IMPLEMENTING TELEHEALTH INTO REHABILITATION PRACTICE

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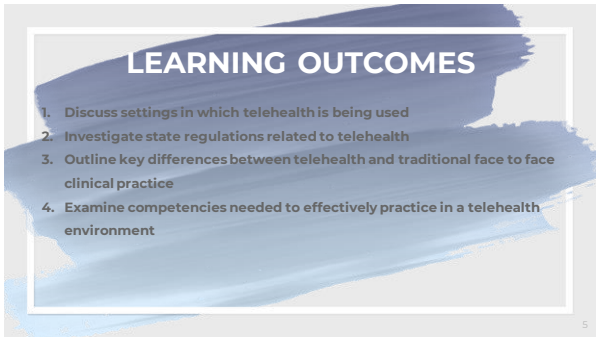
CONFESSION


PURPOSE
Definition
Use
Regulations
Practicalities
4


LEARNING OUTCOMES
1. Discuss settings in which telehealth is being used
2. Investigate state regulations related to telehealth
3. Outline key differences between telehealth and traditional face to face clinical practice
4. Examine competencies needed to effectively practice in a telehealth environment
5


1.
WHAT IS TELEHEALTH
Let's start with the basics


TELEMEDICINE
Remote clinical services
https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine
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TELEHEALTH
Remote clinical services
+
Training, meetings, continuing education
https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine
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AMERICAN TELEMEDICINE ASSOCIATION
"
ATA treats "telemedicine" and "telehealth" as synonyms and uses the terms interchangeably.
http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs
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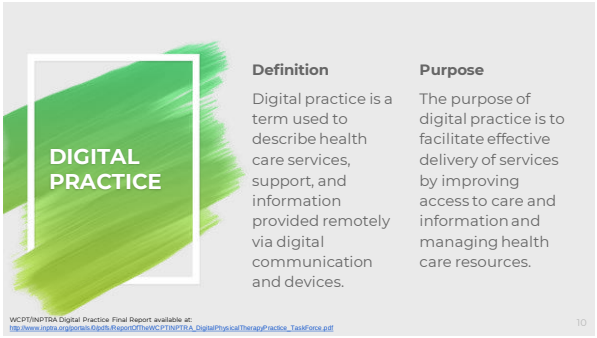
DIGITAL
PRACTICE
Definition
Digital practice is a term used to describe health care services, support, and information provided remotely via digital communication and devices.
Purpose
The purpose of digital practice is to facilitate effective delivery of services by improving access to care and information and managing health care resources.
WCPT/INPTRA Digital Practice Final Report available at:
http://www.inptra.org/portals/0/pdfs/ReportOfTheWCPTINPTRA_DigitalPhysicalTherapyPractice_TaskForce.pdf
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“
The future requires all clinicians to be digitally literate
WCPT/INPTRA Digital Practice Final Report available at:
http://www.inptra.org/portals/0/pdfs/ReportOfTheWCPTINPTRA_DigitalPhysicalTherapyPractice_TaskForce.pdf
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2.
HOW IS IT USED?

- Daily monitoring
  - Glucose
  - Blood pressure
  - Weight
  - Pulse oximetry
  - Falls

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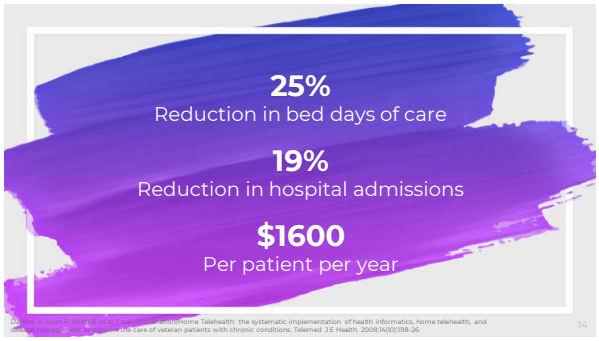

Darkins A, Ryan P, Kobb R, et al. Care Coordination/Home Telehealth: the systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions. Telemed J E Health. 2008;14(10):1118-26.

