Tele-Rehab: a sharing of approaches and processes

RCA Webinar
May 13, 2020
12:00 p.m. – 1:30 p.m.
Participating in the webinar

• You can access your webinar options via the orange arrow button.
• ALL participants will be muted (to reduce background noise).
• Resources related to the webinar can be found in the Handout section.
• If you would like to submit a question or comment at any time, please use question box feature.
• This webinar is being recorded and will be available [www.rehabcarealliance.ca](http://www.rehabcarealliance.ca).
Welcome and Overview

Welcome to this informational webinar on the use of virtual rehab during the COVID-19 pandemic. Just under 1,000 people have registered!

Over the course of the next 1 ½ hours, you will learn about:

» The key components and enablers of using virtual rehab

» Practical tips for setting up virtual rehab quickly including obtaining consent, involving caregivers and other aspects of using virtual rehab

» The lived experiences of those in the field using virtual rehab in individual and group formats.

There will also be a Q&A in the last 15 minutes of the webinar.
### Meet Our Speakers

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Institution/Program</th>
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<tbody>
<tr>
<td><strong>Dr. Meiqi Guo</strong></td>
<td>MSc, MD, FRCPC, CSCN Diplomate(EMG) Physiatrist and Brain Rehab Program Medical Director University Health Network – Toronto Rehab</td>
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<tr>
<td><strong>Edith Ng</strong></td>
<td>Advanced Practice Lead</td>
<td>Toronto Rehabilitation Institute Brain Program</td>
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<tr>
<td><strong>Brenda Colella</strong></td>
<td>Psychological Associate Clinical Neuropsychology Clinical Research Manager Telerehab Centre for ABI Toronto Rehabilitation Institute, UHN</td>
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<tr>
<td><strong>Jennifer O'Neil</strong></td>
<td>PT, PhD Candidate</td>
<td>University of Ottawa Bruyère Research Institute</td>
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<td><strong>Theresa Grant</strong></td>
<td>Community Stroke Rehabilitation Program, Clinical Manager Champlain Local Health Integration Network (LHIN)</td>
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<tr>
<td><strong>Jeanne Bonnell</strong></td>
<td>Director, Home &amp; Community Care</td>
<td>Champlain Local Health Integration Network (LHIN)</td>
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<td><strong>Denise Taylor</strong></td>
<td>Manager Northwest Regional Rehabilitative Care Program and Physiotherapy Professional Practice Leader, St. Joseph's Care Group Thunder Bay</td>
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<tr>
<td><strong>Kristine Stubbs</strong></td>
<td>Speech-Language Pathologist</td>
<td>St. Joseph's Care Group Thunder Bay</td>
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<tr>
<td><strong>Manny Paiva</strong></td>
<td>Coordinator, Inpatient Stroke/Neuro Comprehensive Outpatient Rehabilitation Program Parkwood Institute, St. Joseph’s Health Care, London</td>
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Polling Questions
Overview of Virtual Rehab

Dr. Meiqi Guo
Medical Director, Brain Rehabilitation Program, Toronto Rehabilitation Institute
What is virtual rehab?

▲ Telehealth refers to the use of telecommunications and virtual technology to deliver health care to patients (World Health Organization) [1]

▲ Telehealth + rehab = “telerehab” or “virtual rehab”

▲ Not to be confused with the use of virtual reality for rehab
Why virtual rehab?

▲ Physical distancing -> suspension of outpatient rehab

▲ Timely access to rehabilitation is critical for recovery

▲ Delayed rehab -> poorer functional outcomes, decreased quality of life and impact on mental health

▲ Need to prevent backlog of patients on waitlist after pandemic
Virtual Rehabilitation has been already studied for many rehab patient populations

» Cardiac [2, 3]
  • Similar exercise outcomes compared to in-person
  • Able to draw upon a wealth of mobile health technologies

» Traumatic Brain Injury [4]
  • Telephone based interventions - improvements in global functioning, posttraumatic symptoms and sleep quality, and depressive symptom

