EXERCISE & SPORTS SCIENCE AUSTRALIA

Submission to the Australian Competition and Consumer Commission (ACCC) on the

Private Healthcare Australia Limited's application for authorisation – AA1000487

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1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing over 8,000 members, including university qualified Accredited Exercise Physiologists (AEPs), Accredited Sports Scientists (ASpSs), Accredited High Performance Managers (AHPMs) and Accredited Exercise Scientists (AESs).

AEPs are recognised allied health professionals who provide clinical exercise interventions aimed at primary and secondary prevention; managing sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness. AEPs are university qualified allied health professionals who provide clinical exercise interventions aimed at primary and secondary prevention; managing acute, sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness.

2.0 ESSA's Recommendation

ESSA recommends that the ACCC approves Private Healthcare Australia Limited's application for authorisation – AA1000487 to extend AEP telehealth item codes for Australian Private Health Insurers for a further six months from the date of the ACCC's final determination.

3.0 Impact of COVID-19 pandemic on services delivered by AEPs

Teleconsultations have provided a safe and viable alternative to face-to-face consultations to maintain AEP-client health and to mitigate the need for clients to have to attend clinics and/or hospitals and risk further spread of the virus [1, 2].

The impact that the PHA's notified co-operation has had on ESSA members has been positive. PHA's swift response to the introduction of interim item codes for AEP teleconsultations enabled ESSA's AEP members to pivot their businesses to include telehealth and continue to provide quality care for their clients. The acknowledgement of telehealth and interim provision of new item codes for AEP telehealth services by multiple Private Health Insurers (PHI) has also provided opportunities for clients who live in rural and remote locations and those who have limited access to transport or conditions like are agoraphobia to more easily access AEP services.

3.1 ESSA's bi-monthly COVID-19 Member Impact Survey

The COVID-19 pandemic has had a significant impact on AEPs. ESSA's first bi-monthly *COVID-19 Member Impact Survey*, which was completed by 225 AEPs in April 2020 indicates that the most significant impacts on AEPs have been:

- reduced customer demand
- inability to provide services in the usual manner
- increased social distancing
- reduced cash flow
- a transition to online service delivery
- additional resources to keep practitioners and clients safe
- business closures and
- closure of sporting facilities and cancellation of sporting and community events.

Survey results also found that:

- 35% of AEP member participants experienced a reduction in their income.
- 36% experienced a decrease in revenue of 75-100%; 38% experienced a decrease in revenue of 50-74%; and 13% experienced a decrease in revenue of 25-49%.
- 70-85% were delivering all service options, with only 28% delivering no services at all.
- 42% reported that they had not received any new referrals since COVID-19 social distancing public health orders and the date of the survey.

Ongoing surveys will continue to inform ESSA of the impact of COVID-19 on our workforce.

3.2 Anecdotal feedback

ESSA has received anecdotal, yet consistent, feedback from our members about reduced job security and higher unemployment across all ESSA member segments, including AEPs.

In addition, we have also been advised by some Private Health Insurers (PHIs) that there has been a decline in the number of claims for exercise physiology services from their members, compared to the same time last year. This has manifested in a marked increase in cancellation of appointments, which has also reduced AEP remuneration and job security; and impacted on AEPs' ability to maintain regular clinic hours.

3.3 ESSA's Telepractice Policy Statement and development of Telepractice Standards

ESSA developed an interim *Telepractice Policy Statement* (see Appendix 1) in March 2020 as part of our initial response to the pandemic. The policy statement outlines the minimum requirements and best practice guidelines for ESSA professionals offering teleconsultations in response to COVID-19, and was designed to provide swift and interim guidelines for our members in between our development of a full suite of Telepractice Standards.

This minimum requirements within the ESSA's *Telepractice Policy Statement* align with the Australian Health Practitioner Regulation Agency (Ahpra)'s *Telehealth guidance for practitioners* and provide more detailed guidance for ESSA members than the Ahpra guidance to Ahpra registered health professionals.

The development of ESSA Telepractice Standards is now underway with an anticipated publish date of July 2020.

4.0 AEP telehealth service delivery

4.1 Teleconsultation and AEP professional scope of practice

Telepractice is mode of service delivery within the scope of practice of all ESSA accredited professions and is suitable for a broad range of health conditions and injuries. Active exercise-based interventions are the foundation of AEP interventions. There is **no manual therapy involved**, therefore, these services are very well suited to teleconsultations via video or telephone.

Teleconsultations delivered by an AEP are likely to involve self-directed or at home exercise-based interventions with consultations focusing on exercise prescription, review, education/advice about a range of factors such as client condition/injury, behaviour change, progression, benefits of exercise and self-management. Teleconsultations are also well suited for scenarios in which teleconsultation infrastructure is intact and AEPs are available to apply evidence-based interventions to clients via appropriate platforms. Since Australian health systems have already invested in telemedicine and have national standards (AS ISO 13131:2017: Health informatics - Telehealth services - Quality planning guidelines) [3], AEPs have been well positioned to ensure that clients in unforeseen imposed isolation/containment circumstances receive the appropriate care they need.

4.2 Efficacy of AEP teleconsultations

The efficacy and relevance of AEP service delivery via teleconsults, even prior to the pandemic, is reflected by the fact that multiple Australian compensable schemes already have established arrangements in place to support the delivery of AEP teleconsultations (i.e. National Disability Insurance Scheme [NDIS], State Insurance Regulatory Authority - NSW and WorkCover Queensland). Other compensable schemes have since introduced temporary telehealth item codes for exercise physiology services in response to the COVID-19 pandemic.

ESSA provided a briefing paper to Private Healthcare Australia (PHA) on 27 March 2020 (see Appendix 2) which resulted in PHA recommending to its members to introduce interim new item codes to cover AEP teleconsultations during the pandemic. The paper evidences the efficacy of AEP services delivered via video or telephone for clients with specific conditions. Multiple PHIs have since adopted interim telehealth item codes for their members to claim for AEP services (see Appendix 3).

4.3 ESSA's Telehealth efficacy research project

ESSA recently called for Expressions of Interest for high quality research projects relating to AEP Telehealth practice. This may include (but is not limited to) research into the use of AEP Telehealth services delivered during the COVID-19 pandemic and beyond in alignment with the following themes:

1) Investigation of the efficacy of clinical outcomes of AEP Telehealth interventions OR Telehealth interventions compared with face-to-face interventions.
2) Cost-effectiveness of AEP Telehealth versus Face-to-Face interventions
3) Client and AEP practitioner experience using Telehealth.

ESSA's Telehealth Efficacy Research Project is due for completion in 2021. We look forward to sharing the results from this research with relevant stakeholders to optimise health outcomes and reduce barriers to care for all Australians.

5.0 AEPs and Federal Government, Medicare Item numbers

Each jurisdiction has its own legislation covering essential services as such, there is no consistent definition of what an "essential service" across Australia is. Ensuring that essential needs continue to be met during the pandemic response is critical. As a broad example, essential needs include access to food, healthcare, power, transport, utilities, banking and finance, manufacturing, emergency services and Government services, and supporting supply chains.

In most cases, each state and territory has elected not to list what is 'essential' and what must stay open but has identified what is 'non-essential' and must close to minimise the spread of COVID-19 (hence the requirements for non-essential businesses at different stages of recovery).

The Prime Minister and the Minister for Health have at various times confirmed that health and allied health services are essential with the Prime Minister stating on 24 March 2020:

> "In terms of personal services where there is a lot of contact, obviously, between those providing that service in a premise and the patrons, the following now won't be able to continue: beauty therapy, tanning, waxing, nail salons and tattoo parlours and the same for spa and massage parlours. That **excludes health-related services in those areas**, physiotherapists, **things of that nature, health-related and allied health services**." [5]

The Minister for Health's media release on 29 March, 2020 referred to essential primary health services as well as announcing the introduction of the new interim Medicare telehealth item numbers:

> "To provide continued access to **essential primary health services during the COVID-19 pandemic**, the Australian Government is **expanding Medicare-subsidised telehealth services for all Australians and providing extra incentives to general practitioners and other health practitioners**.