14

- Examples
  - Radiology
  - Dermatology
  - Diabetes

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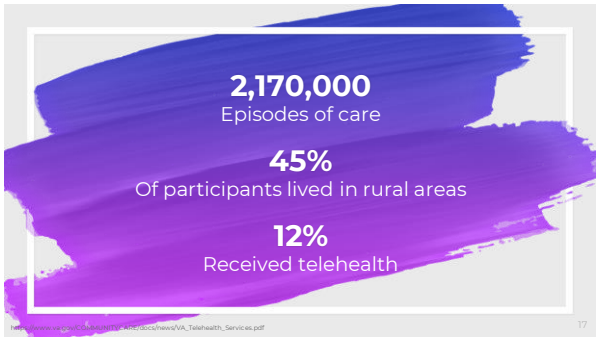
REAL TIME
VIDEO
CONSULT
Examples
Mental Health
Rehabilitation
Primary Care
Cardiology
16


2,170,000
Episodes of care
45%
Of participants lived in rural areas
12%
Received telehealth
17


WHEN WOULD
YOU USE IT?
18

WHEN WOULD YOU NOT USE IT?

20

Effects of Virtual Exercise Rehabilitation In-Home Therapy Compared with Traditional Care After Total Knee Arthroplasty

VERITAS, a Randomized Controlled Trial

Janet Prvu Bettger, ScD, Cynthia L. Green, PhD, DaJuanicia N. Holmes, MS, Anang Chokshi, DPT, Richard C. Mather III, MD, MBA, Bryan T. Hoch, DPT, Arthur J. de Leon, MPT, Frank Aluisio, MD, Thorsten M. Seyler, MD, PhD, Daniel J. Del Gaizo, MD, John Chiavetta, MD, Laura Webb, BS, Vincent Miller, MMCi, Joseph M. Smith, MD, PhD, and Eric D. Peterson, MD, MPH

510(k) clearance in October 2015. VERA is a cloud-based virtual telehealth system that functions with use of 3-dimensional (3D) tracking technology to quantify pose and motion, an avatar (digitally simulated coach) to demonstrate and guide activity, visual and audible instructions and immediate feedback on exercise quality, and a virtual video connection for synchronous telehealth visits with an assigned intervention telehealth physical therapist. Individualized prescribed therapy regimens were electronically programmed for patients through the clinician interface prior to surgery.

The VERA system tracked activity, performance, exercise quality, and adherence; the telehealth therapist monitored the patient's progress asynchronously. Patients had a video visit with their telehealth therapist in the week after hospital discharge and weekly thereafter to review progress and to revise the therapy regimen accordingly. The telehealth therapist provided remote clinician oversight to the patients for the duration of the intervention and communicated progress to each clinical site ahead of the patients' 2 and 6-week postoperative visits. Patients and the telehealth therapist mutually agreed when therapy goals were met for discharge from virtual PT. All patients who were randomized to virtual PT were able to receive in-person PT as clinically deemed necessary.

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	Intervention Group (N = 143)	Usual Care Group (N = 144)	P Value*
Primary outcome: 12-week health service use costs			<0.001
Mean and standard deviation	$1,781.96 ± $2,531.77	$4,526.77 ± $4,498.35	
Median	$1,050.00	$2,805.00	
Interquartile range	$900.00, $1,200.00	$1,644.50, $4,505.00	
Secondary outcome: 12-week health-care utilization†			
Home health physical therapy *(no. of visits)*	36 (0.3 ± 1.6)	686 (4.8 ± 6.3)	<0.001
Outpatient physical therapy *(no. of visits)*	199 (1.4 ± 4.4)	1,450 (10.1 ± 8.1)	<0.001
Physician clinic *(no. of visits)*	379 (2.7 ± 1.7)	398 (2.8 ± 2.0)	NS
Communication with physical therapy† *(no. of calls/emails)*	817 (5.7 ± 5.2)	19 (0.1 ± 0.4)	<0.001
Communication with physician† *(no. of calls/emails)*	149 (1.0 ± 2.0)	126 (0.9 ± 1.8)	NS
Urgent care *(no. of visits)*	11 (0.1 ± 0.3)	16 (0.1 ± 0.4)	NS
Emergency room *(no. of visits)*	10 (0.1 ± 0.3)	14 (0.1 ± 0.3)	NS
Inpatient rehabilitation *(no. of inpatient stays)*	0 (0 ± 0)	2 (0 ± 0.1)	—
Skilled nursing facility *(no. of inpatient stays)*	2 (0 ± 0.1)	5 (0 ± 0.2)	NS
Rehospitalization *(no. of inpatient stays)*	12 (0.1 ± 0.3)	30 (0.2 ± 0.5)	0.007