» Stroke (5)
  • Many studies
  • Cochrane review – similar ADL function compared to in-person therapy
The evidence

» Multiple Sclerosis [6, 7]
  • 2015 Cochrane review – limited evidence
  • 2018 study – similar patient reported outcomes and objective mobility parameters compared to in-person

» Cancer [8]
  • Telerehab + pharmacological management of pain for those with advanced stage cancer -> better function, less pain and decreased hospitalization
Best Practice Recommendations for Stroke Care - "Stroke Best Practices During the COVID-19 Pandemic" [9]

- "Telerehabilitation is an effective and well-accepted method of outpatient and community rehabilitation services and is of particular importance during the COVID-19 pandemic."

World Health Organization - "Rehabilitation considerations during the COVID-19 outbreak" [1]

- “With adjustments to delivery, rehabilitation can continue during the outbreak, including through telehealth.”
- Suggests that governments expand the delivery of telehealth during the pandemic
Key requisites

▲ Technology
  » Ontario Telemedicine Network, or another video-to-video platform/telephone
  » Webcams, wireless headphones/microphones, computers
  » Bandwidth

▲ Personnel
  » Willing and able to adapt to virtual rehabilitation
  » Able to use technology

▲ Environment/Organization
  » Private treatment areas
  » Consent process
Stroke & Acquired Brain Injury

Virtual Rehab: Making the change in less than 4 weeks

Edith Ng
Advanced Practice Leader, Brain Services

Thank You to: Brain Services Virtual Teams, Marla Fogelman, Sheryl Zaitlin-Gencher, Miranda Hong, Brigitt Degeus, Angie Andreoli, Liz Inness, Allison Freeman, Sandra Yue, Amanda Woo, and Karl Wong.
In the next few minutes

Making the change to virtual rehab in less than 4 weeks

▲ Our stages of preparation & key learnings

▲ Bumps along the way

▲ Key Enablers

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Who we are & today's focus

▲ Urban, academic rehabilitation setting

▲ Inpatient Stroke and Acquired Brain Injury (ABI)

▲ Outpatient Stroke, ABI, and Multiple Sclerosis (MS)
  » Early Supported Discharge (ESD) Stroke in-person therapy, typically 4-5 times/week
  » Stroke, ABI, and MS in-person therapy, typically 2-3 times/week

▲ Rehab services for persons with neurological diagnosis and pain (LEAP – Living Engaged & Actively with Pain), and young adults with Cerebral Palsy or Brain Injury (LIFEsplan)
What we did

Stage 1
Learning & building the foundation

Stage 2
Transform learnings into practice

Beginning of Week 4 - April 14th -
Full Roll-Out!

Stage 3
Ongoing Learning & Improvement
Evaluation

Week 1 & 2
Week 2 & 3
Week 4 to now

Some clinicians started providing Virtual Therapy & received 1:1 support
Stage 1 (week 1 & 2)
Learning & building the foundation

• Formed the Virtual Rehab working group (managers, practice leads, research, physician)
• Met with the health profession groups who will be involved to learn from their experiences, questions, and needs
• Explore existing resources and guidelines on virtual rehab
• Began to create our model of virtual rehab
• Start logistic planning, such as OTN registrations, equipment, staffing, space ...
## Stage 2 (week 2 & 3)

**Transform learning into practice**

### Consolidated the First set of Process:
- Referral and Consent
- Safety Considerations (*i.e.* medical protocol, safety checklist)
- Communication within and between Inpatient and Outpatient teams

### Preparing the Teams:
- Share & refine the process
- OTN training sessions
- Access to & sharing of resources

### Preparing the Patients / Caregivers:
- Information handouts
- Instructional tools

### Logistics:
- Staffing
- OTN registrations
- Getting equipment
- Physical space
What we did

Week 1 & 2
Stage 1
Learning & building the foundation

Week 2 & 3
Stage 2
Transform learnings into practice

Beginning of Week 4
April 14th
Full Roll-Out!