> These critical changes have been designed in partnership with key stakeholders in the sector including the Australian Medical Association, Australian College of Rural and Remote Medicine, Council of Presidents of Medical Colleges, National Aboriginal Community Controlled Health Organisation, Royal Australasian College of Physicians, Royal Australian College of General Practitioners, Rural Doctors Association of Australia, **Allied Health Professionals Australia**, Australian Psychological Society, and the Australian Primary Health Care Nurses Association." [6]

These statements confirmed that exercise physiology services as recognised allied health services were "essential services" and enabled practitioners to continue to provide clinical exercise interventions for people diagnosed with chronic disease throughout the COVID-19 pandemic and to mitigate pressure on the primary healthcare system.

The interim Medicare Item Numbers (93000, 93013, 93048, 93061) have allowed the continued safe and vital delivery of clinical exercise interventions for vulnerable populations and people diagnosed with chronic disease until 30 September 2020. This interim policy change provided a catalyst for PHA to consider the development of new item codes to cover AEP telehealth services.

6.0 Benefits of AEP teleconsultations

There is clear evidence demonstrating that teleconsultations provided by AEPs via both video and/or by telephone improve health, wellbeing and clinical status. Pathology domains covered by the services of AEPs include cardiovascular, metabolic, neurological, musculoskeletal, cancers, kidney, respiratory / pulmonary and mental health, and any other conditions for which there is evidence that exercise can improve clients' clinical status.

ESSA conducted a systematic literature review to address the use of AEP based teleconsultation interventions within the various clinical conditions that fall within the scope of practice of an Exercise Physiologist in Australia (see Appendix 1). In summary, evidence shows that the benefits of teleconsultations delivered by AEPs includes, but is not limited to:

- preventing the onset of chronic diseases
- improving sustained physical activity levels [4]
- improving diastolic blood pressure and low-density lipoprotein cholesterol [6]

- providing similar exercise and quality-of-life outcomes than those resulting from face-to-face AEP consultations [8]
- enhancing adherence to exercise and increased functional capacity [7]
- providing lower costs than usual care [11]
- improving access to quality care for vulnerable and rural remote populations [11][19]
- improving physical (fitness, function, and sleep) and psychological benefits (self-confidence, motivation, discipline to exercise, and goal achievement) [12]
- providing an alternative mode of delivery whereby that the majority of populations can cope well with, regardless of their prior level of technical familiarity [12]
- improving fitness and reducing musculoskeletal disorders [15]
- has potential for broad population reach and thus has a role in addressing increasing rates of lifestyle-related chronic diseases [21]
- improving health behaviour, self-efficacy and health status, especially for vulnerable groups [23]
- resulting in favourable changes in weight loss [25].

7.0 Professional standing of AEPs

AEPs are university qualified allied health professionals equipped with the knowledge, skills and competencies to design, deliver and evaluate safe and effective exercise interventions to:

- prevent chronic disease in healthy populations
- support people with acute, sub-acute or chronic medical conditions, injuries or disabilities.

AEPs undertake a minimum of four years equivalent study leading to the award of a Bachelor degree or post–graduate in the area of clinical exercise physiology and are required to meet an extensive accreditation process that includes practicum experience in a range of settings and environments. Some AEPs are dual qualified (physiotherapy/exercise physiology, dietetics/exercise physiology, podiatry/exercise physiology).

AEPs are subject to practice standards that are comparable to other allied health professions delivering supports under the NDIS. ESSA takes steps to ensure that AEPs are aligned with other self-regulating professions (e.g. dietetics speech pathology, audiology) through membership with the National Alliance of Self-Regulating Health Professions (NASRHP).

The NASRHP is an independent body providing a quality framework for self-regulating health professions. NASRHP has a set of standards for membership that have been closely modelled on the standards that health professions regulated by Australian Health Practitioner Regulation Agency (AHPRA) are required to meet. ESSA has achieved 100% of the required self-regulating standards.

The standards developed by NASRHP relate to:

- Scope (Areas) of Practice
- Code of Ethics/Practice and/or Professional Conduct
- Complaints procedure
- Mandatory Declarations
- Professional Indemnity Insurance
- Competency Standards
- Practitioner Certification Requirements
- Course Accreditation
- Recency and Resumption of Practice Requirements
- English Language Requirements
- Continuing Professional Development[i]

AEPs are required to maintain ongoing annual professional practice requirements to uphold their professional accreditation.

Yearly requirements for maintaining AEP accreditation includes:

1. Undertaking a minimum of 20 approved continuing professional development (CPD) points per membership year (1 January – 31 December).
2. Meeting recency of practice requirements
3. Holding appropriate professional indemnity insurance
4. Abiding by ESSA's Code of Professional Conduct and Ethical Practice
5. Holding a current cardiopulmonary resuscitation certificate, where appropriate
6. Holding a current first aid certificate, where appropriate.

8.0 Potential for detrimental outcomes

8.1 Client selection, assessment and health outcomes

The remote nature of teleconsultations can pose risk for clients and AEPs, for example, clients with low health literacy or with a disability likely require face-to-face care. AEPs are highly trained professionals and equipped with the clinical skills, knowledge and professional attributes to assess, select, treat and safely discern which clients are and are not appropriate for teleconsultations. In addition, AEPs are bound by ESSA's Code of Conduct, Professional Standards, Quality Assurance and compliance system, complaint process, and clear guidelines on telehealth service delivery via our Telepractice Policy Statement (see Appendix 1). ESSA's framework, coupled with AEP qualifications mitigates the risk of detrimental outcomes resulting from teleconsultation.

8.2 Cost

ESSA acknowledges that the introduction of additional modes of delivery of treatment comes at a cost. However, evidence shows that teleconsultations actually provide a lower cost alternative to face-to-face consultations [11]. Therefore, it could be argued that costs can be off-set by the health outcome benefits and reduced costs of telehealth delivery. ESSA looks forward to further evidence on the cost-benefit AEP teleconsultations following the completion and publishing of our current Telehealth Efficacy Research Project which is due for conclusion in 2021.

8.3 Competition

ESSA does not perceive that there is public detriment, or anti-competitive behaviour, as all health insurers have the opportunity to implement the COVID-19 measures and to continue utilising the new item codes beyond the pandemic to optimise disease prevention and health outcomes for their members.

The downside of telehealth being available is that clients can access services from any provider across the county and post-COVID-19, this will increase competition for local face-to-face services and may impact on their viability.

AEP teleconsultations post COVID-19 pandemic has the potential to continue to reduce existing barriers to quality healthcare for older Australians, vulnerable populations and populations in rural and remote Australia. ESSA recommends that both the ACCC and PHA work towards the provision of item codes as an ongoing offering to members beyond the interim period, established in response to the coronavirus pandemic.

Ongoing consultation

ESSA welcomes continued consultation from the ACCC and PHA in regards to the delivery of AEP services via teleconsultation. We look forward to sharing the results of our bi-monthly *COVID-19 Member Impact Survey* and our Telehealth Efficacy Research Project in due course. In the meantime, please contact Judy Powell, Policy & Advocacy Advisor at judy.powell@essa.org.au for further information about ESSA, AEPs or teleconsultations.

10.0 Appendices

Appendix 1: ESSA Telepractice Policy Statement (including ESSA Telepractice Policy Checklist Editable)

ESSA Telepractice Policy Statement

Table of Contents

Introduction

The purpose of this policy statement is to outline minimum requirements and best practice guidelines for ESSA professionals offering telepractice. This statement applies to all ESSA professions. A self-assessment checklist is also provided at the end of the statement to assist professionals in implementing safe and effective telepractice.