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LIMITATIONS

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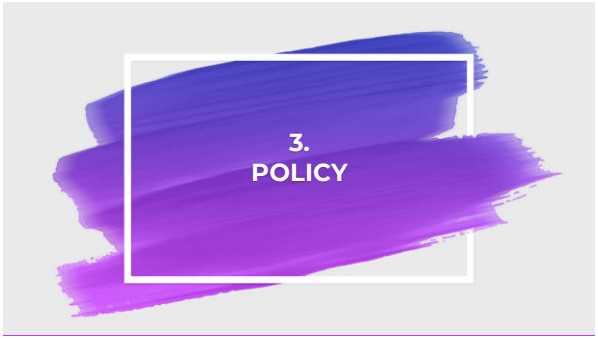
3.
POLICY


PARITY
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“
requiring insurers to cover the same services delivered through telehealth, as are covered in-person, as long as it meets the same standard of care
https://www.cchpca.org/sites/default/files/2019-03/TELEHEALTH%20REIMBURSEMENT%202019%20FINAL.pdf
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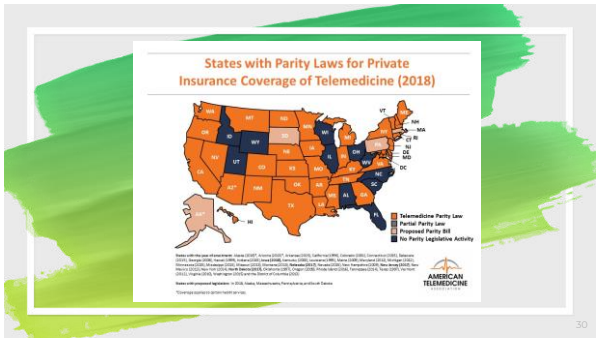

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MEDICARE

- Only live video
- Rural or underserved
- Using facilities
- Providers
- CPTs

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MEDICAID

- 50 states - Live video
- 11 states – store and forward
- 20 states – remote patient monitoring

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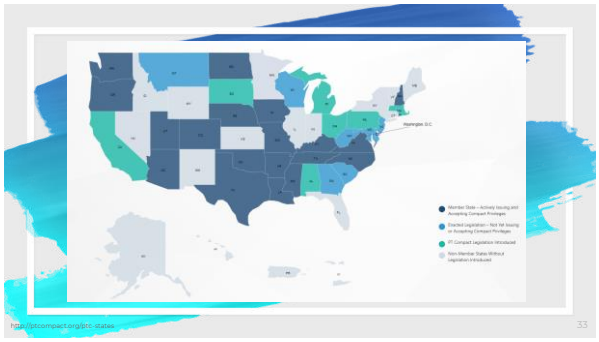

https://evisit.com/state-telemedicine-policy/

tinyurl.com/telehealth-policy

tinyurl.com/COVID-State-Changes

1. What types of telehealth are reimbursed in your state (private and Medicaid)?
2. Are PT's/OT's eligible providers under Medicaid?

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4. TELEHEALTH PLATFORMS

WHAT ARE YOUR NEEDS?

Tinyurl.com/telehealth-platforms

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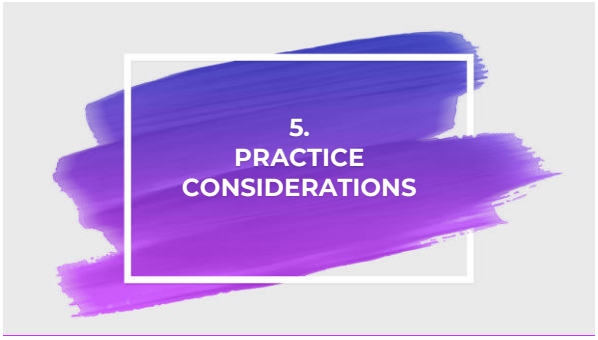
5.
PRACTICE
CONSIDERATIONS


BEFORE
YOU GET STARTED
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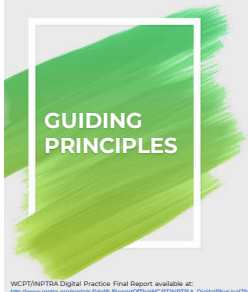
TELEHEALTH
READINESS ASSESSMENT
tinyurl.com/telehealth-readiness
41



- Best interest
- Scope
- Stakeholders
- Access
- Competent (both!)
- Monitor
- Collaborate

WCPT/INPTRA Digital Practice Final Report available at:
http://www.inptra.org/portals/0/pdfs/ReportOfTheWCPTINPTRA_DigitalPhysicalTherapyPractice_TaskForce.pdf

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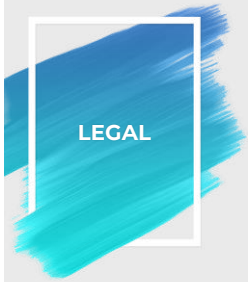