Stage 3
Ongoing Learning & Improvement Evaluation

Week 4 to now

Some clinicians started providing Virtual Therapy & received 1:1 support
Stage 3 (week 4/Apr 14 to now)
Ongoing Learning and Improvement

Supporting the Teams:
- OTN training
- One Drive training
- Learn together to refine processes & to support practice

Continual Learning & Refinement of Process:
- Referral
- Consent
- Safety Considerations (i.e. medical protocol, safety checklist)
- Communication within and between Inpatient and Outpatient teams (i.e. warm-handover)
- Evaluation (adding)

Logistics:
- More OTN registrations
- More of specific equipment (i.e. bluetooth)

50+ Patients
4 change cycles so far...
What we offer

▲ Adapted assessments
  » Adapted speech and cognitive assessments
  » Functional observations and assessments

▲ Adapted treatment
  » Email exchange of photos, videos, and documents
  » Use of videos
  » Use of family caregivers to assist

▲ Develop and implement home programs
  » Making use of what they have at home

▲ Patient and family caregiver education
Bumps along the way & Our Learnings

▲ Patients having technical difficulties when they are at home
  » Discharged before being shown how to connect via OTN
  » Patient's device is not at the hospital for staff to help with OTN setup

▲ Involving and preparing family caregiver for virtual rehab

▲ Unpredictable Internet connection (i.e. interruptions, freezing, choppy audio)

▲ Learning and sharing strategies among team members to optimize virtual delivery

▲ Unexpected staffing shortages
Key Enablers

- Having **dedicated leaderships and support** for Virtual Rehab
- Collaborating and **learning with the teams**
- Learning from **patients & caregivers**
- Recognize this is an **evolving process**
- **Existing experiences** in Virtual Rehab & involvement in the **Telerehab Centre for ABI**


The Telerehab Centre for ABI: Remote Delivery of Group Therapy to ABI Clients across Ontario

Brenda Colella, C. Psych. Assoc.
Clinical Research Manager
Telerehab Centre for ABI
Brain injury consequences
   Enduring symptoms and disability

Dearth of therapy
   Particularly in chronic stages of injury

Many underserviced populations
   Geographically remote, francophone, criminal history

Things get worse for many
   Contrary to prevailing assumptions, there is deterioration in chronic stages of ABI, in cognitive and emotional functioning and in the brain
To deliver specialized, evidence-based therapies via telehealth modalities to ABI patients in the chronic stages of injury across Ontario in order to...

- fill the critical gap in clinical care for chronic ABI patients
- improve brain health, cognition, mood, coping, self-management and community integration for ABI patients
- improve long-term outcomes / prevent decline
- reduce family burden
- reduce healthcare costs
- Integrate research with clinical care to: (i) improve treatment, (ii) develop new treatments
Pre-Pandemic - Why Telerehab?

▲ **Equity of access** – regardless of geographical location, financial status and/or mobility issues

▲ **Scalability** – to reach province-wide and further

▲ **Cost effectiveness** (i.e., savings for healthcare system and patient)
**ARM 1**

**Clinical Arm:**
- Therapist or patient referrals
- Evidence-based cognitive and mental health therapies
- Online measurement of outcomes to ensure they are feasible & effective

**ARM 2**

**Research Arm:**
- New treatments under development
- Highly targeted to known brain mechanisms
- Focused in particular on “self-administered” – for scalability
- Transferred to arm 1 once sufficient level of evidence reached
Delivered by clinicians at Toronto Rehab; patients in their own homes across Ontario; secure videoconferencing

**Group** format
- Cost-effective
- Alleviates the social isolation clients feel
- Provides a sense of belonging and a network of support

Each module runs from 1.5-2 hours + between session assignments
**Menu of Current Clinical Services**

**Goal Management Training:** a cognitive intervention focused on minimizing attentional slips and improving planning and organization to increase goal attainment – long version (9 weeks); brief version (modified for mild TBI, 5 weeks)