Delivery of technology-based services (sometimes referred to as digital practice) is an increasingly common practice across many industries, including the health, fitness and sport sectors.

ESSA supports delivery of exercise and sports science services via videoconferencing technologies and telephone as an effective way to improve the health, fitness, well-being and performance of Australians. Telepractice can improve access to services for clients who are geographically isolated (e.g. those in rural and remote locations) and other clients whom have limited access to local services due to transport or mobility issues due to a medical condition, their family situation, workforce shortages or cultural beliefs.

Definition

ESSA has adopted the term "telepractice" to reflect the breadth of types of services offered by ESSA professionals. ESSA considers that technology-based services are relevant for all ESSA professions and the information in this policy statement therefore applies to Accredited Exercise Physiologists (AEP), Accredited Exercise Scientists (AES), Accredited Sports Scientists (ASpS) and Accredited High Performance Managers (AHPM).

ESSA has defined telepractice as:

'The delivery of technology-based exercise and sports science services supporting wellness, prevention of health conditions, health management and performance improvement which involves the transmission of information using telecommunication technologies including but not restricted to video, telephone, mobile applications and internet.'

Telepractice encompasses both synchronous (real time) and asynchronous (store and forward) practices.

ESSA considers telepractice an appropriate delivery modality for individual and group exercise-based interventions where services are evidence-based and delivered to an equivalent standard of care as in-person services.

Legal and Professional Practice Requirements

Telepractice should be delivered with the same standards and procedural considerations as for in-person services. ESSA's Professional Standards for Accreditation and Foundational Scopes of Practice provide further information about professional practice expectations.

When delivering telepractice, ESSA professionals, at all times, must adhere to the ESSA Code of Professional Conduct and Ethical Practice. This includes requirements to deliver evidence-based, client-centred care in a safe, respectful and inclusive way that is responsive to the diverse needs of people. ESSA professionals must practice ethically and collaboratively, within the scope of their exercise and sports science training including providing referrals to relevant health professionals and/or services as appropriate.

Scope of Practice

Delivery of telepractice is within the full scope of practice of all ESSA accredited professions. ESSA professionals must ensure they operate within their individual scope of practice and are responsible for ensuring they have the appropriate knowledge and skills for providing telepractice. ESSA professionals and business staff may require additional training and education to ensure competency and to comply with business policies and procedures.

Telepractice should not be used to replace in-person services to discriminate against clients, or where a client's situation and wishes would indicate that telepractice are not appropriate.

Privacy

ESSA professionals have professional, legal and ethical obligations to protect the personal information of their clients under *The Privacy Act 1988.* The Australian Privacy Principles outline the legal requirements for collecting, storing and forwarding information. These privacy requirements apply to all forms of service delivery.

Maintaining privacy and confidentiality for telepractice has specific considerations. ESSA professionals must:

- take reasonable and appropriate steps to protect the privacy and confidentiality of clients when using technology;
- communicate to clients that total privacy cannot be guaranteed when using third-party provider technology; and
- explain the steps taken to protect clients' information and obtain consent before proceeding.

Insurance

ESSA professionals must ensure their professional indemnity insurance covers delivery of telepractice. All insurances (including business related) should be based on individual circumstances and professional advice sought from an insurer.

ESSA has worked with our insurance partner, Guild Insurance, to ensure that telepractice are a noted modality for all Guild insured policy holders. As per the terms of the policy, territorial and jurisdiction applies for services which are provided in Australia only.

Interjurisdictional delivery

ESSA professionals must meet all the requirements of the jurisdiction in which they are accredited and practice within. This includes ESSA requirements, federal legislation and any state requirements where they are located/primarily practice from.

ESSA professionals may offer services to clients in other jurisdictions (such as internationally) and should exercise due diligence to ensure they are aware of, and compliant with, any requirements where the client is located.

ESSA professionals providing services internationally must ensure they have appropriate insurance.

Technical Considerations

ESSA recommends the use of standards-based telepractice platforms to ensure the highest levels of security to maintain client privacy and confidentiality. Non-standards-based platforms (e.g. Skype, email) should be used with caution and clients must be informed of any additional risks and steps that can be taken to improve security. It is important to understand that some third-party providers may record data, and this has implications for client privacy and consent.

ESSA professionals are responsible for ensuring the suitability and quality of the technology used. ESSA recommends ESSA professionals investigate and explore limitations of telepractice platforms such as data storage practices to enable them to make an informed decision.

Digital platforms

Platforms may be hardware or software (such as Web Real-Time Communication [WebRTC] or desktop/mobile applications). It is important to consider that several different types of technology may be required to deliver telepractice. For example, video consultation and secure messaging software. Secure messaging platforms allow information to be shared securely such as written communications and documents with clients and other stakeholders, such as referrers.

The technology must be appropriate for the services offered. Selection should consider:

- secure private connections for consultations, such as end-to-end encryption;
- data being stored on Australian servers;
- software with a chat function that can be used if audio and/or video drops out; and
- interoperability with other platforms used for bookings, payment and practice management software.

The type of platform used, how it works, and associated risks must be explained to clients as part of their informed consent to a consultation.

Tips for platform selection

- Review the technology privacy policy to ensure you understand the systems.
- ESSA professionals and clients should update desktop/mobile software to the most recent version to improve security.
- WebRTC platforms are easy to use options for clients, only requiring the opening of a link in a web browser.
- WebRTC readiness can be checked at https://test.webrtc.org/.
- Platforms that meet European General Data Protection (GDRP) or Health Insurance Portability and Accountability Act (HIPAA) regulations are gold standard.
- Review the interoperability of the software with your existing practice software such as appointment booking, practice management and payment systems.

- Consider the interoperability with a range of devices that may be used by clients (e.g. android, Apple, desktop and mobile).
- Consider if technology support is required to set up and maintain service delivery. Are there options to troubleshoot issues with a client on the day?
- Consider whether the technology will be used to communicate with other stakeholders such as health professionals.
- Consider secure messaging platforms if collecting or transmitting a client's health information.

Equipment requirements

Delivery of telepractice also requires appropriate equipment such as:

- computer/mobile device;
- webcam for video consultations;
- telephone;
- headset and/or microphone to improve audio quality;
- appropriate room lighting to improve visual quality; and
- internet connection with appropriate bandwidth, upload/download speed and data allowance.

Clients should be provided with clear, step-by-step instructions on what equipment and platforms they need ahead of the consultation, along with instructions on how to use it and how they can protect their own privacy.

Tips for equipment set-up

- Check internet connection speed at http://speedtest.net.
- Ask clients to check their bandwidth and data allowance.
- Test technology within the business prior to rolling out with clients.
- Pre-test video and audio with the client before commencing the consultation.
- Review business data allowance to ensure you have sufficient data to complete the service without additional charges. Video consults use high volumes of data (approximately 1GB per hour).
- Using a headset and microphone can reduce echo and improve audio quality.
- If using Wi-Fi, ensure it is secured (such as Wi-Fi Protected Access 2 [WPA-2] or using a virtual private network [VPN]) rather than open.
- Set up multi-factor authentication on technology to improve system security

Implementation Considerations for Businesses

Before commencing telepractice, businesses should update policies and procedures to reflect telepractice needs that include:

- privacy statement;
- informed consent process;
- clients' responsibility for costs of their own technical platforms;
- risk management plans (including emergency plans*);
- contingency plans for technological issues;
- client identification confirmation processes;
- cancellation policy, if relevant; and
- complaints process.

Emergency protocols that address how emergencies and adverse events will be managed must be documented clearly, with staff aware and trained in execution.

Physical environment

The physical environment should be prepared prior to commencing any service.

