda:

'Adapting to new models of PR during COVID-19'

Date:	Tuesday 5th May 2020
Time:	1.30 pm – 2.30 pm AEST
Location:	Via Video or Teleconference
Attendees:	192 Pulmonary Rehabilitation Network Members
Meeting Recoding:	https://youtu.be/vth2TyVxHek
Meeting Chair:	Professor Jennifer Alison (JA)
LFA Reps:	Kelcie Herrmann(KH), Emma Gainer (EG)
	(Additional LFA attendees included: Toni Hammond)

1. Welcome & Acknowledgement of Country (JA)

1.1 Recap and Actions from annual meeting held on 31st March 2020

Thank you to the members who attended the previous meeting. It was a very successful gathering with over 100 involved.

Follow up actions:

Julie Redfern and LFA have now developed a partnership to support the wider respiratory community during this difficult time. The Lung Support Service (Texting for Wellness) is now housed on the Lung Foundation website – via following https://lungfoundation.com.au/patients-carers/living-with-a-lung-disease/copd/support/. *See link for more information.*

PR Toolkit and Lung Cancer Survey still open – all clinicians in this area are encouraged to participate: https://www.surveymonkey.com/r/38JQK8M. Only a quick 5 minute survey. Your

feedback will help shape a toolkit update and enable us to provide Lung Cancer exercise support to clinicians working in this area of practice.

Support and Resources through LFA:

Continue to use the COVID-19 section on LFA webpage as a one-stop shop for patients and clinicians. Can be accessed here. : https://lungfoundation.com.au/patients-carers/lung-health/coronavirus-disease-covid-19/what-you-need-to-know/

To specifically support the rehabilitation community during a time in which normal face to face group based pulmonary rehabilitation is not possible, we have collated a number of resources and important links that can be accessed via our Pulmonary Rehabilitation Toolkit site. We will continue to use this tab during this time to provide any new resources, etc. Link here: https://pulmonaryrehab.com.au/covid-19-useful-links/

Free Webinars available: Now available to view: Clinical: COVID-19 in patients with chronic respiratory diseases: Q&A with Prof Christine Jenkins access here: https://www.youtube.com/watch?v=nHdqZ0sgJQc

To be held on Friday 8th May. Consumer focused Webinar: Presented by Janet Bondarenko: Understanding COVID-19: Staying fit at home - May 8 2020 2:00 pm: By registering you will also automatically be sent the recording which can then be sent through to any patients which may have missed out. The link will also go up on our webpage when it becomes available.

Maintaining movement video series continues to be rolled out. Available via the following page: https://lungfoundation.com.au/physical-health/ and through social media.

ACTION: All PR Network Members are welcomed to review links above to gain further support. PR Members encouraged to please complete the PR Toolkit and Lung Cancer survey via the link here.

2. Adapting to new models of pulmonary rehabilitation during COVID-19

Setting the Scene (JA):

Prior to the meeting, network members were asked through a survey to provide feedback on the challenges they faced within their PR programs during COVID-19 'social distancing'/shut down. Below is a list of the common challenges that the membership provided. (Please see appendix 3.0 for more detailed information.)

Common challenges of no face-to-face PR:

- *Supporting patients over the phone at same standard as in person*
- *Keeping patients motivated and engaged remotely*
- *Patients not willing or don't have ability to do video option*
- *Managing initial assessments re: exercise capacity (6MWT) and physical*
- *activity levels*
- *Safety of exercise prescription and progression without a face to face assessment, particularly in severe lung disease patients*

- *Much more time consuming for the health service providing [telehealth]*
- *Getting access to non-online education information for patients who don't have internet access*
- *Patients have unstable internet*
- *Personal clinical skills- adapting face to face skills and tools to this new format*
- *Lack of supportive technology with the health service/ PR facility*

2.1 The Experts: First-hand feedback from two clinical experts on their experience and the required adaptions of their PR programs to telehealth formats during the COVID-19 pandemic. Q & A opportunity after each speaker.

Anne Holland - Professor of Physiotherapy, Alfred Health 'HomeBase Rehab' (Please refer to the presentation slides accompanying these minutes).

- Anne thanked and acknowledged he entire team at Alfred Health who are involved in the PR service

Prior to COVID-19 Alfred Health offered:
- 3 supervised group-based programs per week across 2 health service sites
- Provision of Home-Based Pulmonary Rehabilitation program

Usual Home-Based program: (further information can be found here: https://homebaserehab.net/)
- Centre based assessment – including 6 MWT
- Initial Home visit
- 7 once weekly phone calls. Therapists (Physios or EPs) conducting phone calls are trained in motivational interviewing – either a Physio or AEP.