- Liability
- Payers
- License

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- Use secure portals
- Comply with established security regulations

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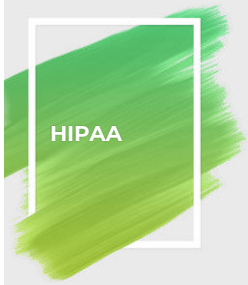

- Privacy
- Security

45

- Correct ID
- Local EMS
- Pathway for referral and follow-up

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- Consent
- + digital considerations

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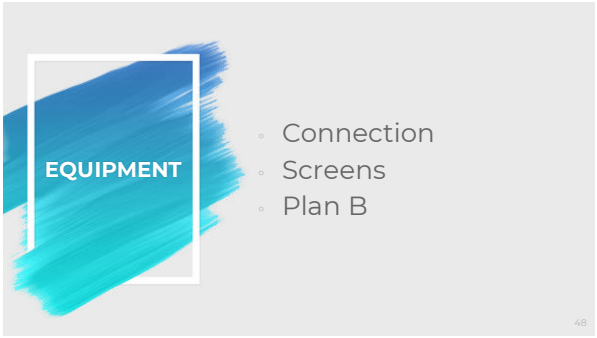
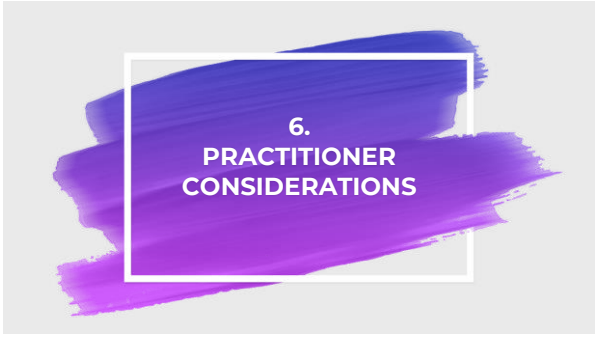

EQUIPMENT
Connection
Screens
Plan B
48


6.
PRACTITIONER
CONSIDERATIONS


WEBSIDE
MANNER
50

> *Many competencies for telehealth … are not novel competencies. They are fundamental to nursing care as a whole and therefore are also indispensable for telehealth.*

Van houwelingen CT, Moerman AH, Ettema RG, Kort HS, Ten cate O. Competencies required for nursing telehealth activities: A Delphi-study. Nurse Educ Today. 2016;39:50-62.

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Domain I: Digital communication and webside manner	Optimal visualization, body language, and speech	*Communication speed*—reduced for clear enunciation to ensure clarity over online platforms. *Colloquial speech*—avoided to differentiate between professional encounter and lifestyle video communication such as FaceTime® *Body motion and gestures*—minimized and made in full view of camera. *Motions* should be slowed to avoid blurring or poor visualization over video. *Background, lighting, and framing* are essential components of a virtual encounter which differ from traditional encounters. *Dress*—solid clothes with a neutral background project optimally in a virtual setting. *Camera*—located in a fixed position with clinician's head and shoulders centered. Clinicians look at the camera rather than screen to maintain "eye contact."
	Graphic-assisted communication	*Imaging and diagnostic findings*—conveyed to patients using a screen share methodology
	Virtual technologies	*Understand*—be familiar with virtual health platforms *Troubleshoot*—from both patient and clinician perspective

Sharma R, Nachum S, Davidson KW, Nochomovitz M. It's not just FaceTime: core competencies for the Medical Virtualist. Int J Emerg Med. 2019;12(1):8.

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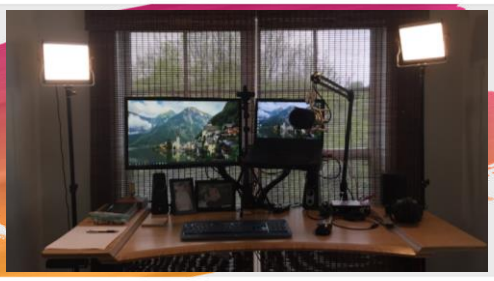

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Telehealth
Demonstration of Gear
Video
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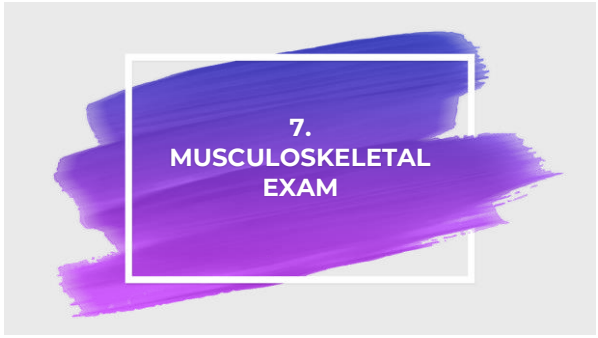
7.
MUSCULOSKELETAL
EXAM