For ESSA professionals, this should include a quiet, private location without interruptions. Video consultations should also consider:

- appropriate lighting and a professional background;
- appropriate camera set-up;
- space to demonstrate assessments/exercises; and
- exercise equipment/supports.

Clients should also have a quiet, private location where possible. For video consultations, recommend clients should also have:

- appropriate lighting;
- exercise equipment/supports;
- space clear of slips, trips and fall hazards; and
- appropriate size of area to undertake assessments/exercises.

Tips for the physical environment

- Ensure the service is provided in a private and secure environment.
- Camera is set-up at eye level to enable good eye contact.
- Consider a tripod.
- Maintain client focus and aim to build rapport to the same level as any other mode of service delivery. Consider cultural sensitivity and adapt the approach to telepractice accordingly.

Service Delivery Considerations

Telepractice can be used for delivery of individual and group exercise-based interventions including but not limited to:

- assessments
- individual consults
- delivery and review of exercise program progress
- group exercise classes
- health and physical activity education (including groups)
- lifestyle modification support
- clinical exercise treatment
- non-clinical exercise interventions
- sports performance progress monitoring
- technique review
- education delivery.

Screening

Clients should be screened for suitability for telepractice and for the most appropriate modality for their needs, which may be in-person, telepractice or a hybrid model.

ESSA professionals should use their professional judgement when determining suitability, which may include exclusion criteria. This should consider:

- current health status of client
- client health literacy
- client digital literacy
- client needs and goals
- risks (including precautions and contraindications)
- physical capacity of client to undertake session
- visual, auditory or cognitive impairment
- language and cultural barriers
- client ability to provide consent
- capacity to access technology
- need and availability for a client support person (e.g. family, carer, allied health assistant) to assist in consult
- service requirements for different modalities, along with type of service. For example, video consultations versus phone calls

The purpose and risks of the session will inform the service delivery.

Assessments

Assessments should be considered prior to commencing sessions, including whether an in-person assessment would provide critical information for service delivery.

Subjective assessment information may be collected in advance via secure messaging and surveying.

Individual consultations

Telepractice may include ESSA professionals using their expertise to provide consultation via video or telephone such as health coaching or following up on progress. They may also include physical exercise instruction, demonstration or supervision of exercise via video. ESSA encourages promotion of self-management and support for lifestyle management.

Telepractice are likely to involve self-directed or at home exercise-based interventions with individual consultations focusing on review, education, behaviour change and progression.

Establishing rapport is crucial in individual consultations. Communication styles may need to be adjusted, requiring regular check-ins with clients that they understand what information has been communicated. Communication with carers, family or support workers may also need to be considered.

Group consultations

Communication should consider how to address and respond to individuals in a group setting and provide intermittent individual care.

Tips for service delivery

- Clients should be accurately identified before personal or health information is discussed.
- Aim to include all the steps of your services as close to an in-person consult as possible.
- Collect information prior to the service where appropriate.
- Education and behaviour change support form core parts of telepractice.
- Provide clear instructions to help clients prepare including what to wear and what equipment is required.
- Send step-by-step instructions and a checklist of what the client should do/expect before the session commence.
- Consider resources to support the intervention such as exercise videos and instructions.

Informed Consent

Informed consent may be written and/or verbal and should be recorded in client records. Consent is an ongoing process and should be obtained in the same way as in an in-person service.

ESSA professionals must explain the purpose of the service, risks, benefits and service options, as well as the client's rights and responsibilities. In addition to these standard considerations for consent, telepractice should also address:

- Telepractice specific risk management strategies for privacy, security and emergencies;
- how the service will run; and
- outcomes expected.

These considerations should be addressed with the client before delivering the service.

Further information on informed consent can be found in the ESSA Members Lounge.

Record Keeping

Client records must be taken and stored in a similar way to the records taken for in-person services. Records must include a note that the service was delivered by telepractice.

All data provided by the client is to be stored securely, including written communications.

ESSA professionals should understand their obligations under the Notifiable Data Breaches Scheme and must have systems in place to assess breaches and report where necessary.

Recording consultations

ESSA recommends that video or telephone consultations are not recorded or stored. If there is a valid and appropriate reason for the recording of a consultation, expressed consent must be obtained from client prior to commencing the service. ESSA also recommends that consent from the client to record the session is also noted.

Tips for record keeping

- Australian Medical Association (AMA) provides good guidance on the use and storage of images in the Clinical images and the use of personal mobile devices guide.
- Secure storage may be cloud based or a secured hard drive.
- Ensure copies of any data are removed from any other devices (e.g. downloads) when storing.
- Have clear organisational policies for who can access client records.
- Be careful to restrict unauthorised access to systems/technology. For example, close all applications and do not leave computer software unlocked.

Evaluation of Services

Evaluation of telepractice is best practice. Businesses are encouraged to implement evaluation strategies to ensure effective service delivery and demonstrate outcomes achieved. This will also support advocacy for future delivery of telepractice.

Tips for evaluation

- Build evaluation of services into business policies and procedures.
- Clients should be asked for feedback on their experiences as part of quality improvement processes.

AEPs delivering telepractice within compensable schemes

ESSA supports telepractice as a safe and effective modality for delivery of clinical exercise physiology services and advocates for recognition within compensable schemes. For current information on the compensable service that approve telepractice, please visit the ESSA website.

For example:

- The NDIS recognises 'telepractice' as an alternative method of delivering therapy supports, which can be used to assist participants to receive support that may otherwise not be available to them in their surrounding areas (for example, participants living in more remote locations).
- Telehealth video consultations may be eligible within some worker's compensation schemes with prior approval from the insurer.

Case records must include a note that the service was delivered by telepractice.

AEPs are responsible for ensuring all compensable scheme service requirements are met. Please review the ESSA Members Lounge via the ESSA website for further details of compensable scheme requirements.

Supervision and Training

ESSA supports telepractice for supervision and training of staff and students. Client consent must be obtained for students or another staff to observe or be involved in service delivery*.

**Some compensable schemes will only allow students to observe services. AEPs providing compensable services must review rules prior to service delivery.*

Appropriate arrangements to ensure privacy, security and service quality can be maintained for where the student or staff is located.

Tips for supervision and training

- If the ESSA professional, client and student/staff are all in different locations, it should be confirmed prior to the service that the technical platform supports more than two locations.
- Contact the Practicum Coordinator to confirm placement requirements can be met.
- AEPs must still meet regulatory body rules for student involvement where a compensable scheme item is claimed.

Date: 13 May 2020 v1.1

Glossary

Asynchronous telepractice: Transmission of information between a provider and client where the parties are not present simultaneously. Also known as store-and-forward, this includes but is not limited to sending referrals, health information and exercise programs via secure messaging platforms

Client-centred: An approach to the planning, delivery and evaluation of services that is grounded in mutually beneficial partnerships among service providers, clients and families

Desktop application: An application that runs stand-alone in a desktop or laptop computer

Evidence-based: Applying the best available research results (evidence) when making decisions about service delivery. ESSA professionals who perform evidence-based practice use research evidence along with professional expertise and client preferences

In-person: Face-to-face services provided directly to client (i.e. professional and client in the same room)

Interoperability: Ability of two or more components or systems to exchange information and to use the information that has been exchanged

Mobile application: An application that runs stand-alone that runs in smartphones and tablets

Telepractice: Delivery of technology-based exercise and sports science services supporting wellness, prevention of health conditions, health management and performance improvement which involves the transmission of information using telecommunication technologies including but not restricted to video, telephone, mobile applications and internet

Synchronous telepractice: Delivery of health information in real time. This involves transmission of health information where the provider and client are present simultaneously, such as in a video or telephone consult

Web RTC: An open framework for the web that enables Real-Time Communications (RTC) capabilities in the browser. It is a web-based application that requires the web browser to run.

Additional information

The following links provide further guidance and useful resources to support telepractice delivery.