**Cognitive Behaviour Therapy:** a psychological intervention focused on developing skills and strategies to manage emotions (10 weeks)

**Relaxation and Mindfulness Skills:** an intervention focused on developing skills to improve emotional well-being and stress management (8 weeks)

**Concussion Education and Symptom Management:** for individuals who have sustained a mild traumatic brain injury and are experiencing persistent symptoms – (6 weeks)
Screened for Eligibility

Intake Interview & Neuropsych Ax

Group Teletherapy Assignment (2 hours/week)

Pre-intervention assessments

Excluded: Did not meet inclusion criteria, declined to participate, other reasons

Cognitive Behavioural Therapy (CBT)

Goal Management Training (GMT)

Relaxation & Mindfulness Skills (RMS)

Concussion Education & Symptom Management

Post-intervention assessments

Structure & Operations of Centre
Commencing Fall 2020
• Beginner, Intermediate & Advanced CBT and Mindfulness Modules
• Acceptance & Commitment Therapy Module
• PTSD Module

Under Development (Arm 2 - Research):
• Self-administered memory intervention
• Anger Management Bracelet
• Cognitive/physical exercise regimen
Ready, Set, Go!
Virtual Rehab for the Novice

Jennifer O’Neil PT, PhD Candidate
University of Ottawa, Bruyère Research Institute
“By failing to prepare, you are preparing to fail.”

- Benjamin Franklin

- Minimal knowledge
- Peer support/champions
- Environment ready
- Mitigating risk
Ready, Set, Go!

▲ Plans and procedures in place
   » Safety Precautions
   » Emergency Plan
   » Communication Plan

▲ Informed Consent
   » Teleconsent

▲ Appropriate Technology
   » Secured Platform
   » Devices
   » Bandwidth
   » Sensory Challenges

COVID-19 updates, resources and tools

Virtual care is an important tool in Ontario’s efforts to slow COVID-19 spread. OTN is working with partners to provide safe, effective and appropriate care.

https://otn.ca/covid-19/
Ready, Set, Go!

👍 Declutter
👍 Chair against wall, breaks on, phone near, use corners of room
👍 Caregiver or partner near
👍 Pets in different room
👍 Emergency plan in place

△ Therapy environment
  » Technology ready, equipment near
  » Confidential, bright and quiet space
  » Appropriate area to demonstrate
  » Practice your video angles.
Heath inequities associated with telerehabilitation or virtual care

▲ Language
  » Interpreter? Family members?

▲ Cultural usability
  » Cultural views on technology and rehab?

▲ Access and cognitive challenges
  » Sensory challenges, attention issues, memory issues...

▲ Digital capacities
  » Internet, technology, education...

Jones et al., 2017; Maar et al., 2010

“Interaction Institute for Social Change | Artist: Angus Maguire.”
Ready, Set, Go!

Patient and Caregiver

- Explain Telerehab
- Training for caregiver
  - Safety and emergency
  - Technology
  - Communication
  - Assistance for
    - assessment,
    - intervention
Provider

◀ Assessment

▶ Evidences for ROM, SOT, gait analysis, swelling, some balance test, functional measures
▶ Clinical judgment to modify existing clinical outcome measures
▶ Schedule longer session
▶ Use activity trackers, mHealth...

Ready, Set, Go!

◀ Intervention / follow-up

▶ Effective as face-to-face
▶ Remember your motivational interviewing skills!
▶ Provide clear and slow verbal instructions
▶ Choose feedback wisely

Mani et al., 2017; Betts et al., 2018; Laver et al., 2020; Nelson et al., 2020

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Telerehabilitation Checklist

Telerehabilitation is defined as a way to provide rehabilitation services remotely using information and communication technology (Brennan, Maroon, & Brownell, 2009). It is a subspecialty of telehealth and involves any rehabilitation delivered using telehealth technologies such as videoconferencing, sensors, chat / text, educational portals and more. In unprecedented times such as a Pandemic, this alternative mode of delivery can serve as an excellent model of care due to the restricted nature of physical contact.