TELEHEALTH
VS
IN-PERSON
Touch
Time
Tools
Triage
56


TELEHEALTH
VS
IN-PERSON
Touch
Time
Tools
Triage
57


TELEHEALTH
VS
IN-PERSON
Touch
Time
Tools
Triage
58


TELEHEALTH
VS
IN-PERSON
Touch
Time
Tools
Triage
59

TELEHEALTH VS IN-PERSON

- Touch
- Time
- Tools
- **Triage**

60

Examination components	Examination techniques	Patient self-performs	Patient performs with assistance of second person
History	Interview	X	
	PROs	X	
Systems Review	Vital signs	X	X
	Environmental scan	X	
	Observation	X	
Movement analysis/screens	Neuro screen	X	X
	Cognitive screen	X	
	Functional screen	X	X
	UQ/LQ screen	X	X

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EXAM?

- PROs
  - orthotoolkit.com

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NEURO SCREEN

Table 1. Methods of examination and interrater agreement for the 22 items of the neurological examination

Item	Method of performance	Level ausprägungen	Kappa coefficients (95% CI)
Deep tendon reflexes: Biceps reflex Supinator reflex Patellar reflex Achilles reflex	Patient lying relaxed, using Trömner hammer, (in video exam performed by assistant, rating by remote examiner by observing response) Absent only after facilitation	Absent Depressed Normal Brisk Clonus	0.49 (0.23–0.61) 0.38 (0.26–0.47) 0.52 (0.33–0.72) 0.45 (0.28–0.59)
Light touch	Touch using cotton wool button at face, forearm, foot (in video exam by assistant)	Normal decreased absent	0.61 (0.39–0.78)
Pin prick	Prick with wooden pin (toothpick) at face, forearm, foot at each side (in video exam by assistant)	Normal decreased absent	0.56 (0.38–0.75)
Babinski's sign	Striking lateral side of planta by reflex hammer (in video exam by assistant)	Present absent	0.61 (0.43–0.81)
Pronator drift	Stretching out both arms 45° while lying on stretcher (note drift and pronation separately)	NIHSS-score arms Arm pronation (present – absent)	0.81 (0.62–1.00) 0.68 (0.42–0.89)
Leg drift	Lifting up both legs, knee holds 90° angle (Mingazzini position)	NIHSS-score legs	0.74 (0.59–0.91)

Awadallah M, Janssen F, Korber B, Breuer L, Scibor M, Handschu R. Telemedicine in General Neurology: Interrater Reliability of Clinical Neurological Examination Via Audio-Visual Telemedicine. Eur Neurol. 2018;80(5-6):289-294.

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Finger nose coordination	Put index finger to nose in wide turn	Hypometric normal hypermetric	0.68 (0.44–0.91)
Heel shin coordination	Put heel to knee in wide turn	Normal atactic	0.57 (0.41–0.86)
Vibratory sensation	Test at big toe using Rydel-Seiffer 128 Hz tuning fork (in video exam by assistant, rating by remote examiner by observing tuning fork)	Scale 0–8 visible at tuning fork	0.34 (0.11–0.53)
Diadochokinesia upper limb	Turning hands in alternate movements	Normal abnormal	0.59 (0.38–0.75)
Diadochokinesia lower limb	Cycling with both legs while lying flat	Normal abnormal	0.67 (0.49–0.80)
Visual fields	Moving fingers alternatively, patient looks at nose (assistance at bedside)	Normal abnormal	0.56 (0.38–0.69)
Speech (dysarthria)	Repeat a difficult phrase ("Fischers Fritz fischt frische Fische". "Die Katze tritt die Treppe krumm")	Normal abnormal	0.68 (0.42–0.94)
Language	Name some objects, follow commands, repeat one sentence	NIHSS-score	0.82 (0.69–0.98)
Eye movement	Follow finger all directions (video: commands)	Normal abnormal	0.58 (0.39–0.88)
Facial paresis	Show teeth, close eyes, lift eyebrow	Normal – abnormal/ peripheral – central	0.55 (0.31–0.72)/ 0.77 (0.42–1.00)
Tongue movement	Stick out tongue	Normal – deviation	0.69 (0.29–0.83)
Muscle tone	Test each arm and leg by passive movement (in video exam by assistant)	Normal rigid spastic	0.32 (0.19–0.46)

Awadallah M, Janssen F, Korber B, Breuer L, Scibor M, Handschu R. Telemedicine in General Neurology: Interrater Reliability of Clinical Neurological Examination Via Audio-Visual Telemedicine. Eur Neurol. 2018;80(5-6):289-294.