What's changed;
- Mid march – entire service moved to the Home-Based PR program
- Existing patients moved across to Home-Based model
- New patients are now offered home-based only
- No centre-based assessments
- No Home visits
- Pre/Post assessment by phone or video (according to patient preference)
- Weekly phone/video call (based on patient preference) once week for 8 weeks
- Weekly video conference support group – peer support online option

What's been good:
- Health service has seen continuing PR being a priority
- Transition has been streamlined – particularly as the service was already familiar with providing a Home-Based service and many staff were already trained in home-based delivery of PR
- Generally, well accepted by patients
- 40 patient program capacity – only slightly less than normal
- Access to Telehealth through health direct which is a new development for the service

COVID-19 model – not 'best practice model':

- Lack of in person exercise test is the biggest challenge
- Absence of an initial home visit adds an extra week to the program
- Home programs not always suitable for 'everyone'; for example, English not first language, cognitive impairment, hearing issues, severe pulmonary hypertension, patient preference etc.
- Most choosing the phone call over video option when given choice

What are we doing without an exercise test?:
- Initial assessment over the phone
- Taking a more detailed assessment and a virtual home visit trying to understand the home environment
- Making more use on LFA resources – particularity around making sure patients have the Better Living with Exercise book and understand the BORG scale/managing their breathlessness.

Planning / what will we keep?:
- Better access to Telehealth moving forward
- Flexibility for staff at home
- Have been able to provide new support to patients – a virtual peer support group

Things we would like to resume as restrictions are slowly lifted (in order):
- In-person exercise test
- Home visits
- Supervised exercise training

<u>What test to do when we don't have an in-person option?</u>
- Reviewed 105 studies on this topic (Thanks to team for support on this)
- 4 exercise tests have been utilised at home within the studies
- 2 have been completed remotely: 6MWT app to measure distance & 3MST remote via video

The studies showed:
- 6MWT the distance isn't valid inside house as the distance is too short – but outside is fine
- Not much detail about the other tests
- Apps for 6MWT distance is accurate for distance not sure about saturation

In summary:
- 6MWT completely fine with an outside walk and supervision
- Measurement properties great for TUG, STS and all step tests: reliable, valid, responsive to change with pulmonary rehabilitation
- Want to know about Desaturation? Significantly less desaturation on all tests compared to a 6MWT
- TUG, STS and all step tests are useful for outcome measurement, but it is unclear whether they help with assessment of response to exercise (including desaturation) or exercise prescription

Planning for the future:
- Take the good bits and restore the previous components - particularly centre-based exercise testing in the first instance
- Centre-based exercise when able to safely
- Train additional staff to provide home based models and include student training
- Continue to offer 'choice' to patients long term

Q&A

1. Are you instituting any of those tests in your service? (JA)

   No we have not. We are currently starting patients without an exercise test.

2. When you are monitoring patients at home are you entirely using a symptom based approach? (JA)
   Yes - using the breathlessness scales and spending a lot more time educating patients about this initially so they understand them. Use of the BORG scale in the Better Living with exercise book

3. How may physios would you allow for 40 patient capacity?
   1.4 physio's plus .6 AEP/AHA. Body of work to cover: Calls allowing a 45 minute block and Assessment 1.5 hours per patient

4. Is OT within the program standard or is this referral basis only?
   OT is referral out – from outcomes of the initial assessment.

5. Are you taking any health related quality of life measure at the current time?
   Have always taken the CRQ, CAT, HADS and MRC and are continuing to do this over the phone.

Unable to answer all questions due to time. Anne will answer offline, with questions shared to the group. Please see Appendix 1.0 further information regarding these questions and their answers.

Renae McNamara - Clinical Specialist Physiotherapist, Pulmonary Rehabilitation Coordinator Prince of Wales Hospital – 'TeleRehab' (Please refer to the presentation slides accompanying these minutes)

- Prior to COVID-19 patients were surveyed re options for PR - 12% patients choose a TeleRehab video conference option
- Since COVID-19 all patients transitioned to telehealth – home based model – either Anne's model above or the TeleRehab video conference model
- No longer traditional in the sense that no longer providing centre based 1:1 assessment – the below is our experience and how the COVID-19 model runs
- Currently 20-25% uptake of telehealth model during COVID-19
- 3 groups a day
- Patients attend twice a week supervised for an 8 week program
- *The pandemic has caused a rapid translation of evidence into practise in the telehealth area*
- *Evidence is still growing and new in TeleHealth*