Telerehabilitation is complex and requires each therapist obtain proper training to develop new and specific skill sets in order to properly implement it as a tool. However, in emergency situations, extensive training may not be possible. For this reason, we have created a telerehabilitation checklist to support safe and rapid implementation within our clinical roles.

We plan on updating this checklist frequently as the situation evolves and evidence emerge on this topic.

<table>
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<tr>
<th>Initial Phone Call</th>
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<td>Informed Consent</td>
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<tr>
<td>Emergency Contact</td>
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<td>Phone:</td>
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<td>Client Address</td>
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<td>(emergency)</td>
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<td>Privacy Policy</td>
<td>Date:</td>
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<td>Send Consent Email</td>
<td>Date:</td>
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<td>Send Client Booklet</td>
<td>Date:</td>
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<td>Items Reviewed / Date</td>
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<th>Initial Remote Session</th>
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<tr>
<td>Informed Consent</td>
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<tr>
<td>Explained Telerehab and use of technology</td>
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<tr>
<td>Communication Plan</td>
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<tr>
<td>Safety Precautions</td>
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<td>Emergency Plan</td>
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<th>Each Remote Session</th>
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<td>Informed Consent</td>
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<td>Cuff removed, no pets present</td>
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<td>Lighting quality</td>
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<tr>
<td>Partner present</td>
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<tr>
<td>Phone accessible</td>
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<tr>
<td>Walking aid near</td>
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<tr>
<td>Hearing aid / glasses on</td>
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<tr>
<td>Safety: Chair vs wall, brakes on bed, hand support nearby e.g. standing in center</td>
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<tr>
<td>Footwear checked</td>
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<td>Adverse event protocol reviewed</td>
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Ontario Telemedicine Network (OTN) Ressources https://otn.ca/covid-19/
The lived experience of implementing tele-rehab with existing resources within Home and Community Care

Champlain LHIN Community Stroke Rehabilitation Program

Theresa Grant, Community Stroke Rehabilitation Program Clinical Manager

Jeanne Bonnell, Director, Home & Community Care
Systems level experience

▲ Previous capacity:

» iPads with SLP apps and FaceTime – lent to patients

» Virtual visit pilot project (OT and SLP)

» Jintronix systems

▲ Rapid expansion and adoption of tele-rehab practice

Therapist given time to:

» Attend webinars

» Review tele practice guides

» Scheduled meetings to share/problem solve with each other

» Research, think and plan
Systems level experience

▲ Rapid assimilation and sharing of tele-rehab resources (i.e. professional associations, CRSN, best practice leads)

▲ Kept patients on caseload (not on-hold) to allow check-ins

▲ Collaboration with IT and privacy:
  » What tools can we use?
  » How should we use them?
  » What is reasonable given the circumstances?

▲ Enhancing the soft-handover
Clinical experience:

» Higher reliance on family involvement to assist with set up and report observations

» Higher degree of co-ordination within teams (if a face to face visit had to be done by one team member, info gathered for the rest of team)

» Much could be done in many cases with some adaptation
  • OT: Modified assessments (e.g. MoCA – blind version), work sheets and activities via screen sharing
  • PT: use of functional strength measures; added questions for family observations, FAME on-line resources from UBC
  • Family following patient with tablet for functional activities
  • Patio window observations
Clinical experience

▲ Expected challenges
  » Hearing/visual impairments
  » No phone or internet; poor internet
  » No family support or community supports
  » Lack of motivation

▲ Unexpected Challenges
  ▲ Therapist and patient fatigue
  ▲ Energy required to motivate, interpret voice and facial expressions
  ▲ Managing interaction between patient and session partner
  ▲ Too much intense “eye-ball to eye ball” - turn screen sideways
  ▲ Need for ambulance calls during visits
Practical Tips and Learning for Implementing Tele-Rehab in Rural and Remote Locations

