Survey: Investigation of Criteria used in Participant Selection of Pulmonary Rehabilitation Programs in Australia

This survey is intended for people who co-ordinate a pulmonary rehabilitation program within Australia. Please only answer one completed survey per program.

1. Which State or Territory is your program located?
   Please tick box: Queensland [ ], New South Wales [ ], Victoria [ ], South Australia [ ], Western Australia [ ], Tasmania [ ], Australian Capital Territory [ ], Northern Territory [ ]

2. Where is your program location?
   Please tick as many boxes as required:
   Metropolitan [ ], Regional [ ], Rural [ ]

3. Where is your program based?
   Please tick box:
   Hospital – outpatient based [ ], Hospital – inpatient based [ ], Community-based [ ], Home-based [ ]

4. How many years has your program been running?

5. How many courses were completed by your program in the last twelve months?
If your program is a continuous or rolling program, please tick this box □

6. How many people were **enrolled or booked** into your pulmonary rehabilitation program in the last twelve months?

<table>
<thead>
<tr>
<th>People</th>
</tr>
</thead>
</table>

7. If someone was referred to your pulmonary rehabilitation program today, how many weeks would they have to wait to attend a program?

<table>
<thead>
<tr>
<th>Weeks</th>
</tr>
</thead>
</table>

8. If your program has no waiting list please tick this box □ and Go to Q10

9. If your pulmonary rehabilitation program has a waiting list, how many people are currently waiting to attend?

<table>
<thead>
<tr>
<th>People</th>
</tr>
</thead>
</table>

10. Does your program prioritise referrals to the program? Yes □ No □

    If ticked Yes, please could you indicate what criteria are used for this prioritisation. Please tick as many boxes as required:

    - Requirements prior to surgery or medical procedure
    - Due to severity of individual’s condition
    - Due to a medical practitioner’s request
    - Particular individuals are more likely to benefit from pulmonary rehabilitation

    Other □ Please specify:
11. Who does your pulmonary rehabilitation program accept referrals from?
Please tick as many boxes as required:

- General Practitioners
- Medical Specialists
- Respiratory Nurses
- Community Nurses
- Physiotherapists
- Other Allied Health Professionals
- Emergency Department
- Self-referral

Other Please Specify:

12. Does your pulmonary rehabilitation program accept all people referred with respiratory disease or are there some entry or exclusion criteria?
Please tick one box:

- Program accepts all people referred with a respiratory disease
  => Thank you for your help in completing the survey.

- There is some selection process or entry criteria used
  => Please answer Q13-17

Question 13 to 17 – Please go to next page.
13. If there is some selection process or entry criteria used in your pulmonary rehabilitation program, could you indicate the purpose of this selection process. Please tick as many boxes as required:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>To manage the high demand on the program</td>
<td>☐</td>
</tr>
<tr>
<td>To manage the waiting list of the program</td>
<td>☐</td>
</tr>
<tr>
<td>To manage safety risks to individual participants</td>
<td>☐</td>
</tr>
<tr>
<td>To select individuals who are more likely to benefit from pulmonary rehabilitation</td>
<td>☐</td>
</tr>
<tr>
<td>To increase participation by selecting individuals least likely to drop out of pulmonary rehabilitation</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other: Please specify:

14. If there is some selection process or entry criteria used in your pulmonary rehabilitation program, who manages this selection process? Please tick as many boxes as required:

<table>
<thead>
<tr>
<th>Manager</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>☐</td>
</tr>
<tr>
<td>Respiratory Nurse</td>
<td>☐</td>
</tr>
<tr>
<td>Respiratory Physician</td>
<td>☐</td>
</tr>
<tr>
<td>Other Medical Specialist</td>
<td>☐</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>☐</td>
</tr>
<tr>
<td>Other Allied Health Professional</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other: Please specify:
15. If there is some selection process or entry criteria used in your pulmonary rehabilitation program, how does this occur?  
Please tick box:

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>From the written referral</td>
<td>☐</td>
</tr>
<tr>
<td>From a telephone contact</td>
<td>☐</td>
</tr>
<tr>
<td>Pre-program screening clinic</td>
<td>☐</td>
</tr>
<tr>
<td>At the start of the program</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
</tr>
</tbody>
</table>

16. If there is some exclusion criteria used in your pulmonary rehabilitation program, could you indicate what is used?

a. Unstable heart disease:   Yes ☐  No ☐  
   If ticked Yes, please specify (eg participants are not accepted if they have had a recent myocardial infarction):

b. Severe cognitive and/or psychological impairment:  Yes ☐  No ☐  
   If ticked Yes, please specify (eg participants are not accepted if they have severe dementia):

c. Relevant infectious disease:  Yes ☐  No ☐  
   If ticked Yes, please specify (eg participants are not accepted if they are colonised with MRSA):

d. Musculoskeletal disorder:  Yes ☐  No ☐  
   If ticked Yes, please specify (eg severe osteoarthritis):

e. Smoking Status:  Yes ☐  No ☐  
   If ticked Yes, please specify (eg current smokers are not accepted into the program):
17. If there is some entry criteria used in your pulmonary rehabilitation program, could you indicate what is used?

a. Lung Function: Yes ☐ No ☐
   If ticked Yes, please specify (eg participants are only accepted with a FEV₁ less than 50%):

b. Dyspnea Level: Yes ☐ No ☐
   If ticked Yes, please specify (eg participant are only accepted with a MRC dyspnea scale ≥ 3):

c. Walking Ability: Yes ☐ No ☐
   If ticked Yes, please specify (eg if a participant six minute walk distance >500m the participant is not enrolled):

d. Muscle Strength: Yes ☐ No ☐
   If ticked Yes, please specify what measure is used:

e. Other Criteria Yes ☐ No ☐
   If ticked Yes, please specify (eg Program only accepts Indigenous Australians):

Thank you for your time in completing the survey
Please return to:
Mr James Walsh c/o Physiotherapy Department, The Prince Charles Hospital, Rode Road, Chermside, QLD 4032
Or via email: james_walsh@health.qld.gov.au