Choosing a platform:

- *Public health facility generally will have a platform they recommend or mandate.*

What to consider re a telehealth platform:

- *What telehealth platforms does your health district allow?*
- *What is the capability for providing groups?*
- *What size group can it take?*

- *Bandwidth*
- *Does your platform have technical support if needed?*
- *Privacy and security*
- *Are you able to access information relating to installation and troubleshooting – we have found that patients find it useful to have written information on how to get started*
- *Important to know if person is using a Desktop or Tablet*
- *Understand what browser works best for the platform*

Make a decision on the technical support you are going to offer:
- *Are your clinicians going to provide the support from your service?*
- *Are you going to refer them to an external service?*
- *We have taken the option to take all the tech support internally with therapists supporting patients in this area*

Patient selection and preparation

Need to make sure they are eligible by:
- *Adequate hearing and vision*
- *English language or interpreter*
- *Able to mobilise- independent and safe*
- *Access to phone*
- *Suitable home*
- *Access to technological device*
- *Ability to operate device independently or with support if available at home*

Exclusion:
- *Cognitive impairment*
- *Unstable medical condition*
- *Unable to participate in exercise training due to pre-existing conditions*
- *Poor balance with risk of falling*

Telehealth Capability and readiness:
- *Access to the device – may also have access from another family member*
- *Internet available from that device*
- *Establish any existing knowledge from the device*
- *Existing an email address if they have it –or understand how to use a web browser*
- *Self-rated tech device and internet skills questionnaire*

Willingness and consent:
- *Willingness to participate*
- *Able to provide informed consent – patient and everyone in the home at the time*
- *Support person available and consents*

Set-Up a test call:
- *Away from group environment*
- *Make sure as a clinician you are very familiar with the system and you know how to use both Window based desktop computer and smart phone and tablets.*
- *Support person may need to be available*
- *Allow time – sometimes it can take multiple attempts and LOTS of patience*

Virtual Tour of patient home:

- *Work out best walking track*
- *Select most appropriate chair*
- *Availability of step/s or home exercise equipment*
- *Consider safety factors – trip factors etc*

Test Call/s
- *Virtual waiting room*
- *Using device*
- *And using phone*

Set up environment for best experience:
- *Noise*
- *Lighting*
- *Camera positions*
- *Devise to be charged*
- *Understand how to work with multiple people*
- *Therapist needs to become a conductor – make sure patients are aware they can't have confidential discussions int he environment*
- *Allow therapist to be on 15 minutes prior to commencement*

Optimal screen view: Consider what will work best for you

Assessment 'Standard via telephone and video conference':
- *Prior to their assessment they are sent a pack with all the information*
- *Physical assessment via video conference : use 5 STS and 1 minute STS (see meeting recoding of video demonstration at 49 minute mark of following link:* https://www.youtube.com/watch?v=vth2TyVxHek&feature=youtu.be)
- Most import tip – there is a delay in the video conferencing so if using a stopwatch always record what you see rather than when you say start

Exercise Training:
- Minimal equipment
- Education via this model as well – we use a discussion model – short duration due to screen fatigue

Other considerations
- *Ratio - we currently have 6 patient max in TeleRehab – because we want to see them visually on the screen all at once*
- *Use a rolling program to ensure not everyone is new – as it can be hard to support them all at one time*
- *Consider grading the sessions - for example larger groups for more advanced tech savvy and physically more physically able and then small groups for those who need more assistance.*
- *Current service is about to move back to do face to face assessment for our program but will still consider repeating baseline at home as well as we don't know what the future will hold and what the location may be for the post program assessment*
- *Don't forget the support person – include and knowledge them.*

Unable to answer questions due to time. Renae will answer offline, with questions shared to the group. Please see Appendix 1.0 further information regarding these questions and their answers.

2 Grass Roots: Metro, Rural, Regional, Remote – sharing your experiences and hearing your feedback are important to the wider rehabilitation community.

Lorraine O'Hare - Physiotherapist Pulmonary Rehabilitation Co-ordinator Albury Wodonga Health Service VIC & NSW (Cross Boarder Service).