Denise Taylor, PT, MPH
North West Regional Rehabilitative Care Program Manager and Physiotherapy Professional Practice Leader
St. Joseph’s Care Group, Thunder Bay
To be Discussed:

- **Benefits and challenges** of facilitating visits and groups across telehealth modalities.
- Factors to consider when **preparing** to facilitate an individual session or remote group through a virtual care platform.
- Strategies to **build rapport and increase involvement** during virtual care visits.
- Considerations when facilitating a **physical activity** through a telepractice platform.
- Strategies to **increase involvement** during virtual care groups.
Benefits & Challenges of Virtual Care

Benefits

▲ Access
  » When in-person care is not possible (e.g. during a health pandemic)

▲ But also important post-pandemic for those with:
  » Geographical barriers to care (rural, remote communities)
  » Mobility impairments
  » Transportation issues

Challenges

▲ Ability to “connect”
▲ Internet/bandwidth
▲ Rapport
▲ Geography-local context
▲ Groups
Moving On after STroke (MOST)
Those in the remote areas appreciated the accessibility via videoconference and felt they were part of the group

“We’re all in different parts of the country but basically we are all one big group when we were having our session.” (PwS)

“Well it’s terrific. We can make the trip [to Thunder Bay], but I certainly wouldn’t have been making it twice a week” (CG)

“It’s better than telephone, and it’s better than driving to Thunder Bay.”
“It was an opportunity for us to meet with other people in the same situation as we were, and how [they were] dealing with it, and how to move on. Because you feel like you’re the only ones and when you see other people like you, you realize you’re not the only ones and people handled this situation in different ways..” (CG)
Factors to Consider when Preparing

▲ Partnership
  » Local contact person-room booking, emergencies
  » Understanding local context

▲ Technical support
  » Test
  » Early connection

▲ Safety
▲ Potential for audio delay
▲ Visual limitations
▲ Participation limitations
Practical Tips - Building Rapport

▲ Work at establishing a connection, show that you care
  » Listen carefully and reflect/summarize
  » Focus on determining and addressing their goals, e.g. tub transfer
  » Comment on what you are seeing, e.g. the beautiful view outside
  » Establish personal connection and use humour where appropriate, e.g. I can’t see without my glasses either

▲ Be aware of power differentials
  » Avoid any use of jargon, clear language is a sign of respect and encourages participation

▲ Articulate the client or the families strengths
  » e.g. I can see you’ve been working hard, your balance has really improved

▲ Visuals can confirm communication
  » Use gestures and hand signals e.g. nodding and pointing
  » Demonstrate a movement rather than just explain
  » Virtually shake hands on an agreed goal, give a high-five
Exercise: Keeping it Safe

▲ Assessment
  » In person either host site or locally

▲ Appropriate room/space

▲ Assistance and support

▲ Monitoring the distant site
  » Watching camera,
  » Adjusting camera,
  » Determining level of difficulty, effort required

▲ Focus on leader of group

▲ Corrections to whole group not individuals
Practical Tips - Working with Groups

**Visual compromise**
- Introduce as one large “room”
- Zooming in, presets, same seating plan (fax ahead)

**Audio lag and Group inclusion**
- Frequent use of names to get to know one another
- Stay unmuted if possible
- Allow more time for questions
- Invite participants to interact with one another, not just through facilitator
- Start brainstorming at distant sites vs. in-person site
- If serving refreshments, ensure all sites have the same
- If possible, meet in-person first; more than one in the room
- Connect individually outside of the group
- More facilitator “energy” required
Using Virtual Care - Other Tips

- Keep initial visit simple - observational, based on history
- Take advantage of available camera features e.g. zoom, stylus, portability
- Ask for clarification from client or care providers e.g. effort
- On-screen treatment often limited to suggestions and/or demonstrations
- Allow time for follow-up activities after visit e.g. contacting vendors, mailing handouts, signing documents
- Be sensitive to confidentiality e.g. clients can be at home with other people, may need to defer sensitive discussion

“I think we can strongly say videoconferencing is a wonderful technology and it certainly increases a lot of opportunity. It certainly is never going to replace face-to-face. We do video calls with our grandchildren, but it’s not going to replace having fun with them. You can’t give a hug across video call.”

