

Article

How Do People with Neurological Disease Evaluate Their Experience with Telerehabilitation? Experiences of People with Multiple Sclerosis

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Abstract

Background: Telerehabilitation has grown with the advances of modern communication technologies, but it experienced its greatest surge during the COVID-19 pandemic. Our department also wanted to offer our patients with chronic neurological conditions (specifically, multiple sclerosis (MS)) the opportunity to exercise with a physiotherapist remotely during pandemic restrictions. We continued with telerehabilitation afterwards, but for further development of telerehabilitation programs we sought feedback from participants. **Methods:** People with multiple sclerosis (MS) who participated in any form of telerehabilitation offered at our MS centre between January 2021 and June 2024 were invited to complete a brief semi-structured interview to assess their feedback. To ensure unbiased responses, the feedback was obtained from a therapist other than the one with whom they had completed the online session. **Results:** A total of 95 multiple sclerosis (MS) patients (14 of whom were male) participated in telerehabilitation programs during the study period, with a mean age of 46.5 years. Of these, 82 agreed to participate in short interview. Patients particularly valued the ability to avoid commuting and the time flexibility in scheduling sessions. They perceived the limited opportunities for hands-on correction and the lack of personal interaction with the therapist and other patients as the most significant disadvantages. **Conclusions:** Telerehabilitation appears to be a viable complement to in-person physiotherapy for some patients with chronic conditions. In our experience, it is feasible to deliver telerehabilitation to people with multiple sclerosis who do not have severe disability, without the need for complex equipment.



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1. Introduction

Telerehabilitation as part of telemedicine is closely tied to advances in modern communication technologies. However, the real growth in remote consultations, telemonitoring, and telerehabilitation occurred during the COVID-19 pandemic, when the traditional provision of rehabilitation services was curtailed due to public health restrictions [1–3].

This trend is also evident, for example, from the number of publications in the PubMed database, which rose from a few dozen to more than 300 publications in the first year of the pandemic, exceeding 500 in the following years, with publication rates on the topic still remaining high.

Some of the common medical fields using telerehabilitation include cardiorespiratory rehabilitation [4], type 2 diabetes mellitus [5], orthopaedic rehabilitation (especially arthritis and back pain) [6], and neurorehabilitation. In neurorehabilitation, the remote therapy interventions are most commonly targeted at people with multiple sclerosis and stroke [7,8]. For these neurological conditions, telerehabilitation offers a wide range of options, including general mobility training, balance training, hand function therapy, cognitive training, speech therapy, and patient education [9]. Thus, it focuses on some of the most common and disabling symptoms of these acquired neurological diseases such as balance disorders, gait disturbances, decreased muscle strength, impaired fine motor skills of the hand, memory and concentration disorders, speech disorders, depression, fatigue, etc.

For people with multiple sclerosis (MS), a variety of options are used for telerehabilitation interventions, such as special web-based programs (websites that provide exercise instructions and enable online communication with a therapist), are often used for telerehabilitation interventions [10–12]. Another possible type of telerehabilitation delivery is that of the smartphone exercise app, such as those offering stretching exercises to reduce spasticity [13].

A stability platform connected to a biofeedback game system [14,15] or, for example, a dance mat used for step training [16,17] can also support balance and general mobility training. Conversely, other studies used only physiotherapist-led exercises via videoconferencing, such as in a study focusing on pelvic floor muscle training [18].

Telerehabilitation interventions can also be delivered without the need for special equipment, websites, or apps. For example, home-based Pilates exercises using a DVD recording combined with online physiotherapist support [19], or online guided imagery exercises [20] have also shown potential benefits. Alternatively, online exercises led by a therapist without any equipment [21].

We were therefore interested in learning about the experiences and personal evaluation of people with MS who had direct experience with a telerehabilitation program. The aim of the study was therefore to use short semi-structured interviews to describe and evaluate the experiences of people with MS of varying ages and with different levels of disability. The aim was to find out which elements were important to participants during the telerehabilitation programs and whether any technical difficulties occurred during online exercises led by a physiotherapist.

2. Methods

2.1. Participants

People with multiple sclerosis (MS) who participated in any of the telerehabilitation programs offered by our rehabilitation department (MS centre, Department of Neurology, General University Hospital) between January 2021 and June 2024 were contacted by a physiotherapist and invited to participate in short semi-structured interview. The inclusion criteria thus included prior participation in the MS centre's telerehabilitation program. Exclusion criteria included severe neurological or cognitive impairment or any other current serious medical condition that made communication very complicated or impossible. All participants signed an informed consent form prior to the interview, in accordance with the ethical considerations for research involving human participants as set forth in the Declaration of Helsinki.