- *Cross Boarder service – at both Wodonga (Vic) and Albury (NSW) sites*
- *Normal scenario would have PR running in centre at both locations with addition of allowing home based 1:1 program based on patient preference*
- *Now gone with a full virtual group platform using a Blue Jeans platform*
- *2 sessions a week : including both Education and 40 minutes of exercise followed by 20 minutes relaxation. PR exercise 6 at one time online*
- *Confidence using technology has been concern but providing easy to read resources and have family members support has been important.*
- *Also having a landline phone is important too for those without internet / bas connection*
- *The virtual rehab is keeping them socially engaged with their community and has been an advantage for all*
- *Helpful for the out of town clients who live a large distance from the centres*
- *Believe that keeping the model after COVID will help with the flexibility and reach for our patients*

Kirsty Hearn – Clinical Lead Physiotherapist (Cardiorespiratory) - Eastern Health VIC

- *Eastern Health has three sites that are geographically different – ranging from suburban to rural*
- *Telehealth didn't exist before this time for our service – team has been quick and agile at changing the service, and now fully online*
- *Doing a systematic review looking at PA post PR using health coaching. Outcome measure we are using: BORG, CRQ, EQ5D, MMRC, UQ Active Australia Survey, and measure for step count etc.*
- *Where we need better support: more ideas around how to support the patients we are missing – for example Aboriginal and Torres Strait Islander people and what we can do for them?*

Big wins:

- *Patient waitlist times have come down – in particular for our more remote locations as they can access the online option right away*
- *Ability to provide the same care for suburban and rural patients during this time*

Please see Appendix 3.0 to review a report on shared experiences from Pulmonary Rehabilitation programs from across the country.

Closing - JA

- *Any new updates will be provided on the PR Toolkit here: https://pulmonaryrehab.com.au/covid-19-useful-links/*
- *The NSW Agency of Clinical Innovation Respiratory Network document around delivering PR via telehealth during COVID-19 will be available soon. Document link to be put in the toolkit tab here.*
- *To view the meeting recoding please click here: https://youtu.be/vth2TyVxHek*
- *Lung Foundation will be in contact with network members soon to advise of any subsequent meetings. The high number of people engaged today demonstrates the need for continued meetings and support as a collaborative network.*

Appendix

Appendix 1.0 - Anne Holland & Renae MacNamara Q& A

The following questions directed to Anne & Renae were answered proceeding the meeting

Q&A Anne Holland

Q. Do you supply the Better Living with Exercise booklet to the clients free of charge?

A. Yes we do and we find it very useful. Where possible we will email this to patients, and where that's not possible we have sourced cheap printing options.

Q. How about physical activity? Do you use physical activity as an assessment tool other than formal exercise testing?

A. No, we haven't gone down that path for the clinical program, although we did use it in the home-based research.

Q. Normally outside of COVID how often are you providing HV?

A. Once for each patient. The physio or EP helps establish the initial exercise goals and supervises the first exercise session at home. Very occasionally the patient will need an additional home visit, but that doesn't happen very often.

Q. Are you providing any group teleconference sessions with participants?

A. Individual teleconference sessions can be very time consuming and group sessions can be much more time effective? We generally find the individual phone-based sessions very time-effective. They are once a week and involve highly structured goal setting, so a very different model to group sessions and requires quite intensive one-on-one focus. The calls take less than half an hour. We currently offer a video support group for these patients as well, once a week. In our telerehab patients we do group sessions of up to 5 people, but that is for supervised exercise training. I'd love to offer a choice of both models, I think there are patients who will have a preference for one model or the other.

Q. Is there nursing involvement in the program or linking back to GP/ practice nurse?

A. Yes our COPD nurse is involved in the program and we can link to our outreach service if required.

Q. Just wondering your approach to monitoring patient technique/pain during resistance exercises (squats, UL). I am thinking about a few of our patients who have attended PR prior to COVID where we had to make modifications for them (eg. for shoulder pain, LBP etc.) and how this would work in the home setting.

A. Yes this is a common issue. In our normal (pre-COVID) model we frequently addressed this at the initial home visit. I think it's very important that the subsequent weekly phone calls are delivered by someone who is used to modifying exercise for people with comorbidities of all types, including musculoskeletal, and we can successfully address any new issues over the phone in most instances. In current times (with no home visit) it is more difficult. We have had some patients elect to do video calls (rather than phone calls) for exactly this reason, so we can modify their program more easily.

Q. Are you doing a falls risk screening with the initial assessment. And if at risk are you suspending their programs until centre based program available?

A. Yes and yes, we waitlist the patient for centre-based PR if they are a falls risk.

Q. Does anyone have good suggestions for tech savvy patients for exercise monitoring app?

A. We have most commonly used the step counter on a patient's smart phone, as a simple motivational tool, not as an accurate measure. We haven't had patients who were keen to use more sophisticated tools as yet.