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Examination components	Examination techniques	Patient self-performs	Patient performs with assistance of second person
Activity	ROM	X	
	Accessory motion		X
Muscle performance testing	MMT	X	X
	Functional strength assessment	X	
Special tests	FABER, SLR, etc	X	X
Palpation	For pain, edema, etc	X	
Physical performance measures	Hop testing, 6MWT, TUG, etc	X	X

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EXAM?

- ROM
  - Gross eyeballing?
  - Give % of full ROM
  - Put goniometer on the screen (Dent et al)
  - Smartphone app (Keogh et al)
  - Patient measures (Collins et al)

Dent PA, Wilke B, Terkonda S, Luther I, Shi OG. Validation of Teleconference-based Goniometry for Measuring Elbow Joint Range of Motion. Cureus. 2020;12(2):e6925.
Keogh JWL, Cox A, Anderson S, et al. Reliability and validity of clinically accessible smartphone applications to measure joint range of motion: A systematic review. PLoS ONE. 2019;14(5):e0215806.
Collins JE, Rome BN, Daigle ME, Lerner V, Katz JN, Losina E. A comparison of patient-reported and measured range of motion in a cohort of total knee arthroplasty patients. J Arthroplasty. 2014;29(7):1378-1382.el.

EXAM?

- Regional Exam
  - Shoulder
  - Elbow
  - Low back
  - Hip
  - Knee
  - Ankle

Table 1: Example of physical examination recording and coding.

Test	Rating	Data coding
Postural deviation	Normal/mild/moderate/severe	0/1/2/3/4
ROM (e.g., (L) shoulder flexion)	Full/restricted	0/1
Limiting factor (to ROM)	Nothing/pain/stiffness/pain and stiffness	0/1/2/3
Pain on active ROM	Scale from 0–10	0/1/2/3/4/5/6/7/8/9/10
Strength (e.g., (L) middle deltoid)	Full/reduced	0/1
Pain on SMT (e.g., middle deltoid)	Pain ISQ/pain Increase	0/1
Special orthopaedic test (e.g., O'Briens)	Negative/positive	0/1

(L): Left; ROM: range of motion; ISQ: in status quo.

Steele L, Lade H, Mckenzie S, Russell TG. Assessment and Diagnosis of Musculoskeletal Shoulder Disorders over the Internet. Int J Telemed Appl. 2012;2012:940745.

Table 2 Validity, intra-rater and inter-rater results for the binary data tests

Binary tests	Comparison	% agreement	P-value
Range of motion	Validity	88	0.001
	intra-rater	95	<0.001
	inter-rater	93	0.000
Nerve	Validity	46	0.616
	intra-rater	98	<0.001
	inter-rater	68	0.003
Special orthopaedic tests	Validity	73	0.003
	intra-rater	94	<0.001
	inter-rater	91	<0.001
Pain response	Validity	82	<0.001
	intra-rater	97	<0.001
	inter-rater	98	<0.001
Joint assessment	Validity	47	0.386
	intra-rater	81	<0.001
	inter-rater	97	<0.001
Strength	Validity	90	0.006
	intra-rater	98	<0.001
	inter-rater	96	<0.001
Limiting factor	Validity	68	<0.001
	intra-rater	86	<0.001
	inter-rater	84	<0.001

Lade H, Mckenzie S, Steele L, Russell TG. Validity and reliability of the assessment and diagnosis of musculoskeletal elbow disorders using telerehabilitation. J Telemed Telecare. 2012;18(7):413-8.

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Table 3. Levels of Agreement in Identifying If a Lumbar Spine Movement Direction Was Painful

DIRECTION OF MOVEMENT	% EXACT AGREEMENT	CHI-SQUARED	P VALUE
Flexion	96%	22.16	< 0.001
Extension	89%	15.37	< 0.001
Lateral flexion			
Right	81%	10.40	0.001
Left	88%	14.28	< 0.001
Rotation			
Right	89%	13.58	< 0.001
Left	92%	18.58	< 0.001

Table 4. Levels of Agreement for Symptoms and Sensitization of the Straight Leg Raise

	% EXACT AGREEMENT	CHI-SQUARED (P VALUE)	KAPPA STATISTIC
Painful	90%	28.59 (<0.01)	
Symptoms	84%		0.62
Sensitivity			
DF	90%	25.78 (<0.01)	
Hip IR	88%	20.26 (<0.01)	
Active neck flex	82%	2.17 (0.14)	

DF, dorsiflexion; IR, internal rotation.