ACRRM Telehealth resources and training

http://www.ehealth.acrrm.org.au/

AHPA Telehealth and Allied Health Delivery

https://ahpa.com.au/advocacy/telehealth-allied-health-service-delivery/

AMA Clinical images and the use of personal mobile devices

https://ama.com.au/article/clinical-images-and-use-personal-mobile-devices

Australian Cyber Security Centre

https://www.cyber.gov.au/

Australian Privacy Principles

https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-quick-reference/

Guidelines for use of Telehealth for Clinical & Non-Clinical settings in NSW

https://www.telemedecine-360.com/wp-content/uploads/2019/02/2015-ACI-telehealth-guidelines.pdf

MBS Online Privacy Checklist for Telehealth Services

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TelehealthPrivChecklist

Office of the Australian Information Commissioner (OAIC)

https://www.oaic.gov.au/

RACGP Telehealth video consultations guide

https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-video-consultations-guide

RACP Telehealth Guidelines and Practice Tips

https://www.racp.edu.au//docs/default-source/advocacy-library/telehealth-guidelines-and-practical-tips.pdf?sfvrsn=daa2f1a_18

Appendix 1: Telepractice provider checklist

This checklist is for ESSA professionals and their organisations and outlines common considerations for delivering safe and quality telepractice.

ESSA recommends completing the sections of the checklist relevant to the services being offered and storing with business policies and procedures.

Legal and Professional Standards Considerations

Competency, Insurance & Jurisdiction	**Business Response**
ESSA professional competent to deliver telepractice e.g. • training in use of chosen digital platform • training in approach to exercise delivery via telepractice • reviewing ESSA's Code of Conduct for professional practice obligations	
Professional Indemnity Insurance covers telepractice	
Service delivery location jurisdiction requirements considered e.g. • Australia/state/international	

Technical Considerations

Digital Platforms	**Business Response**
Platform selection considers: • hardware vs software (desktop/mobile application or WebRTC) • platform privacy policy • how and where data is stored • interoperability with other business software • accessibility for clients • secure messaging facilities • privacy and security settings (e.g. end-to-end encryption, multi-factor authentication)	
IT management and support plans e.g. • platforms are updated regularly • IT support available to manage overall performance of digital platforms and systems	
If using non-standards-based platforms, investigate alternatives to improve security	
Technology is tested by business before rolling out to clients	

Equipment	Business Response
Appropriate equipment for service delivery e.g. • computer/mobile device/phones • webcam (for video consultations) and/or tripod • telephone • internet plan • exercise equipment • headset and/or microphone	
Business has sufficient internet security, data and bandwidth (including download and upload speeds) to provide uninterrupted service e.g. • up to 5MB for video • fixed line internet, NBN or strong 4G connection • internet connection speed minimum approx. 200KBp/s • data allowance up to 1GB per hour	

Implementation Considerations

Business Policies and Procedures	Business Response
Business privacy policy updated to include telepractice relevant information	
Risk management plans in place e.g. • risk analysis and management • client exclusion criteria for services	
Emergency &/or first aid policies and procedures are in place e.g. • client location is known • whether other people are on site	
Contingency plans are in place for technology issues • provider is trained in addressing common technical issues • IT support is available	
Client information and instructions have been developed e.g. • technical platforms required and any client costs to access • instructions on how to access and use platform • steps client can take to protect their security	
Providers have been suitably trained to use digital platforms and adapt services for safe and effective telepractice delivery	

Policies and procedures have been reviewed against Australian Privacy Principles	
Procedure in place to confirm client identity	
Policies updated to include telepractice considerations for: • complaints • cancellations	
Business staff have been trained in all policies and procedures	

Physical Environment	**Business Response**
Service delivery space for ESSA professional includes: • private, quiet location • technical equipment (phones, computers, devices) For video consultations e.g. • lighting • professional background • camera set-up at eye level • tripod available if demonstrating exercises • space to demonstrate assessments/exercises • exercise equipment/supports	
Business staff are aware of consultation and know not to disturb	
Space for client includes: • private, quiet location • technical equipment (phones, computers, devices) For video consultations: • appropriate camera set-up • space clear of slips, trips and falls hazards • space to perform assessments/exercises • exercise equipment/supports	

Service Delivery Considerations

Client screening	Business Response
Digital literacy e.g. • client is comfortable with technology • client technology accessibility has been reviewed	
Client suitability • current health status of client • client health literacy • client needs and goals • precautions and contraindications • physical capacity of client to undertake session • visual, auditory or cognitive impairment • language barriers • ability to provide consent • need and availability for a client support person to assist in consult	
Instructions and information have been sent to client prior to service including: • how to access digital platform • what to wear • equipment needs	
Resources to be used during service delivery are prepared for the session	

Assessments, Individual and Group Consultations	Business Response
Client information (such as subjective assessments) is collected securely before service e.g. • secure messaging software OR private surveying applications / software – e.g. Typeform or Formstack	
Clients who need additional technical or safety support have in-person or virtual assistance in place during sessions	
Technology has been tested with client prior to commencing service • connectivity • video and audio quality	
Client identity confirmed prior to commencing service	

Informed Consent	Business Response
Business consent policies and procedures updated with telepractice information e.g. • informed consent form updated	
Pre-session informed consent form completed by client	
Purpose of service, expectations, risks, benefits and other service options explained to client	
Ongoing consent processes with client followed	
Consent in recorded in case notes	

Record Keeping	Business Response
All client information stored securely e.g. • cloud-based software (consider HIPAA or GDPR compliant software) • secured hard drive • hard copies in locked secure location	
Client information removed from devices (e.g. downloads, desktop, emails) once received	
Telepractice service modality recorded in case records including length of service	
Business policies and procedures include: • data breach processes • who can access records and for what reason? • all staff trained in procedures	
Systems shut down securely at end of service delivery e.g. • applications closed properly • computers locked	

Evaluation	Business Response
Evaluation of service quality/outcomes included in business policies and procedures	
Evaluation questions included in client follow-up	

Supervision & Training	Business Response
Service delivery model supports where appropriate: • junior staff/allied health assistants • support workers/carers • students	
Student practicum requirements discussed with Practicum Coordinator	
Student set-up confirmed • student location • equipment	
Consent received from client for student/staff to be involved	
Student/staff involvement meets regulatory body requirements	

Disclaimer

This self-assessment checklist is provided to support providers in providing safe and appropriate telepractice. Providers should use best practice and professional judgement and undertake appropriate research. This document is not binding and is not considered to indemnify providers.

Appendix 2: Briefing Paper prepared for Private Healthcare Australia on the clinical effectiveness of Exercise Physiology Teleconsultations, 27 March 2020

Exercise & Sports Science Australia

Briefing Paper prepared for Private Healthcare Australia

on the clinical effectiveness of Exercise Physiology Teleconsultations

27 March 2020

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Background

On the 23 March 2020, Private Healthcare Australia (PHA) contacted Exercise & Sports Science Australia (ESSA), on behalf of their membership, to request a briefing paper detailing the evidence available on the clinical effectiveness of accredited exercise physiology (AEP) teleconsultations by both video and by telephone. PHA indicated that this evidence was being requested in response to the coronavirus (COVID-19) pandemic and would be used to determine if Private Health funds should consider amending their rules regarding teleconsultations for the next six months to cover individual exercise physiology consultations where:

- there is an existing treatment plan
- the appropriate technology is available, and
- the patient has an existing relationship with the service provider.

Introduction

The coronavirus (COVID-19) pandemic poses unique challenges to health care delivery. The pandemic highlights the importance of using telehealth to deliver care, especially as a means of reducing the risk of cross-contamination caused by close contact. Worldwide response to the acceptance of telehealth is broad and encouragement to transition to teleconsultation services is global.

Solutions must be considered on how to best contain COVID-19. One way is through the provision of telehealth services. Evidence suggests that at risk clients receiving preliminary screenings or information remotely, avoid going to crowded clinics or hospitals and risking further spread of the virus. [1, 2].

