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Facilitating good communication in telerehabilitation

THINGS TO CONSIDER WITHIN THE SESSION

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Things to consider within the session

This document has four key sections:

1. Starting the session
2. Principles to facilitate relationships and communication
3. Involving different parties
4. Finishing the session

1. Starting the session

Get the technology sorted

The first part of the call is often focused on getting the technology set up. This might be made easier if you have done a practice call first. Once it is all set up, explicitly mark that you are moving into the start of the session (e.g. “OK, now that’s all sorted, tell me, how are you?”) [1].

Identity and consent

It’s important to make sure that you’re talking to the right person [2]. Your organisation might have some clear requirements about this. If you know the person, the identification verification is easy. However, if you’re on the phone or if this is a new client, you should explicitly verify their identity. The AHANZ guidelines suggest three identifiers are needed (e.g. name, date of birth, gender, address) [3].

It is also important that you know who is in the space with the client (and vice versa). They may be out of sight, but always ask. If you have other clinicians or students in your space, or if you have colleagues who have also connected separately, make sure everyone introduces themselves.

Consent is always required for clinical care. Some suggest that consent can be implied because the person has actively connected to the telerehabilitation server, but it is good practice to confirm this consent verbally (or non-verbally through head movement/facial expression if the person has communication impairments) [2].

2. Principles to facilitate relationships, engagement & communication

The flow of the session

The telerehabilitation session will have a flow, most likely technology check → small talk and rapport building → therapeutic activities → summary and making plans. It is valuable to make the transitions explicit to the patient. Often these would be signalled through your non-verbal behaviours such as moving resources around; these behaviours might not happen, or if they do, might not be visible to the client. We also often have our own patter that we use to indicate transitions within face-to-face sessions, but we may forget to do this when working differently [4].

Within activities, you will switch between micro-actions (e.g asking a question, writing down the response). Again, these might not be visible, so let the client know what you're doing [5].

Remember to do what you would normally do at the start and end of a face-to-face session. Consider the cultural needs of clients, including karakia, if clients and whānau wish.

At times, the sessions may be disrupted by technological glitches such as freezing or lags. Whilst these may make the session a little less fluid, they are unlikely to have a significant impact on relationship building [1, 6]. Make sure that the client is aware that these can happen. When talking, pause regularly in case of lags and try to wait until the other person has finished speaking before you talk.

Building and maintaining therapeutic relationships

It's not uncommon for people to be concerned that it will be harder to build a therapeutic relationship via telerehabilitation [7, 8]. This concern usually goes away after people start using telerehabilitation! The evidence indicates that relationships can be just as strong as in face-to-face therapy [9]. However, the clinician may need to work more intentionally to embed relationship-building within the interactions. Normal moments for rapport-building may not be there (e.g. walking from waiting room to treatment area). It is important to explicitly focus on building and maintaining the relationship, and to reflect on how each person is engaged throughout the telerehabilitation process.

Behaviours that facilitate a relationship include [2, 8, 10, 11]:

- Rapport-building activities such as small talk;
- Talking about 'everyday things' which might be prompted by talking about what you can see in the person's background and sharing something about what is in your background;
- The use of humour;

- Active listening which shows you are closely attending to the person and to what they are saying and to what is unsaid, such as emotions;
- Attending to the therapeutic relationship throughout the session, not just in the early moments of 'building rapport';
- Communication that is easily understood, that seeks people's perspective and responds to these; and
- Connecting the work you are doing to the client's needs and priorities.

Specific communication considerations in telepractice

Telerehabilitation changes the dynamic between the clinician and client. This is partly because there is a change in how clinicians work and convey expertise (e.g. something often done through touch or the use of the clinician's resources), and clients have more ability to choose to disengage if their needs and priorities aren't being met [2, 7, 12]. This can result in an even-ing of the relationship with some clients saying they feel they are on a more equal dialogue with the clinician [12]. Telerehabilitation research from other diagnostic groups (e.g. COPD, osteoarthritis) suggest that remote-delivered interactions can help the patient become a more active participant in managing their condition, and can empower and foster independence and autonomy [7, 12].

Telerehabilitation requires clinicians to think carefully about their communication. Some suggest clinicians need to "step up" with their verbal communication skills as these are the primary way clients and clinicians now connect, with limited non-verbal communication, including no physical touch [2].

Research with clinicians before and after using telerehabilitation highlighted that they noticed significant differences in how they worked with clients with osteoarthritis. Before working in telerehabilitation, they were concerned at the lack of touch, the need to rely on patient self-report, challenges in teaching exercises, and the loss of non-verbal cues. However, after working in this way, they noticed they listened a lot more, focused on what motivated patients, moved to a coaching approach, and spent more time in conversation rather than active, hand-on treatment. This communication approach is consistent with one that supports self-management and autonomy [7].