Table 2. Range of Lumbar Spine Motion Data for Face-to-Face and Telerehabilitation Assessments

DIRECTION OF MOVEMENT	MEAN ± SD			STANDARD ERROR OF THE MEAN	PEARSON'S CORRELATION (P VALUE)
	F2F	EHAB	DIFFERENCE		
Flexion	13.6 ± 10	13.14	1.5 ± 5	1.34	0.88 (<0.001)
Extension	6.2 ± 6	6.1	0.1 ± 4	0.81	0.83 (<0.001)
Lateral flexion					
Right	4.9 ± 2	4.6 ± 7	1 ± 4	1.14	0.68 (<0.001)
Left	4.5 ± 3	4.5 ± 7	−1 ± 4	1.14	0.67 (<0.001)

All measurements are in centimeters.
EHAB, eHAB telerehabilitation; F2F, face to face; SD, standard deviation.

Truter P, Russell T, Fary R. The validity of physical therapy assessment of low back pain via telerehabilitation in a clinical setting. Telemed J E Health. 2014;20(2):161-7.

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Table 1 Self-administered examination (SAE)

Examination manoeuvre	Description	Positive test
Trochanteric palpation[20 21]	Patient instructed to lie on the side with symptomatic leg facing the ceiling, hips flexed to 45° and knees held together. Patient then instructed to palpate lateral hip for tenderness.	► Pain with palpation of the anterior, lateral and or posterosuperior facets of the greater trochanter.
Restricted range of motion (ROM)—hip rotation	Patient instructed to sit in chair with hip flexed to 90°. Active internal and external rotation performed to end point and held for 5 s.	► ROM assessed visually. ► Assessment for presence of concordant pain, pain during motion or pain at end of ROM.
Restricted ROM—supine hip flexion	Patient instructed to lie supine with hips flexed. Knees are brought directly in line with the shoulders and then brought outside of the shoulders.	► Reproduction of concordant hip pain.
Flexion abduction external rotation (FABER)[22]	The lateral malleolus of the symptomatic leg is placed above the patella of the contralateral leg. The pelvis is maintained level and parallel to the bed. The bent knee is allowed to fall towards the bed without moving the pelvis.	► Restricted visual mobility. ► Reproduction of concordant hip pain compared with contralateral side.
Bilateral bent knee fallout	Lying flat on the back with both knees bent and feet flat on the floor. Both knees are gradually allowed to fall to the outside with the feet maintained on the floor.	► Reproduction of concordant hip pain.
Bilateral resisted hip abduction[23]	Sitting in a chair, subject is instructed to place one flat between the knees. They then apply as much force as possible for up to 5 s.	► Reproduction of concordant hip pain.
Sitting hip abduction	Sitting in a chair with knees together, a belt is placed around both knees. The subject attempts to push the knees apart with as much force as possible for up to 5 s.	► Reproduction of concordant hip pain.
Single-leg stance[24]	Standing next to a wall, the contralateral hand is used for balance. The asymptomatic foot is raised until the thigh is parallel to the floor. This position is held for up to 30 s.	► Reproduction of concordant hip pain.
Three-way squat	1. Traditional squat: with feet and knees shoulder width apart, slowly squat into a chair. 2. Sumo squat: keeping the knees as wide apart as possible, slowly squat into a chair. 3. Knock knee squat: keeping the knees as close together as possible, slowly squat into a chair.	► Reproduction of concordant hip pain.
Single-leg squat	Standing on one leg while holding a stationary surface for balance, subject slowly squats as far as possible.	► Reproduction of concordant hip pain.

Ovusu-akyaw KA, Hutyra CA, Evanson RJ, Cook CE, Reiman M, Mather RC. Concurrent validity of a patient self-administered examination and a clinical examination for femoroacetabular impingement syndrome. BMJ Open Sport Exerc Med. 2019;5(1):e000574.

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Table 1. Example of rating scale for conversion of physical examination findings for analysis.