Q. Do you find you need to exclude many patients?

A. There are some that we have put on a waiting list for when centre-based PR becomes available. They are the minority, but they are important. The common reasons for this are that the patient is not considered safe for unsupervised exercise (eg high pulmonary artery pressures), language barriers for our patients from CALD backgrounds, or that the patient has a preference for a centre-based program.

Q&A Renae McNamara

Q. Are you doing a falls risk screening with the initial assessment. And if at risk are you suspending their programs until centre based program available?

A. We don't use a formal falls risk screening tool, but do question falls history in last 12 months, and if there is a positive report of a fall/s, then we question further to determine cause, and ascertain if it is safe. Presence and availability of a family member/carer is important to know, as well as home environment setting and suitability (this is where a virtual tour is beneficial).

Q. Does anyone have good suggestions for tech savvy patients for exercise monitoring app?

A. I have not used any exercise monitoring apps, however Anne Holland's rapid review of remote exercise testing may have found evidence for use of an app.

Q. Do you find you need to exclude many patients?

A. In a recent review of 159 patients referred to PR, 26% (n=42) were not eligible for telerehab. Reasons included: falls/balance issues (n=21), NESB (n=15), hearing/vision impairments (n=5), no phone access (n=1).

Q. How do they do their exercise groups? By that I mean is it fully instructed from start to finish with all participants doing the same thing, or is it partially directed where there might be an activity each person is told to do, but the repetitions are customised to that person?

A. We run a group led by the physio where each exercise component starts and finishes together, however each patient has their own individualised program eg. walking laps, no. of STS, weight size, sitting or standing options, continuous vs intervals etc. within that specific exercise component.

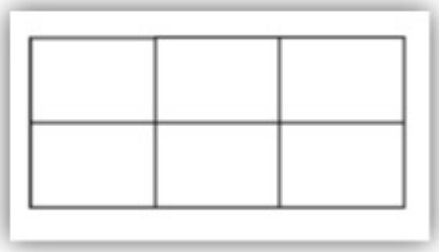
Q. Re: no telerehab service and doing telephone follow-up - I have a couple of patients who were not super compliant when coming to the gym and are not doing anything at home. I feel like I need to keep them on for a bit longer than I would with patients who are just non-compliant with the gym program because of the extra challenges of motivating themselves to do a home exercise program. Do you have any thoughts on this?

A. I believe we need to be super flexible at the current time, and for some patients the program can be shortened, others will require an extended program, and some patients may need to be put on hold and brought back once we are back to face-to-face supervised training.

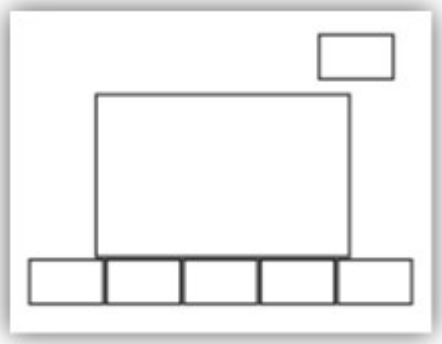
Q. What platform have you found is best for your group exercise sessions?

A. We have used VSee and PEXIP for telerehab, but we have used a lot of ZOOM and Skype for Business for work to be able to make comparisons.

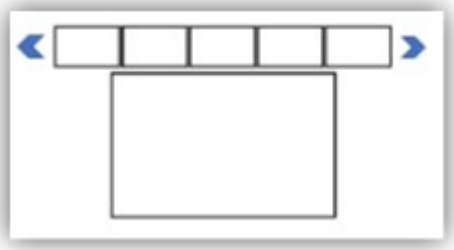
VSee was very simple for patients to log in (one touch icon), but the bandwidth required was too much for our hospital network, so we had too many issue with poor connections and drop-outs. But from a screen image perspective it was ideal as we could make all patients images (and ourselves) even sized (which is our preference for ease of monitoring, and patients prefer seeing everyone at the same time to follow conversations easily).



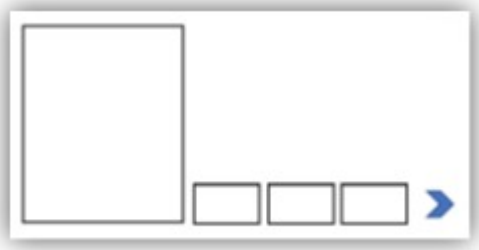
PEXIP is NSW Health-supported, so it's been very reliable with clear quality pictures and no poor connections/drop-outs. The screen image options are not ideal, as our image sits in the top right hand corner, and whichever patient speaks/makes the most noise features in the large centre image box. We unfortunately cannot fix our image to be the largest for the patient to view easily (so this is difficult for patients using a small smartphone screen). The only option for equal sized screen images is if there are 4 people or less online.