Not equivalent to face-to-face interactions

but...(in some cases)

Benefits outweigh the shortcomings
An Overview of the Regional Tele-Speech Program at St. Joseph’s Care Group:

Kristine Stubbs, SLP
St. Joseph’s Care Group, Thunder Bay
Considerations:

1) Program Rationale
2) Program Objectives
3) Criteria
4) Partnerships
5) Referrals and Scheduling
6) Other Considerations
7) Challenges & Successes
Providing Rehab in a Group Format Through a Virtual Environment – Experiences from the Community Stroke Rehab Team

Manny Paiva
Coordinator, Rehabilitation Program
Parkwood Institute, St Joseph’s Health Care
London
Community Stroke Rehabilitation Team (CSRT)

Serves the South West LHIN

Providing 1:1 and group services

Groups:
- Memory (Occupational Therapist & Rehabilitation Therapist)
- Aphasia (Speech Language Pathologist & Rehabilitation Therapist)
Why Groups?

- Continue with program flow
- Mitigate future wait-list issues
- Address patient needs related to chronic issues (i.e. aphasia and memory)
- Opportunity for social interaction
Platforms

▲ Sharing our experience with OTN and WebEx

▲ Think carefully about the purpose of your group and the required tools/resources
   » Consider which platform is most appropriate
Useful Applications (WebEx)

▲ Email Communication: Customization of meeting invitation to participants

▲ Whiteboard & Annotation
  » Type text / Use key words
  » Drawing
  » Save images and send to participants afterwards

▲ Announcements: sharing key resources with participants

▲ Mute: Ability for host to mute individual participants
Tips for Group Facilitators

▲ Support individuals with set-up prior to starting group
  » Have contact information for tech support

▲ Have two individuals to run the group
  » One person to facilitate + one person to troubleshoot technical issues
  » Have a method for communicating during group (e.g. text, email, chat)

▲ Prepare for disruptions & establish a backup plan

▲ Length of session:
  » ~1 hour
  » Give time at the beginning and end of each session

▲ Follow-up after each group

▲ Get comfortable with the uncomfortable
General Tips

▲ Sit close to your router / Get a Wi-Fi booster

▲ Avoid disruptions:
  » Email notifications
  » Turn phone on silent but keep close if needed

▲ Speak slowly as there may be a delay in the sound

▲ Check in to make sure communication is clear
Setting-up Patients for Success

- Manage expectations at the beginning
- Determine each individual’s level of comfort with groups
- Sharing materials before starting
- Homework
Involvement of Caregivers

▲ Manage expectations and clarify role

▲ Learning along with their family member

▲ Support set-up

▲ Support facilitation
  » Repeating questions
  » Reading out answers
Considerations

▲ Consent

▲ Goals for virtual group may differ from in-person groups

▲ Organizational support
  » Leaders supporting staff to take time to modify resources, explore platforms and work with technical support

▲ Keep lines of communication open

▲ Include self-management approaches
Future Opportunities

▲ Measure success: pre/post outcome measures to determine benefits

▲ Ability to reach client groups that were previously not possible

▲ Opportunity to build groups taking into consideration functional abilities, personalities, and group dynamics
Feedback from Participants

▲ Positive

▲ Appreciative that there is some service

▲ Surprised at how they’ve been able to progress

▲ Ability to use technology

▲ Not for everyone
Crystal Branco, Janna Elder, Erin Macaluso, Suzanne Mugford, Christine Naraine, and Martha Scott
Given the high number of registrants, we may not be able to address all of the questions. Further inquiries can be sent to info@rehabcarealliance.ca

A final reminder that the recording of this webinar will be posted within a few days on the RCA website at http://rehabcarealliance.ca/webinars

Thank you for attending our webinar

Tele-Rehab: a sharing of approaches and processes
Final Polling Question