	Examiner rating	Conversion for statistical analysis
Walking		
Biomechanical issues	Nil/mild/moderate/ severe	0/1/2/3
Pain (VAS)	Scale from 1–10	0/1/2/3/4/5/6/ 7/8/9/10
Pain	No/yes	0/1
Knee flexion (R) ROM		
Active ROM	Full/restricted	0/1
Active ROM pain (VAS)	Scale from 1–10	0/1/2/3/4/5/6/ 7/8/9/10
Active ROM pain (binary)	No/yes	0/1
Active ROM Limiting factor	Nothing/pain/ stiffness/ pain and stiffness	0/1/2/3
Clinically relevant	No/yes	0/1
Knee (R) MCL test		
Test result	Negative/positive	0/1

VAS: visual analogue scale; ROM: range of movement; MCL: medial collateral ligament.

Richardson BR, Truter P, Blumke R, Russell TG. Physiotherapy assessment and diagnosis of musculoskeletal disorders of the knee via telerehabilitation. J Telemed Telecare. 2017;23(1):88-95.

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Table 1. An example of the clinical observation rating form and the associated coding for analysis

Task	Rating	Conversion for analysis
Ankle dorsi-flexion (left)		
Active ROM	Full / restricted	0 / 1
Active ROM pain (VAS)	Scale from 1–10	0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10
Active ROM pain	No / Yes	0 / 1
Active ROM limiting factor	Nothing / Pain / Stiffness / Pain and stiffness	0 / 1 / 2 / 3
CFL stress test (Left)		
Test result	Negative / Positive	0 / 1
Gait analysis		
Antalgic gait	Nil / mild / moderate / severe	0 / 1 / 2 / 3
Biomechanical issues	Nil / mild / moderate / severe	0 / 1 / 2 / 3
Pain (VAS)	Scale from 1–10	0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10
Pain	No / Yes	0 / 1
Clinically relevant	No / Yes	0 / 1
Single leg squat (left)		
ROM	Full / restricted	0 / 1
Biomechanical issues	Nil / mild / moderate / severe	0 / 1 / 2 / 3
Pain (VAS)	Scale from 1–10	0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10
ROM Limiting factor	Nothing / Pain / Stiffness / Pain and stiffness	0 / 1 / 2 / 3
Pain	No / Yes	0 / 1
Clinically relevant	No / Yes	0 / 1

ROM = range of motion; VAS = visual analogue scale; CFL = calcaneo-fibular ligament.

Russell TG, Blumke R, Richardson B, Truter P. Telerehabilitation mediated physiotherapy assessment of ankle disorders. Physiother Res Int. 2010;15(3):167-75.

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EXAM?

- Physical Performance
  - TUG
  - 6MWT
  - Berg

Hwang R, Mandrusiak A, Morris NR, Peters R, Korczyk D, Russell T. Assessing functional exercise capacity using telehealth: is it valid and reliable in patients with chronic heart failure?. J Telemed Telecare. 2017;23(2):225-232.
Stienen MN, Gautschi OP, Staartjes VE, et al. Reliability of the 6-minute walking test smartphone application. J Neurosurg Spine. 2019;31(6):786-793.

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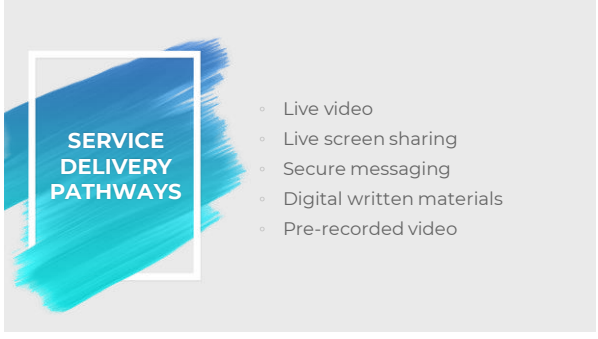
8.
INTERVENTIONS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DELIVERY
PATHWAYS
Live video
Live screen sharing
Secure messaging
Digital written materials
Pre-recorded video


WHAT?
SO WHAT?
NOW WHAT?
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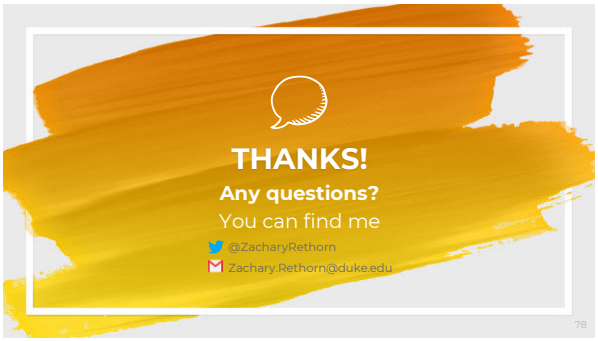
THANKS!
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