ZOOM (free version) has a maximum time of 40 mins, so you would require the ZOOM paid version for longer sessions. And ZOOM would have the same issue of the person who speaks/makes the most noise features as the larger image (I mention this because we have a gentleman who is a very heavy, noisy breather and he has a very sensitive microphone on his laptop, so often he is always the featured image even when he is not talking just due to the noise of his breathing!). And you are required to use the arrow to scroll through small images to see everyone if more dial in than the small images allow, so you can't continuously monitor everyone on the one screen.



Skype for Business has the same issue of the person who is speaking dominates the larger image, and you need to use the arrow to scroll across to see everyone.



My advice would be to consider using the platform supported by your Hospital, Local Health District or Dept of Health, because internet connection/bandwidth has been our biggest issue. And the health-supported platform would have an external hotline for technical support for yourself and patients. We currently use PEXIP (NSW Health-preferred platform).

We personally prefer to manage our patients technical issues ourselves on the spot (but this takes time). It reduces the patient's frustration because they know and trust us and we are

familiar with their set-up because we helped them with this, and I feel an external hotline could lead to frustrations and program drop-outs.

We find most patients struggle joining the first few times, but then it is smooth sailing once they have logged in multiple times (hence the recommendation to have a rolling entry, and also 'open' the virtual door earlier than the class time to allow staggered entry and the ability to problem solve technical issues prior to the session start time).

Appendix 2.0 Use of Video conference on options

Below is a collation of the feedback obtained from network members during the meeting within the chat function around what video conference platform they have been using.

Type of platform	Total
HealthDirect	14
Zoom	7
Pexip	5
Microsft Teams	4
Skype for business	4
Webex	3
MeCare	1
NeoRehab	1
Scopia	1
Vydio	1
Total respondents	41

Appendix 3.0 Sharing the network experience during COVID-19

In the lead up the to May 2020 Pulmonary Rehabilitation meeting, Network members were welcomed to share their experiences and provide feedback to the wider rehabilitation community.

Possible items on which to provide feedback included:

- *How have you adapted during this time?*
- *What are the biggest challenges?*
- *What is it that would enable you to better support your rehabilitation patients?*
- *Do you have a big 'win' to share?*

Name	Health Service	My Shared experience and Feedback
Coralie Brannelly	Top End Health Services	keeping the clients motivated, all clients were sent information on COVID-19, exercise booklets (OTAGO) and doing phone catch up. Difficulties have been having not enough staff to call each client on a weekly basis

Tonya Jones	Peninsula Health	We are providing a home based PR program at present.
annabel askin	Wimmera Health Care Group	We are launching a modified PR telehealth program 8 weeks of phone and or video delivery to 10 patients. Adaptions: resource development 'fine tuning patient handouts' Collaborating some talks together in shorter formats Challenge : no physical capacity assessment has been completed - all subjective information so can make exercise prescription challenging. We are using the Better Living with Lung Disease Exercise booklet for this. Information is posted so there is a often a 7 day lag (due to age of participants) Challenge: time required to rebuild resources, individual phone consulting Better support: mimic resource portal and sharing of resources similar to that of the Cancer Council's Cancer Wellness Program.
Robyn Paton	MLHD	MLHD has just commenced PR education via PEXIP, first session today w2hich went well. Most of these patients have not had a face to face assessment to are just encouraged to do general exercise at this stage but we are hoping to incorporate some of the resources from this group.
Mel	Peninsula Health - Pulmonary Rehab Program	We have shifted to offering a phone based service which commenced last week.
Judy Murrells	Gold Coast Health Service	Referrals have reduced due to self isolation of clients, Resp Specialist OP closure, reduced hospital admissions & reduced GP contact. Fever clinic operating Robina Health Precinct 4/6 resp nurses supporting clinic. Weekly phone contact with active clients -PRP. Daily clients of concern risk of hospitalisation consulting with GP's & as required Resp Physician. Helensvale Team developed a home exercise support program with 30 clients waiting for PRP -Corinne French will discuss. At Robina 44% consented to telehealth/virtual & 55% consented to phone calls only-PRP commencing 11/5/20. Reviewing video/education with the MDT for clients to view, clinician will be available for Q & A following session to maintain ABF. Steep learning curve and changes in MOC future??
Matthew Hutchins	Mater Hospital Brisbane	Outcome measures are difficult to assess, but educating people about moving and their condition is important.
Lorna Hatcher	Central Coast Area Health	We don't have our own Internet/Intranet page. I believe if we had of we would have been able to communicate with other health employees and the community more efficiently.
Kiera Vyce	Albury Wodonga Health	- our team is using video conferencing technology to continue to run our group pulmonary rehabilitation program remotely. - we also have health direct telehealth services in place for individual appointments, otherwise mostly phone based assessments and therapy. - challenges to this include: technology (resources and ability to use technology) on clients end, availability of resources for health professionals (lack of