A total of 95 people (13 men) with diagnosis of MS and a mean age of 46.5 years were approached. During this period participants could enrol in one of the following telerehabilitation programs: Pilates group or individual online exercise or individual strength or balance training with physiotherapist [21,22]. Our department did not use any specialized telerehabilitation, relying instead on common communication platforms for online sessions.

2.2. Procedure

The short semi-structured interview (Supplementary File S1) consisted of several open-ended questions to assess their feedback as well as a question asking them to rate the quality of therapy on a numerical scale (from 1 (best) to 5 (worst)). The open-ended questions explored the perceived benefits and challenges of telerehabilitation, including any technical difficulties. We also asked whether patients missed direct in-persona contact with the physiotherapist and, if so, in what aspects. In addition, participants were also asked whether they would be interested in another telerehabilitation program in the future, and possibly in what type of rehabilitation exercise they might prefer. The interview questions had previously been pilot-tested on two patients.

Participants were also asked about their experience with remote therapy (whether they had any other experience with online exercise prior to participation in the MS centre's telerehabilitation program) or any prior experience with telerehabilitation and the technology used. Participants were contacted personally during their visit to the MS centre and their responses were orally recorded and subsequently transcribed and coded (in open questions). To reduce potential bias, the questionnaire was administered by a therapist other than the one who conducted their telerehabilitation sessions. The study was approved by the ethics committee of the General University Hospital in Prague (No: 87/24 S-IV AP).

2.3. Data Analysis

Verbal responses to the open-ended questions were coded into categories to capture the range and frequency of participants' answers. The coding was performed by the primary author of the study. In cases of uncertainty, consultations were held with the other authors of the paper. Respondents were not limited in the length of their answers to open-ended questions. Based on their responses, the following code categories were created: for perceived benefits, the categories were time savings, less fatigue, time flexibility, and higher motivation. For perceived disadvantages, the following code categories were used: no disadvantages, lack of a therapist, lack of motivation, lack of social contacts, and lack of equipment. Respondents were not offered any answer options, and coding was performed solely based on their spontaneous responses.

For statistical comparison, respondents were grouped by age (younger <50 years vs. older ≥ 50 years) and by degree of neurological disability (participants with mild neurological disability, EDSS 0–3 vs. those with gait limitations EDSS 3.5–6.5). The age threshold of 50 was chosen because the secondary progression phase typically begins after this age [23]. The classification of EDSS scores below 3.0 and above 3.0, according to the Kurtzke scale, was chosen to distinguish between mild versus moderate and severe disability.

The chi-square test was used for statistical comparison of categorical data. Descriptive statistics were used to analyse the remaining data. Statistical analyses were conducted using IBM SPSS Statistics Version 22 (IBM Corp., Armonk, NY, USA).

3. Results

3.1. Demographical and Clinical Characteristic of Participants

Of the 95 people contacted, responses were received from a total of 82 people (11 men), yielding a response rate of 86%. The participants had an average age of 47 years (SD 11 years) and ranged from mild to middle neurological disability as evaluated by Kurtzke's Expanded Disability Status Scale (EDSS), ranging from 0 to 8 and with a mean of 3.0. The remaining 13 participants could not be reached for interview. Most participants had a moderate degree of neurological impairment (e.g., presence of paresis, spasticity and impaired sensitivity, but with preserved ability to walk without support), although individuals with lower and higher deficits were also represented (see Table 1). All study participants are patients receiving long-term care at the MS centre of the neurological department of a university hospital, where they are provided with comprehensive pharmacological and rehabilitation treatment (on an outpatient basis) tailored to their medical condition. All respondents therefore completed a telerehabilitation program led by physiotherapists from the MS centre, which included at least 30 min of exercise twice a week for two months. As part of this program, participants also had weekly individual telephone or other contact with a therapist to ensure adherence. More details about specific telerehabilitation programs are described in the authors' previous publication [21,22]. While participating in the telerehabilitation program, the participants did not receive any other outpatient physiotherapy.

Table 1. Demographic characteristics of the respondents.