Find out what person's needs, experiences and priorities are. An open discussion, with the use of communication supports if needed, can be invaluable in developing a therapeutic relationship and informing therapy planning [7]. As part of this, consider the different domains that matter, including emotional wellbeing. While this is always important with stroke survivors as many experience post-stroke depression, it is particularly important in the current health context. Getting to know the person, what matters to them, and what they are wanting from you is core to person-centred practice and client engagement, whether this is face-to-face or in a telerehabilitation setting [13].

Eye contact. When using video platforms, remember to sometimes make eye contact by looking directly at the camera, not just at the image of the client (or yourself) on your

screen. This helps maintain the connection between you. If you can have the camera at eye level, this will be easier [11].

Clear communication.

- It is important to be clear and concise in your verbal explanations and questions because there are reduced visual and non-verbal cues for the client to pick up on [14].
- Don't give too many instructions or information at once – break it into chunks to allow for technological lags and for the other person to process and/or ask for clarification.
- When you start an assessment or an activity, find out what they know about this. They might have done the assessment before, in which case you might not need to explain as much – though of course, you'll need to explain what's different given the telerehab delivery [14].
- Watch for the use of jargon! Clear easy English is important for conveying messages clearly and reducing the likelihood of misunderstanding [14].
- Remember to modify your communication if the person has cognitive and/or communication difficulties. Simple language, use of writing keywords and other supported conversation strategies will help. These can be low tech (showing a piece of paper to the camera) or higher tech, using inbuilt capabilities within the telepractice platform (e.g. Whiteboard function in zoom). See our guides for working with people with communication issues and cognitive issues for more details.
- In telerehabilitation, you lose body communication (messages such as reassurance or small corrections of movement that are conveyed through bodily actions such as touch). You will need to do this through your verbal communication instead. For instance, you might need to verbally explain what you would usually show (e.g. how to do a particular movement), but also make sure you show whatever you can, and you might need to prompt the client to explain how something feels [14, 15].

Check understanding. It is important to monitor how instructions are carried out and what people experience when they're doing what you've said – something you might normally pick up through touch or by observing subtle body movements. You may need to prompt the client to show you what they're doing, not just rely on their verbal statement (usually indicated by an affirmative 'yes') [14]. Different health literacy techniques such as teach-back and show-me[1] can help you check the client's understanding.

Check in regularly. Because it is harder for you to monitor understanding, fatigue, emotions etc, make sure you regularly check in with the client to see how they are getting on. You may need to negotiate rest breaks or change how you are doing this based on their feedback. You should also check in to make sure they're seeing you and hearing you [11].

[1] https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/partnering+with+consumers+and++the+community/health+literacy

Demonstrate connectedness. Actions such as nodding, engaged facial expressions, gestures, paraphrasing and empathetic statements can help show you are actively listening and engaged with what is happening [5, 7].

Monitor your body language. Sometimes people can be very active when talking (e.g. lots of head movement which might be distracting) whilst others can go very still. Keep an eye on your body language and make adjustments as required [5].

Be mindful of what might be missed by you and the client. While technology has come a long way, fine aspects of communication can often be missed. These include people's facial expressions (often fine movements in one part of the face), the client's fatigue levels which might change during the session, their emotional state, and the clinician's own indicators of empathy [11, 16]. This means the clinician needs to use elicit this information, and convey this information, verbally. Other things to attend to are:

- Ask regularly about fatigue levels.
- Ask about people's emotions and for signs of depression and anxiety, or general withdrawal which might usually be indicated by body movements.
- Your pace of speech is important.
- Think about how you might show empathy, for instance, by leaning into the camera or by different verbal expressions.
- People may be reliant on your cues to help them understand (e.g. lip reading), so ensure that there is good lighting so your face is clear and easy to see.

Communicating and planning rehabilitation in a time of uncertainty

In times of significant crisis, such as during a pandemic, people are isolated and uncertain. Being able to make a connection, listen to what is happening for them, and support them through what might be 'small' steps can be particularly critical. Making connections and supporting people where they are at may be key right now [17]. 'Normal' ways of working, assessing and 'doing' rehabilitation, may look quite different.

The Bridges self-management programme suggests six key steps in having initial conversations that lay the groundwork to build people's confidence and ability to manage their life and make progress [17, 18]:

1. **Introducing yourself** and the purpose of the call, including that you're wanting to hear how things are going and working out the next steps from here
2. **Setting the context,** explaining why you are calling and finding out how things are going. In this, listen to where people are at, asking about how things are going, how it is going being at home, what is worrying people, and listening to their answers. When people have the sense of being heard, it can be invaluable for building relationships [13].

