1. **Purpose**

This guideline provides recommendations regarding best practice to support Telehealth - Provided by Accredited Exercise Physiologists (AEP).

2. **Scope**

This Guideline provides information for Queensland public health system Accredited Exercise Physiologists (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting AEP’s).

The guidelines are envisaged to be used in the following settings:

- For AEPs facilitating group education in a hospital or private setting.
- For AEP’s providing home based assessment reviews with exercise prescription, if patient has undergone face to face screening and assessment within hospital or community facility. Such assessments would be conducted in accordance to Qhealth and ESSA standards and equip clinicians to provide clinical judgment on patient suitability. In this circumstance patient is to be provided with education regarding risks of home based exercise review and limitations of telehealth technology, e.g. unable to render first aid. Patients need to be found to be low risk of adverse event or falls, (consider appropriately qualified staff to attend home if available for assessment to increase patient safety).
- For AEPs conducting an initial assessment where telehealth link is between own hospital site and another hospital site. This circumstance can only occur when suitable care and trained staffing is available at receiving site to maintain patient safety.

These guidelines are **NOT** to be used in the following settings:

- For AEP’s conducting home based initial assessments. Home visit assessments via telehealth fail to provide appropriate detail to assess for safety/suitability and screen for contraindications to exercise.

3. **Aboriginal and Torres Strait Islander considerations**

Implications include – Improved access to health services in rural and remote areas via the use of telehealth to ‘Close the gap’. Cultural support will be provided by an Indigenous health worker (IHW) when client identifies need. Client’s will be asked whether IHW support is preferable.

4. **Related documents**

Standards, procedures, guidelines

- ACI-telehealth-guidelines

Forms, templates

- ACI-telehealth-guidelines – Organizational Telehealth Readiness Assessment Tool Page 19-21
5. Guideline for Accredited Exercise Physiology Telehealth

- **Before progressing further complete:** Organisational Telehealth Readiness Assessment Tool Page 19-21 and Practitioner Telehealth Readiness Assessment Tool Page 23, 24. ACI-telehealth-guidelines. If low/moderate scores are obtained for the organisational (less than 129) and practitioner readiness tools (less than 80), complete an analysis of barriers and produce a plan with appropriate parties to rectify. Complete tools again to finalise potential problems before continuing to telehealth use.

- Contact local telehealth department for further advice and technical requirements.

5.1. Exclusion criteria

- Increased falls risk
- Absolute risks to exercise criteria
- Relative risks to exercise that may require face to face supervision
- Hypertension that requires consistent monitoring
- Prone to hyper/hypo glycaemic events
- Medication and adherence that may cause adverse effects and situations
- Demonstrates risky behaviour (Disinhibition, poor insight, poor judgement, poor impulse control)
- Significant cognitive impairment
- Current suicidal ideation
- No phone, landline, electricity or internet coverage
- Unsafe environment (flooring, living conditions)

5.2. Initial face to face consult assessment for suitability – Including chart reviews

- Falls Risk- Indicated by chart review or questioning falls history: complete falls risk assessment and refer to PT to obtain falls risk, if HHS policy dictates. Mod to high – Patient not cleared for Telehealth. Low risk – Cleared for telehealth in the hospital. Telehealth in home with PT aggreance – consider support worker. Alternatively, a Short physical performance battery can be undertaken. Scores below: 9 contradict home based telehealth and scores below: 7 contradict centre based telehealth. Instructions and scoring sheets: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845214/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845214/)
• Medication adherence risk that may cause adverse effects and situations – Questioning: How often do you miss taking your medication? Do any make you dizzy or feel unwell or unsteady? If yes, not cleared (Patient GP contacted for review)

• Prone to hyper/hypo glycaemic events – If suspected or patient reports these events/symptoms (this question is indicated by T2DM or met syndrome diagnosis. If reported or found in chart review, patient is not cleared and should be reviewed by GP. Hyperglycaemic event may benefit from exercise intervention

• Cognitive impairment risk- Indicated by chart review or questioning/Ox, complete OT referral for cognitive screen. Mod to high – patient not cleared for Telehealth. Low risk – Cleared for telehealth in the hospital. Telehealth in the home with OT agreeance.