Teleconsultations are well suited for scenarios in which teleconsultation infrastructure is intact and Accredited Exercise Physiologists are available to apply evidence-based interventions to clients via appropriate platforms. Since Australian health systems have already invested in telemedicine and have national standards (*AS ISO 13131:2017: Health informatics - Telehealth services - Quality planning guidelines*) [3], Accredited Exercise Physiologists (AEPs) are well positioned to ensure that clients in unforeseen imposed isolation/containment circumstances receive the care they need. In this instance, teleconsultations are the ideal tool to maintain Accredited Exercise Physiologist - client health.

Several Australian compensable schemes already have established arrangements in place to support the delivery of Accredited Exercise Physiology services via telehealth (i.e. NDIS and WorkCover QLD). Other compensable schemes have introduced temporary telehealth item codes for Accredited Exercise Physiology in response to the COVID-19 pandemic (refer to Appendix A).

ESSA has developed a *Telepractice Policy Statement*. The purpose of this policy statement is to outline minimum requirements and best practice guidelines for ESSA professionals offering tele-services (refer to Appendix B).

Objective

ESSA recommends that Private Healthcare Australia amends the relevant Private Healthcare Insurer (PHI) rules to cover teleconsultations for AEP interventions, for the next six months, to protect the health of Australian individuals. As such, the objective of this document is to:

i) provide evidence of the clinical effectiveness of teleconsultations by both video and by telephone
ii) specify areas of Accredited Exercise Physiology practice where the evidence is clear that teleconsultations are efficacious.

Methods

A review of published literature was performed to address the use of AEP based teleconsultation interventions within the various clinical conditions that fall within the scope of practice of an Exercise Physiologist in Australia.

Results

Exercise Physiologist: Telephone delivery effectiveness of Physical activity Counselling

A 2017 study, the Newcastle Comparison of Activity Coaching for Health (NewCOACH) pragmatic RCT, compared five face-to-face expert physical activity counselling sessions by an AEP, one face-to-face counselling session followed by four telephone calls by an AEP and a generic mailed physical activity brochure (usual care) for insufficiently active primary care patients. According to the authors, no previous trials of exercise referral programs have utilised objective assessment of physical activity unlike previous RCTs which have used self-reported measures to evaluate physical activity. Referral of patients (regardless of their chronic disease status) to expert PA counselling resulted in small but important improvements in activity that were maintained for nine months after intervention completion. Face-to-face only and counselling conducted predominantly via telephone were both effective, although the telephone group showed a trend to better outcomes.

Provision of expert physical activity counselling to insufficiently active primary care patients resulted in a significant increase in physical activity (approximately 70 minutes of walking per week) at 12 months**. Face-to-face only and counselling conducted predominantly via telephone were both effective.** This trial provides evidence to expand public funding for expert physical activity counselling and for delivery via telephone in addition to face-to-face consultations [4].

Cardiac Rehabilitation

Physical activity level was higher following exercise-based cardiac rehabilitation (exCR) than after usual care. Compared with centre-based exCR, telehealth was more effective for enhancing physical activity level, exercise adherence, diastolic blood pressure and low-density lipoprotein cholesterol. Telehealth and centre-based exCR were comparably effective for improving maximal aerobic exercise capacity and other modifiable cardiovascular risk factors.

Rawstorn et al. has advised this is the first systematic review and meta-analysis to examine the use of telehealth specifically for delivering and monitoring structured, individualised, prescriptive exercise in a CHD population. Eleven RCTs (n=1189) were included in the review. **The main findings were that telehealth exCR appears to be at least as effective, and in some cases more effective, for improving cardiovascular risk factors and functional capacit**y, although there was some evidence of heterogeneity between studies. Characteristics of the telehealth platforms likely influence the intensity of telehealth exCR interventions and may contribute to the variability; the influence of telehealth platform characteristics on intervention delivery and effectiveness warrants further consideration.

Authors concluded that Telehealth exCR appears to be at least as effective as centre-based exCR for improving modifiable cardiovascular risk factors and functional capacity and could enhance exCR utilisation by providing additional options for patients who cannot attend centre-based exCR. Telehealth exCR must now capitalise on technological advances to provide more comprehensive, responsive and interactive interventions [5].

Telehealth intervention delivered cardiac rehabilitation does not have significantly inferior outcomes compared to center-based supervised program in low to moderate risk CAD patients. Telehealth intervention offers an alternative deliver model of CR for individuals less able to access center-based cardiac rehabilitation [6].

Exercise Telemonitoring and Telerehabilitation Compared with Traditional Cardiac and Pulmonary Rehabilitation: A Systematic Review and Meta-Analysis clearly demonstrates with an increasing need for better access to rehabilitation for patients with CVD and COPD, **Telerehabilitation (TR) interventions may offer a feasible, effective, and safe option.** In this systematic review of nine studies, TR interventions in which a health care practitioner monitored patient symptoms before and during exercise appeared to offer similar benefits to the standard exercise components of CR and PR programmes. The findings from this systematic review and meta-analysis suggest that allied health practitioners who are interested in developing TR interventions for their patients with CVD and COPD can expect similar exercise and quality-of-life outcomes for their patients, provided the technology and level of monitoring are similar to those used in the studies presented here. Researchers should also continue to explore the different barriers and factors at play in implementing TR interventions in CR and PR, including both quantitative and qualitative research to explore and identify solutions to barriers to TR programme implementation and participant motivation [7].

A systematic review on behaviour change techniques (used by exercise physiologists and well within their scope of practice) in physical activity (PA) eHealth interventions for people with cardiovascular disease found eight of the 15 interventions that had physical activity as an outcome measure reported statistically significant improvements in PA between the experimental and control groups. **The review found eHealth interventions were at par with or were significantly better at improving PA levels of cardiac patients when compared with standard cardiac services** [8].

Stroke

Telerehabilitation can be a suitable alternative to usual rehabilitation care in post-stroke patients, especially in remote or underserved areas. Larger studies are needed to evaluate the health-related quality of life and cost-effectiveness with the ongoing improvements in **telerehabilitation** networks.

No significant differences between the telerehabilitation and control groups in terms of the Barthel Index (SMD –0.05, 95% CI –0.18 to 0.08), Berg Balance Scale (SMD –0.04, 95% CI –0.34 to 0.26), Fugl-Meyer Upper Extremity (SMD 0.50, 95% CI –0.09 to 1.09), and Stroke Impact Scale (mobility subscale; SMD 0.18, 95% CI –0.13 to 0.48]) scores. Moreover, the majority of included studies showed that both groups were comparable in terms of health-related quality of life (of stroke survivors), Caregiver Strain Index, and patients' satisfaction with care. **One study showed that the cost of telerehabilitation was lower than usual care by US $867**. Delivered by rehabilitation specialists [9].

Galloway et al. **demonstrates that accessing suitable fitness programs post-stroke is difficult for many.** Overall, the level of satisfaction and enjoyment expressed by participants was high. Participants perceived both physical (improved fitness, function, and sleep) and psychological benefits (improved self-confidence, motivation, discipline to exercise, and goal achievement) and therefore quality of life post-stroke may be higher for these people. Many commented favourably on the convenience telehealth provided. It decreased the burden of transport, often cited as the major barrier for stroke survivors and other clinical populations to access centre-based exercise programs (Marzolini et al., 2016; Nicholson et al., 2013), and many participants liked that telehealth sessions were quick and left the rest of their day free.