	Age (Years) Mean (SD) Median (Range)	Disease Duration (Years) Mean (SD) Median (Range)	Neurological Disability (EDSS Scale) Mean (SD) Median (Range)
All respondents (<i>n</i> = 82)	47.2 (SD 11.1) 46 (min 1–max 73)	12.5 (SD 9.5) 10 (min 1–max 50)	3.4 (SD 1.6) 3.25 (min 0–max 8)
Younger < 50 years (<i>n</i> = 49)	39.8 (SD 6.6) 40 (min 21–max 50)	9.5 (SD 7.5) 6 (min 1–max 29)	2.9 (SD 1.6) 2.5 (min 0–max 8)
Older ≥ 50 years (<i>n</i> = 33)	58.2 (SD 6.2) 58 (min 51–max 73)	17 (SD 10.3) 16 (min 3–max 50)	4.2 (SD 1.4) 4 (min 1.5–max 6.5)
Mild disability (EDSS ≤ 3) (<i>n</i> = 41)	42.3 (SD 10.4) 42 (min 21–max 69)	8 (SD 7.1) 5 (min 1–max 35)	2 (SD 0.6) 2 (min 0–max 3)
Moderate and severe disability (EDSS ≥ 3.5) (<i>n</i> = 41)	52.1 (SD 9.5) 51 (min 36–max 73)	17 (SD 9.3) 18 (min 4–max 50)	4.8 (SD 1.2) 4.5 (min 3.5–max 8)

EDSS—Extended Disability Status Scale.

3.2. Previous Experience with Online-Led Exercise

Of all respondents, 51% reported prior experience with online exercise videos (most commonly unsupervised, random videos found on YouTube not specifically intended for MS patients). Some participants, however, had no previous experience and were initially very sceptical about the concept of telerehabilitation. For example: one patient asked incredulously during the initial examination: “How can you help me remotely? I could understand teleconsultation on managing finances, but with pain? I can't do that!”. No statistically significant difference in previous experience was found between younger and older respondents ($p = 0.557$), nor between those with lower and higher levels of disability ($p = 0.885$).

3.3. Technology Used

Most participants used a laptop to watch exercise videos and communicate with their therapist ($n = 40$, 49%). They particularly appreciated being able to better position or tilt the screen for better visibility of the exercise. The second most common used device was a smartphone ($n = 27$, 32%), followed by a desktop computer ($n = 8$, 10%), and a tablet ($n = 4$, 4%). There were no significant differences in device preference by age ($p = 0.957$) or level of disability ($p = 0.511$).

Regarding communication platforms, respondents most often preferred using MS Teams ($n = 18$, 22%), Zoom ($n = 22$, 26%) and WhatsApp ($n = 14$, 17%). Preference for communication platform did not differ based on age ($p = 0.305$) and disability level ($p = 0.177$).

The vast majority of respondents reported no technical difficulties in remote communication with the therapist (70%). Among those who did experience problems, most were able to resolve them based on the advice from the remote therapist or with the help of family members, often during the initial setup. When comparing by age ($p = 0.734$) and level of neurological disability ($p = 0.114$), no significant differences were found in the incidence of technical difficulties (for details see Table 2).

Table 2. Preferred technology.

Preferred Technology for Communication	Device Used for Telerehabilitation
Zoom ($n = 22$)	Notebook ($n = 40$)
MS Teams ($n = 18$)	Mobile phone ($n = 27$)
WhatsApp ($n = 14$)	PC ($n = 8$)
Facebook and YouTube ($n = 12$)	PC connected to TV ($n = 4$)
Google Meet ($n = 6$)	Tablet ($n = 3$)
Skype ($n = 2$)	
No preference ($n = 6$)	

3.4. Perceived Benefits

Most participants rated the experience with telerehabilitation very positively, with a score of 1.5 (on a 1–5 Likert scale, where 1 represented the best and 5 the worst experience). The most frequently mentioned benefits were the elimination of commuting to rehabilitation centre and the flexibility of scheduling sessions.

Those with lower and higher levels of disability differed significantly in perceived benefits ($p < 0.000$). Participants with lower levels of disability particularly emphasized the time savings in commuting. In contrast, those with more severe disabilities (e.g., due to muscle weakness, spasticity, fatigue, etc.) also emphasized avoiding travel but mostly for reasons of conserving energy. Several mentioned that they could exercise more intensively because they did not have to save energy for the return journey home. A significant difference was also found between younger and older participants ($p = 0.015$). Younger participants particularly valued time savings, while older participants perceived telerehabilitation as less physically demanding (for details see Table 3).