3. **Find out what matters to people**. Explore their priorities, their concerns, and fears and worries. This helps you understand their situation and what matters most to them.
4. **Explore how people are managing already**. Explore the positives and strengths, what has worked for people, things they have been able to do, the strategies they've tried, what resources they currently have around them. This helps people see what they're doing and recognise their efforts, building self-efficacy.
5. **Acknowledge and validate their efforts to date**. Identify what's working and what might be more challenging and might be areas that could be focused on. Reflect on previous experiences, how people have managed challenges and how those strategies might be useful now, how things have changed recently.
6. **Identify the next steps**. Through questions, help the person identify a small thing that they might want to work toward. Take it a week at a time. Talk through who can help them, what might stop them, how they can record how things are going. Find out what will help them be motivated to keep working toward what matters to them. Ask how you can help to support them. Finish with a plan – encourage them to write it if they can, or you could write it up and email it to them. Be clear about what supports they have or need from you.

'Difficult' conversations

We need to recognise that these conversations are often ones that cause us discomfort. They can be easy to avoid or put off in face-to-face rehabilitation and may be more vulnerable to being forgotten in a telerehabilitation context. The topics below are just examples of some of the 'difficult' conversations that may need to considered.

One topic is sexuality. This is often not discussed face-to-face, even though it is important to many clients. Clinicians and clients may be even more reluctant to raise it as an issue, or may be concerned about having space to discuss this privately. One strategy to manage this may be to send a checklist of 'things I would like to discuss' to clients in advance, with a range of topics on it. At the very least, this gives clients the chance to indicate that it is something they wish to discuss.

Clinicians often consider breaking bad news should be done face-to-face. This is not necessarily the case, as it may be more comfortable for people to be in their own homes [1]. It is important to make sure conversations which might have an emotional component are thought through and sign posted in advance. Consider who should also be present for those discussions, such as a partner or support person. Things like discharge from rehabilitation should not come as surprise, and should be clearly signposted to the client. Within the conversations, it is important to attend to how you convey empathy, as subtle markers of empathy such as leaning forward or forehead movement may be less visible on videoconference. It is also valuable to follow up the conversations with a short call the next day, and to provide a written summary of the conversation.

3. Involving different parties

Involving family and whānau

Find out if family/whānau are present but off screen. If they are there but are not visible, their contribution is likely to be missed/ If they both wish to be involved, prompt them to position the camera so they can both be seen [6].

When working with family, make sure to do this in a way that still maximises patient confidence and agency [10]. Agency can sometimes be undermined when the clinician focuses their interactions on the family member rather than the client. While it may sometimes be quicker to rely on the support person (e.g. getting answers or giving a therapy plan), if the interactions are primarily between the support person and clinician, this can exclude person with stroke, limiting their active participation and possibly influencing their engagement [10]. This may be more likely to occur when the client has communication and/or cognitive impairment. It is often very appropriate or necessary to work directly with the support person as you would in face-to-face sessions, but the client should always be included in the conversation.

Managing multiple team members

You can use telehealth platforms for family meetings. Families often report this is a valuable use of telehealth and it helps them feel connected with rehabilitation and helps them build a relationship with the clinicians. As with all family meetings, there can be a risk of the team members dominating, so skilled facilitation will be important. Different platforms can allow the moderator to control the flow of the interaction, including muting people and hiding video feeds, so consider what is most appropriate. When talking in this forum, make sure it is clear who is talking [19, 20]. Ideally, if done via video-based platforms, their image should be the main image to help clients connect with the speaker. It may be useful to have backchannels open to facilitate team communication during these meetings (an alternative approach that is separate to the platform being used, e.g. email or a messaging system) [20]. In family meetings, team members might communicate via subtle non-verbal behaviours, such as indicating concern or ‘stop talking’ or ‘we’re running out of time’, and these will be missed in technology mediated meetings.

4. Finishing the session

Finishing a telerehabilitation session

When finishing a session, it is important to clearly signal this shift is happening. Outlining the structure of the session at the start helps provide some 'picture' of how the session will go.

Summarise what was discussed, reinforce the key points, confirm the next steps (including checking the client's confidence in continuing their work at home), and check how the session went from the client's perspective (including how the technology went and any communication issues).

Be clear that the session is about to finish and tell them how it will come to an end (e.g. that the clinician will finish the session).

After a session

After the session, it may be valuable to send a short summary to the client to summarise what was discussed and the plan moving forward. Resources should also be sent (e.g. written programmes, videos). If there are things the client needs to do before the next session, these should be clearly indicated [11, 15].

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