They found that delivering exercise sessions aimed at improving fitness to people after stroke via telehealth was highly feasible for those who participated and contributed to lowering secondary stroke risk in most participants. While we are unaware of any similar trials published in stroke (Chen et al., 2015; Sarfo et al., 2018) our results are in agreement with findings from other clinical populations. A systematic review of telehealth fitness programs in people with chronic heart failure found that the prevalence of adverse events was similar to centre-based programs (Hwang et al., 2015), and in cardiac rehabilitation trials, telehealth programs were at least as effective as usual care in improving cardiovascular risk factors and functional capacity (Chan, Yamabayashi, Syed, Kirkham, & Camp, 2016; Clark et al., 2015; Rawstorn, Gant, Direito, Beckmann, & Maddison, 2016; Southard et al., 2003). In regard to age and level of technical familiarity our findings are also in agreement with other trials (Shulver et al., 2017) and highlight that most participants coped well with the technology, regardless of their prior level of technical familiarity [10].

Cystic fibrosis- Assessing exercise capacity using telehealth

In this study assessing the feasibility of supervising a test of exercise capacity using video-conferencing technology there were no significant differences in terms of monitored physiological parameters between occasions**. Participants indicated no preference for in-person over remote supervision, and video-conferencing as the format for telehealth delivery in this context was well received.**

In summary, in adults with CF, the 3-min step test, a submaximal test of exercise capacity, was performed and supervised equally as well via remote video-conferencing as it was when an allied health clinician was in attendance, in participants with a range of disease severity. Physiological performance measures and participant comfort were not different during remote supervision conditions, compared to in-person supervision. Remote assessment of exercise tolerance may be appropriate in the CF population. Delivered by clinicians. [11].

Cancer

The 'Get Healthy Service' (GHS), a state health-funded 6-month telephone-delivered lifestyle program resulted in meaningful improvements in weight, in physical activity and in the mental component of quality of life. Delivered by Health coaches employed by the GHS were all university-qualified health professionals and included psychologists, nurses, dietitians, **exercise physiologists**, **sports scientists**, social workers, and physiotherapists. With limited healthcare resources and a growing number of breast cancer survivors, **identifying programs that are acceptable and effective in supporting breast cancer survivors to make lifestyle changes is needed for improving survivorship** [12].

The telehealth system (e-CUIDATE) to improve quality of life in breast cancer survivors: rationale and study protocol for a randomized clinical trial demonstrates that breast cancer survivors suffer physical impairment after oncology treatment. This impairment reduces quality of life (QoL) and increase the prevalence of handicaps associated to unhealthy lifestyle (for example, decreased aerobic capacity and strength, weight gain, and fatigue). Recent work has shown that exercise adapted to individual characteristics of patients is related to improved overall and disease-free survival. Nowadays, **technological support using telerehabilitation systems is a promising strategy with great advantage of a quick and efficient contact with the health professional. It is known the role of telerehabilitation through therapeutic exercise as a support tool to implement an active lifestyle which has been shown as an effective resource to improve fitness and reduce musculoskeletal disorders of these women** [13].

The results of **"Feasibility and acceptability of an interactive web-portal for oncology patient physical activity and symptom tracking" demonstrate the feasibility of using a remote digital health intervention to track and promote physical activity levels and function and that personalised coaching messaging appears to increase participant engagement** [14].

Most patients with advanced-stage cancer develop impairment and pain-driven functional losses that jeopardize their independence. The study by Cheville et al. was to determine whether collaborative telerehabilitation and pharmacological pain management improve function, lessen pain, and reduce requirements for inpatient care**. It was concluded that Collaborative telerehabilitation modestly improved function and pain, while decreasing hospital length of stay and the requirement for post-acute care**, these outcomes were not enhanced with the addition of pharmacological pain management [15].

Chronic Obstructive Airway Disease (COPD)

An eight week home based telerehabilitation exercise programme using real time videoconferencing software showed a statistically significant increase in endurance shuttle walk test time and self-efficacy when compared with usual care with no exercise training in patients with COPD.

This is the first RCT in patients with COPD examining the effects of home-based telerehabilitation with supervision of all exercise sessions using real-time videoconferencing.

The exercise prescription in this study aimed to reflect typical supervised centre-based programmes. Supervision was provided by an allied health practitioner experienced in PR enabling continuous monitoring and progression in exercise intensity and duration [16].

Multiple Sclerosis - Improving Physical Activity

Fatigue and depression are extremely common among individuals with multiple sclerosis and other chronic illnesses. Telephone-based interventions represent a promising means of overcoming barriers and improving access to care.

Improvements in physical activity mediated improvements in fatigue with a similar trend for depression. Teleconsultation was highly feasible (participants completed 99.5% of schedule telephone sessions) and well tolerated (100% rated it highly successful). Conclusion: **Telephone-based counselling with home monitoring is a promising modality to improve physical activity and treat fatigue and depression** [17].

Spinal Cord Injury

People with spinal cord injury increased their physical activity levels after 8 weeks of telehealth coaching. Physical activity motivation support (one, 1-hour counselling session per week, for eight weeks) delivered via an online videoconference platform by trained physical activity counsellors can increase physical activity motivation. The intervention group reported greater autonomous motivation (Hedge's g = 0.91) and LTPA (Hedge's g = 0.85) post-intervention. Large to moderate effects supporting the intervention group were found for health participation at six weeks (Hedge's g = 0.97), and meaningful life experiences (Hedge's g = 0.72) and social cognitive predictors of LTPA (Hedge's g > 0.76) post-intervention [18].

Validity of teleconsultations

Telephone-delivered interventions targeting physical activity and dietary change have potential for broad population reach and thus have a role to play in addressing increasing rates of lifestyle-related chronic diseases. The purpose of this systematic review is to update the evidence for their potential to inform translation, including effectiveness in promoting maintenance, reporting on implementation, and costs [19].

Vince et al. states; Exercise Physiology Video Consultations: **The participants were also asked to describe the advice provided by the exercise physiologist and what they thought about the goals set during video consultations. Themes that arose from their descriptions of these consultations included the following: motivating practitioner, tailored and flexible goals, and gained knowledge and confidence**. The participants were overall very favourable about their experiences with the exercise physiologist consultations. The exercise physiologist was perceived by all the participants to be very motivating, supportive and realistic, and offered advice that was highly flexible and tailored to needs, lifestyle and changing circumstances. The exercise physiologist had been perceived to work closely in conjunction with the participant to create a tailored and targeted program, provide advice that was aligned with personal goals, and most importantly, fit in with current routines, practices and capabilities [20].

Telephone coaching for people with chronic conditions can improve health behaviour, self-efficacy and health status. This is especially true for vulnerable populations who had difficulty accessing health services. This rapid scoping review found that **telephone-based coaching can enhance the management of chronic disease**, especially for vulnerable groups [21].

Individualized health coaching for adults (BMI ≥30 kg/m2) by a multidisciplinary team (registered dietitian, **exercise physiologist**, and medical doctor) **over a 12-week intervention via videoconferencing led to more favourable changes in weight loss**, PA (steps/day), and HOMA-IR than in-person (IP), or no health coaching. Weight loss was greater ($p < 0.05$) for VC (8.23 ± 4.5 kg; 7.7%) than IP (3.2 ± 2.6 kg; 3.4%) and CG (2.9 ± 3.9 kg; 3.3%), respectively. Steps/day were significantly higher in VC than IP at week 4 and VC was significantly higher than the CG at weeks 6, 8, 9, and 11 ($p \leq 0.05$) [22].

Fatehi et al. showed results of Validity Study of Video Teleconsultation for the Management of Diabetes: A Pilot Randomized Controlled Trial demonstrate the preliminary evidence on the validity of recommendations via video consultation. Sic "**Video teleconsultation can substitute for a considerable proportion of conventional outpatient specialty consultations for people with diabetes**", albeit relating to endocrinology, the value of teleconsultation is clear [23].