Table 3. Perceived benefits and disadvantages.

	Perceived Benefits
All respondents ($n = 82$)	Time saving ($n = 42$) Less fatigue ($n = 18$) Time flexibility ($n = 12$) Higher motivation ($n = 10$)

Table 3. *Cont.*

	Perceived Benefits
Younger respondents < 50 years (<i>n</i> = 49)	Time saving (<i>n</i> = 32) Less fatigue (<i>n</i> = 7) Higher motivation (<i>n</i> = 6) Time flexibility (<i>n</i> = 4)
Older respondents ≥ 50 years (<i>n</i> = 33)	Less fatigue (<i>n</i> = 12) Time saving (<i>n</i> = 10) Time flexibility (<i>n</i> = 7) Higher motivation (<i>n</i> = 4)
People with lower neurological disability (EDSS ≤ 3) (<i>n</i> = 41)	Time saving (<i>n</i> = 27) Time flexibility (<i>n</i> = 7) Higher motivation (<i>n</i> = 5) Less fatigue (<i>n</i> = 2)
People with higher neurological disability (EDSS ≥ 3.5) (<i>n</i> = 41)	Less fatigue (<i>n</i> = 19) Time saving (<i>n</i> = 15) Time flexibility (<i>n</i> = 4) Higher motivation (<i>n</i> = 3)
	Perceived disadvantages
All respondents (<i>n</i> = 82)	Lack of therapist (<i>n</i> = 37) No disadvantages (<i>n</i> = 18) Lack of social contacts (<i>n</i> = 11) Lower motivation (<i>n</i> = 10) Lack of technical equipment (<i>n</i> = 6)
Younger respondents < 50 years (<i>n</i> = 49)	Lack of therapist (<i>n</i> = 25) No perceived disadvantage (<i>n</i> = 8) Lack of social contacts (<i>n</i> = 6) Lower motivation (<i>n</i> = 6) Lack of technical equipment (<i>n</i> = 4)
Older respondents ≥ 50 years (<i>n</i> = 33)	Lack of therapist (<i>n</i> = 12) No perceived disadvantage (<i>n</i> = 9) Lack of social contacts (<i>n</i> = 5) Lower motivation (<i>n</i> = 4) Lack of technical equipment (<i>n</i> = 2)
People with lower neurological disability (EDSS ≤ 3) (<i>n</i> = 41)	Lack of therapist (<i>n</i> = 21) Lack of social contacts (<i>n</i> = 6) Lower motivation (<i>n</i> = 5) No perceived disadvantage (<i>n</i> = 6) Lack of technical equipment (<i>n</i> = 3)
People with higher neurological disability (EDSS ≥ 3.5) (<i>n</i> = 41)	Lack of therapist (<i>n</i> = 16) No perceived disadvantage (<i>n</i> = 13) Lower motivation (<i>n</i> = 5) Lack of social contacts (<i>n</i> = 4) Lack of technical equipment (<i>n</i> = 3)

3.5. Perceived Limitation and Disadvantages

Respondents did not differ in perceived disadvantages by age ($p = 0.677$) or by disability level ($p = 0.283$). All participants identified the lack of direct personal contact with a therapist as the main limitation. This is especially because it allows manual correction of body position and direct guidance during movement. They also noted a lack of personal human interaction and of small talk with the therapist (for details see Table 4).

Table 4. Perceived absence of therapist.

	Perceived Absence
All respondents (<i>n</i> = 74)	Manual correction (<i>n</i> = 36) Touch (<i>n</i> = 17) Personal contact (<i>n</i> = 14) Inability to see everything (<i>n</i> = 5) Therapist knowledge (<i>n</i> = 2)
Younger respondents < 50 years (<i>n</i> = 43)	Manual correction (<i>n</i> = 19) Personal contact (<i>n</i> = 11) Touch (<i>n</i> = 8) Inability to see everything (<i>n</i> = 3) Therapist knowledge (<i>n</i> = 2)
Older respondents ≥ 50 years (<i>n</i> = 31)	Manual correction (<i>n</i> = 17) Touch (<i>n</i> = 9) Personal contact (<i>n</i> = 3) Inability to see everything (<i>n</i> = 2) Therapist knowledge (<i>n</i> = 0)
People with lower neurological disability (EDSS ≤ 3) (<i>n</i> = 41)	Manual correction (<i>n</i> = 19) Personal contact (<i>n</i> = 9) Touch (<i>n</i> = 8) Inability to see everything (<i>n</i> = 3) Therapist knowledge (<i>n</i> = 2)
People with higher neurological disability (EDSS ≥ 3.5) (<i>n</i> = 33)	Manual correction (<i>n</i> = 17) Touch (<i>n</i> = 9) Personal contact (<i>n</i> = 5) Inability to see everything (<i>n</i> = 2) Therapist knowledge (<i>n</i> = 0)