		cameras, microphones, laptops, quiet space to undertake video/telehealth appointments). - some concerns around remotely providing exercise prescription for clients that have not had face to face (or telehealth) appointment with EP or PT, or for clients that may experience desaturation and need guidance on pacing when clinicians are unable to monitor this in person.
Lorraine O'Hare	Albury-Wodonga Health	We have adapted our Pulmonary Rehab service by providing a virtual group program. This includes twice a week video-call sessions – the first being education only, and the second being exercise and relaxation. Clients are able to dial in on their computers, mobiles phones with an app or even a landline phone (to receive the audio only). Our biggest challenge is building the digital literacy and digital confidence of our clients, many of whom are very unfamiliar with using the internet. Building this service has been a big win for us to not only enable continuity of care, but to assist our clients, many of whom are isolated and are struggling with anxiety and/or depression, to remain socially engaged in their community and with others going through a similar journey.
Kristine Berry	NNSWLHD Ballina Community Health	Mixed model of care. Some first assessments, then Home programme of exercises and follow up phone calls. Skype and telehealth use being organised. Decreased numbers of referrals as GP's have told clients not to come to the hospital, so contact has dropped off.
Charlotte Steed	WACHS - SW	I may have to leave early as I normally finish at 4pm (WA time)... I will see if I can stay to 4.30 - thanks
Kathryn Barker	Western Health	Adapted - centre-based programs closed and transitioned to telehealth (either phone or video) Biggest challenges - resources to provide telehealth models (either phone or video). Including: technology and supporting items (e.g. headsets for telephones) at clinician point of contact, patients access and knowledge of using technology, work space (noise, privacy etc)
Sarah Candy	Counties Manukau Health	In NZ we have just formed a PR network to work together to share resources, experiences and challenges. A We have 20 DHBs with representation from 16 services. We have a total of approx. 36 services across NZ. Many are block courses and if between courses have been on hold. Approx half the services are adapting to home based and telerehab services. The biggest challenge has been access to device and digital literacy. This has reduced ability for teleconferencing and limited to phone interviews. Many clinicians are feeling challenged by not being able to do objective measures for exercise prescription and concerns with safety aspects. Enabler - one of the initiatives in NZ has been delivering education and wellness via TV. This has been for schooling for children who do not have access to device/internet and more recently for >65yrs to keep active and reduce falls risk. This maybe an ideal

		avenue for accessing PR participants. Big win - finally getting out own PR network established! Other aspects which seem to be working well is SMS messaging for giving those motivational nudges.... learning and adapting as we go! Thank you
Bronwyn Hemiak	Werribee Mercy Hospital	My biggest challenge was commencing tele-rehab. Learning the new system and encouraging patients to give it a try as many were reluctant initially. It has also been challenging working out how best to support my patients during this time and how to continue to encourage and motivate them to continue completing their home exercise program.
Christine Hardy	Latrobe Regional Hospital	Our Health Service have mailed out resource packs including home exercise programs to our respiratory clients. We are currently looking at the best way to manage our Pulmonary Rehabilitation Group in the future and welcome any ideas.
Sophie Mummery	Tasmanian Health Service-South	Biggest challenges- working out what the relevant infection control procedures are if we do need to see face-face/home visit e.g. urgent airway clearance. - how to manage pts without any face-face contact (telephone only) or do we just waitlist them?
Yuna Han	Canterbury Hospital	At the moment, the biggest challenge is lack of technology, one does not fit for everyone, some clients do not have any technology to have a Virtual meeting/ assessment, etc. Weekly Telephone is also appreciated by clients. However, time consuming is biggest challenge. For Virtual meeting, without any support from Admin, it takes time as making appointment/ sending invitation/ sending reminder text/ answering the phone during the virtual session due to technology issues from clients side. However, it is great time for us to enjoy no matter what. They appreciate the effort that we try to contact them, to assist them, to provide advice, sending the exercise link, etc. Hope it would be helpful to assist clients to stay in the community safely.
Rebecca Kinnear	Werribee Mercy Pulmonary Rehab	I have found the lack of supporting technology a large challenge in keeping up a service delivery.
Paul Cavendish	NNSW LHD	adaptation: using telehealth as primary source of assessment and program education Challenges: (personal skills)- adapting face to face skills and tools to this; challenge with patients- supporting people with lower health literacy that are not online Support: social isolation is something that was there before COVID-19 and now more so. Facilitated support options (phone and online) in a group format would be interesting to see uptake; keen to see alternative technology (e.g. Apps) in providing information and interaction in future; No big win at this stage unfortunately!