Conclusions

This brief review clearly demonstrates the value of accredited exercise physiology services delivered via teleconsultation and highlights the need for Private Health Care insurers to continue to support access to Accredited Exercise Physiology services during the COVID-19 pandemic. There is clear evidence demonstrating that teleconsultations provided by Accredited Exercise Physiologists via both video and/or by telephone are clinically effective. The results above outline only "some" specific conditions that an Accredited Exercise Physiologist's scope of practice is able to intervene with.

AEPs are university qualified allied health professionals equipped with the knowledge, skills and competencies to design, deliver and evaluate safe and effective exercise interventions for people with acute, sub-acute or chronic medical conditions, injuries or disabilities. Pathology domains covered by the services of AEPs include cardiovascular, metabolic, neurological, musculoskeletal, cancers, kidney, respiratory / pulmonary and mental health, and any other conditions for which there is evidence that exercise can improve the client's clinical status.

Exercise & Sports Science Australia is the peak professional body and sole accrediting authority for Accredited Exercise Physiologists. ESSA is also the accrediting body for Accredited Exercise Scientists, Accredited Sports Scientists and Accredited High-Performance Managers.

To gain AEP accreditation with ESSA an individual must:

- Graduate from a minimum 4 years of study in an ESSA accredited course meeting the AQF requirements for Level 7 that leads to bachelor degree qualifications.

- Meet the professional standards for exercise science, leading to accreditation as an Accredited Exercise Scientist (AES)*, including 140 hours of practical experience for the purpose of undertaking an exercise intervention to improve health and fitness, wellbeing or performance, or focus on prevention of chronic conditions.

- Meet the professional standards for exercise physiology, including 360 hours of practical experience with clients with clinical conditions.

AEPs are dual accredited, holding the foundational accreditation of AES in addition to their AEP status.

To maintain accreditation with ESSA, an AEP is required to meet ongoing professional practice requirements:

1. Accrue 20 points of continuing professional development (CPD) points each calendar year.
2. Meet recency of practice requirements.
3. Hold appropriate professional indemnity insurance, either personally or through a third party (such as an employer).
4. Hold a current first aid certificate (HLTAID003) unless engaged in a role that does not involve provision of face to face physical activity and exercise services directly to clients.
5. Hold a current CPR certificate (HLTAID001) and renew yearly unless engaged in a role that does not involve provision of face to face physical activity and exercise service directly to clients.
6. Advise ESSA as a soon as is practicable of any changes to the mandatory declarations signed at accreditation application and/or renewal e.g. criminal or ethics history.
7. Abide by the ESSA Code of Professional Conduct and Ethical Practice at all times.

AEPs typically work in a number of environments, including but not limited to:

- public and private hospitals settings
- primary, secondary and tertiary health care
- within private and multidisciplinary clinics
- population health
- workplace health and rehabilitation
- ageing and aged care
- fitness centres, gymnasiums, business
- sporting settings.

ESSA strongly encourages the support of the PHIs to assist Australians in this extreme time of need, by supporting Accredited Exercise Physiologists to maintain frontline healthcare for those persons whom are unable to see their AEP "in person" due to isolation restrictions.

Limitations

Due to the unforeseen global need of teleconsultation services on such a large scale so quickly, there is a dearth of comprehensive literature available.

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Appendix A

Compensable Schemes supporting AEP service delivery via Telehealth **(Position as at 27 March 2020)**	**Telehealth Terms and Conditions**
National Disability Insurance Scheme	All NDIS providers can use Telehealth where appropriate and with the agreement from the participant. Providers should ensure they meet the NDIS Code of Conduct and NDIS Practice Standards to ensure quality service provision.
State Insurance Regulatory Authority (SIRA)	The Fees Order 2020 - Accredited Exercise Physiology No 2 outlines that Telehealth services means delivery of consultations via video or telephone. Consultations would be inclusive of any electronic communication to support the delivery of the treatment service. Accredited Exercise Physiologists must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis. Telehealth services require pre-approval from the insurer and must be consented to by all parties – the worker, Accredited Exercise Physiologist and insurer.
WorkCover Queensland	The Exercise Physiology Table of Costs July 2019 already supports telehealth as a method of service delivery. Exercise Physiology telehealth services are restricted to video consultations only and requires prior approval from WorkCover Queensland.
Return to Work SA	Temporary COVID-19 Allied Health Practitioner fee items have been introduced. Exercise physiology guidance outlines telehealth/telephone individual sessions are available for workers with an existing claim that are unable to attend an appointment because they have been impacted by COVID-19. Review, planning, education, instruction, supervision and upgrade of prescribed functional and work-related exercise activities. Maximum of 10 sessions, up to a

	maximum of 1 hour per session. An Exercise Physiology Management Plan is required on commencement of this service.
Worksafe Victoria	New Item Codes for Exercise Physiology have been introduced. These items codes are temporary measure and will be reviewed regularly. It is expected that telehealth services are provided when clinically appropriate and should not replace face-to-face consultations unless there is a need.
Workcover WA	The use of telehealth services are encouraged for consultations where direct patient contact and examination is not essential. As there are no specific Workcover WA service codes for telehealth, medical and allied health providers should use the relevant service codes that apply to consultations generally. The fees for these services should also be applied.

Appendix B

ESSA Tele-Practice Policy Statement

Follows in Appendix 2 below

Appendix 3: ESSA: PHIs with telehealth item codes as at 30 April, 2020

Telehealth Coverage - Private Health Insurance Funds Fact Sheet - Updated 30 April, 2020

For a patient to receive a rebate from their Private Health Insurer, the patient's cover must include exercise physiology services and the treatment must aim to prevent, delay or ameliorate a chronic disease or injury. Insurers **do not** pay a benefit for general fitness programs.

- * = No information available yet confirming telehealth for any Allied Health Profession.
N for AEP telehealth = the provider has telehealth for other Allied Health Professions.

Health Fund	Individual Benefit	Group Benefit	Telehealth Benefit for AEPs
ACA Health Benefits Fund	Y	N	-*
AHM Health Insurance	Y	N	Y
Australian Unity	Y	N	Y
Apia	Y	N	-
Bupa Australia Pty Ltd	Y	N	Y
CBHS Health Fund Limited	Y	N	Y
CUA Health Limited	Y	N	Y
Defence Health	Y	Y	N#
Doctors Health Fund	N	N	N
Emergency Service Health	Y	N	N
GMHBA Limited	Y	N	N
Grand United Corporate Health	Y	N	Y
HBF Health Limited	Y	N	Y
HCF	Y	Y	Y
Health Care Insurance Limited	Y	Y	-
Health Insurance Fund of Australia Limited	Y	N	N
Health Partners	Y	Y	N
Hunter Health Insurance	N	N	-
Medibank Private Limited	Y	Y	Y
Mildura District Hospital Fund Ltd	Y	N	Y
Navy Health Ltd	Y	N	N
NIB Health Funds Ltd.	Y	N	Y

Onemedifund	Y	Y	N
Peoplecare Health Insurance	Y	N	-
Phoenix Health Fund Limited	Y	Y	N
Police Health	Y	N	Services on a case by case basis. Clients should seek approval first.
Queensland Country Health Fund Ltd	Y	Y	Y
Railway and Transport Health Fund Limited	Y	Y	Y
Reserve Bank Health Society Ltd	N	N	N
St Lukes Health	Y	N	-
Teachers Health Fund	Y	Y	Y
Transport Health	Y	N	Y
TUH	Y	Y	Y
Westfund Limited	Y	Y	-

All receipts should include providers details (including name, practice address, contact details), business details (business name, ABN), member details (name, address), service details (receipt number, date of service, explanation of the type of service, item code). The following codes developed by ESSA, in conjunction with HICAPS and Private Health Care Australia:

Item Number	Full Description	Abbreviated Description
102	Initial Session – once only per course of treatment > 45 min	Initial consultation
202	Standard Consultation 30 – 60 minutes	Standard consultation
502	Group Session 60 minutes (maximum of 8 people)	

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