• Unsafe environment (flooring, living conditions) – Ask the following questions: Do they have a home/landline/internet/phone or laptop? What is the home living arrangement? Any small children or pets? (Pets can be locked away). Can they tell you about a suitable room that has space required for exercise, if need be? Is the flooring safe? If they are no to any of the questions but small children and pets, they may still be eligible for in hospital telehealth. A home visit maybe advised to assess patient’s environment for telehealth in the home to occur.

• If patient outcomes give clearance for hospital or home-based telehealth provide - Patient Information Sheet on participating in a Telehealth, Page 25 - ACI-telehealth-guidelines (link above), Complete Patient/Public Telehealth Readiness Assessment Tool, Page 22- ACI-telehealth-guidelines (link above)

5.3. In event of emergency

• Maintain calm and communicate with patient/carer/staff member

• If carer/staff member present instruct to provide basic first aid if able

• Call appropriate emergency service using number 000

• Maintain communication contact until emergency services arrive and take control of the situation.

• Fill out incident form/Riskman and inform line manager of incident

• Contact patient or carer to follow up as appropriate

5.4. Prior to consult

• Ensure readiness assessment tools have been completed and education provided: Patient Information Sheet on participating in a Telehealth, Page 25 - ACI-telehealth-guidelines (link above). Patient/Public Telehealth Readiness Assessment Tool, Page 22- ACI-telehealth-guidelines (link above)

• Consider the appropriateness for the consultation to be held via telehealth or by face to face

• Ensure all patient information/results have been sent to the clinician prior providing the
consult

- Depending on your HHS please consider secure messaging software- you can discuss this with your local Telehealth manager/ or IT (for sending information about patients)
- Identify a contact at the far site where the patient will be and consider if a staff member is required to be with the patient during the consult
- Identify if patient has a carer who should be included in all correspondence about the upcoming telehealth session.
- Have patients home address and phone number in case of emergency
- Confirm appointment with patient or his/her carer
- It is ideal to build some rapport with the patient and his/her carer (if applicable) prior to the telehealth consultation to make them more comfortable (i.e. a phone call prior) applicable- from the local site where the patient will be for the consultation

5.5. Day of Consult

- Test the equipment 30 minutes prior
- Ensure positioning of the camera and remember to look at the camera when talking. It is ideal to have the camera above the screen so when you look at the screen the camera is directed at your face (i.e. rather than your side)
- Ensure all documentation has been received – Have patient phone number and address ready in case of emergency or technical error.

5.6. Time of Consult

- Put mobile phones to silent
- Be aware there is a slight delay in using videoconferencing- when asking questions wait until the party has stopped speaking and then respond
- If applicable in multi-site telehealth consults- please ensure your site is on ‘mute’ if you are not talking
- Provide an overview on how the technology works and how the session will run
- Introduce yourself and all contributing clinician names and roles (if needed)
- All clinicians at all sites have agreed to participate in the consultation and document where possible any additional staff who enter the room during the consultation- document names in the telehealth documentation template
- **Receive verbal consent** from patient and his/her carer to continue with the consult and document in notes
- Confirm Medicare bulk billing (if applicable)
- Inform the patient and his/her carer that this session is private; is a confidential secure link and it will NOT be recorded
- Record notes of the consult at both ends (if applicable)
- Discuss next steps and follow up appointment (if required)
• Ensure the patient, his/her carer and other staff involved in the consultation are clear on the next steps and don’t have any other questions

5.7. After Consult

• Ask staff/and or patients and their carers to complete a survey based on their experience (if appropriate)

• Enter the Occasion of Service for Activity Based Funding if applicable/
  submit claim to Medicare if applicable

• Enter patient notes in their medical record

• Organise follow up (if applicable)

6. Definitions of terms used in the guideline

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<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
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<tbody>
<tr>
<td>AEP</td>
<td>Accredited Exercise Physiologist – Allied Health Professional</td>
<td>Exercise and Sports Science Association</td>
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<tr>
<td>HHS</td>
<td>Hospital and Health service</td>
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7. Document approval details

Document custodian
Senior Clinical Exercise Physiologist – Luke M Snabaitis SCHHS

Approval officer
Statewide Exercise Physiologist Advisory Group

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8. Version control

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<td>11/03/19</td>
<td>Luke M Snabaitis</td>
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