Shaun Guy	Bunbury Hospital	Been challenging not being able to see clients face-face and changing work space and infrastructure challenges, providing mainly phone based support and trying to increase use of telehealth video.
Caroline Dickins	Barwon Health	From our perspective, we have kept in contact with our enrolled PRP clients via the phone and done some health coaching with them. As we step up our service it would be interesting to see what is planned. I have thought of smaller group numbers and not having groups for education, and looking at different ways of providing education for clients. Only approx. 1/2 of our clients have devices where we could provide telehealth. I would find this interesting to workshop with others what they are planning to do.
Lissa Spencer	SLHD	in short: assessing patients on ward and following via zoom ex class or home ex program with phone follow-up
Elise Harding	WSLHD	The biggest challenge I have found is motivating and engaging rehab patients via telehealth to continue with their home exercise program when there are no known dates i.e. classes resuming, COVID_19 restrictions ending.
Rebecca Chambers	Metro North Hospital and Health Service	Adapting to providing PR with less face to face patient contact - using telephone or telehealth instead. Challenges around safety of exercise prescription and progression without a face to face assessment, particularly in severe lung disease/pts who may desaturate during exercise. Would welcome discussion and opinions on this topic. To better support our patients we need: - more patients to have telehealth access/equipment at home - advice on virtual model of care development - particularly patient safety, outcome measures (physical and quality of life), telehealth vs telephone
Natalie Walsh	Hunter New England Health	We have adapted very quickly to a telephone/telehealth based service - we have many clients that have welcomed the service changes. Biggest challenges are time - it does take longer to contact clients individually as opposed to a class format and this isnt very well understood by managers higher up; not having information as to how long we are unable to run face to face/classes as it seems to be very different within health services and around the state; To better support patients it would be great to have more resources - lots of clients dont have stable internet so scopia etc just cant be done and we dont have lots of cameras etc; plus the post could be quicker!! Also when the guidelines come out for the state this will give our service some support to management higher up that what we are doing is valuable overall i feel we are doing the best we can in an ever evolving landscape!
Kirsty Hearn	Eastern Health	I am the clinical lead in physiotherapy (cardiorespiratory) at Eastern Health & over see the service provision of cardiorespiratory services across the network (including PR)

		How have you adapted during this time? Because my pull has been into planning the IP response, the utilisation of research staff within our network to assist with the development of a Telerehab response has been invaluable · What are the biggest challenges? Managing initial assessments re: exercise capacity (6MWT) and physical activity levels · What is it that would enable you to better support your rehabilitation patients? Learning/education for patients to be easily avaliable via other forums except online for patients who are less tech savy. · Do you have a big 'win' to share? PR team has moved successfully to telerehab and have even found they are not bound by location in regards to which PR service they access. NOTE: EH has a large catchment with 3 PR program locations. We are noew not bound by catchment which is allowing us to manage our waitlists better
Kathryn Wallace	FWLHD	FWLHD currently supporting clients with Telehealth mixed model of care. 1:1 nil exercise groups
Kellie Castle	MLHD	Home based rehab programs Assessments over the phone Commencing a 'virtual PR' trial using PEXIP next week Finding it challenging supporting patients over the phone. Difficult to maintain motivation without the group interactions
Nola Cecins	Sir Charles Gairdner Hospital	My biggest challenge is that less than half of the people I call can use or are willing to use video conference calls. I have found that people with straight forward lung disease (eg stable mild to moderate COPD) with few comorbidities respond well to the telephone and telehealth intervention. They are pleased with their improvements. I am trying to work out how best to capture this. However I am finding telehealth is more difficult for complex patients where we have no baseline exercise test. People with depression have also been difficult to motivate without face to face interaction. I am interested in the tools that are being used to evaluate the 'telehealth' experience in other programs?
Mary Santos	POWH	Adapted by using telehealth and telerehab to provide PR
Stephanie Fulford	Monash Health	Challenge: providing PR via telehealth and monitoring response to exercise