3.6. Perceived Effect of Telerehabilitation

The positive finding is that 42% of respondents consider telerehabilitation to be comparable to outpatient rehabilitation. A total of 39% of respondents evaluate in-person outpatient rehabilitation physiotherapy as more effective and 7% of respondents rate telerehabilitation as more effective. When comparing the subjective perceived effectiveness of conventional therapy and telerehabilitation, no difference by age ($p = 0.522$) or disability ($p = 0.777$) was found.

3.7. Further Interest in Telerehabilitation

A total of 69 respondents (84%) expressed interest in further therapy in the form of telerehabilitation. Many indicated a preference in exercising the pelvic floor muscles, back muscles, stretching, strengthening, or relaxation. Several respondents said that they would appreciate a hybrid format—that is, telerehabilitation intervention combined with an occasional personal visit to a physiotherapist. A few ($n = 3$) also mentioned that, due to fatigue, they would be more comfortable with shorter therapy (less than 30 min). In terms of interest in future telerehabilitation therapy, respondents did not differ by age ($p = 0.933$) or by disability level ($p = 0.779$).

4. Discussion

Our study provides new insights into patients' perspectives on the practical application of telerehabilitation in clinical practice for individuals with multiple sclerosis in a middle European setting. A key finding is the consistent positive ratings of telerehabilitation by both younger relapsing remitting participants and also older patients in secondary

progressive MS, regardless of their level of neurological disability. This contrasts with a recent survey conducted in Turkey, where age was associated with perceived benefits of telerehabilitation [24]. In our sample we found no such association. We also found no significant difference in the level of satisfaction with telerehabilitation among people with more severe levels of neurological disability. However, the difference may also be due to the use of different questionnaires.

Our results align with an Australian qualitative study, which reported that older adults found telerehabilitation quite well accepted and convenient, especially when they had prior experience in using communication technologies [25]. Consistent with studies from Anglo-Saxon countries, most participants preferred direct synchronous telerehabilitation with video call or at least regular telephone contact. They primarily used laptops or personal computers with a webcam for these sessions [26].

The main benefit perceived by patients was the reduced need to commute to therapy sessions. The reasons why people with MS perceived this as a major benefit varied according to the level of neurological impairment. Participants with lower levels of disability highlighted time savings as a valued benefit with, several noting that they appreciated being able to fit exercise sessions into their lunch break. Younger participants appreciated not only the time savings but also the time flexibility. In contrast, individuals with more severe disability, who already have impaired walking ability, appreciated the energy saving by avoiding travel. Exercising at home allowed some to exercise more intensively as they “did not have to save energy for the journey home”. This finding is also consistent with the results of other studies [25].

In a previous study, low technical literacy, cognitive impairment, poor balance or the presence of pain were identified as barriers to participation in telerehabilitation for people with MS [27]. However, evidence from various studies shows that, with appropriate exercise selection and careful choice of exercise positions to ensure safety, balanced training can be successfully performed by people with MS [11,12]. A recent systematic review confirms the positive effects of various forms of tele-exercise in the alleviation of fatigue and depression and the improvement of quality of life, particularly its psychological aspects [28].

Participants in our telerehabilitation programs identified the main limitation as the lack of direct personal contact with the therapist and especially the absence of manual contact. Other authors have also confirmed these findings [29,30]. Similarly, a study evaluating the use of telerehabilitation among US physical and occupational therapists cited the lack of manual contact as an important barrier—both during patient examination (especially in muscle tone and sensitivity assessment) and during therapy (providing manual guidance for exercises in persons with greater disability) [31]. The absence of manual guidance of movement may also limit therapy for people with cognitive deficits [27]. The lack of face-to-face contact likely explains why patients in other studies prefer synchronous forms of telerehabilitation (i.e., real-time communication between patient and therapist) [30]. Other barriers to the implementation of telerehabilitation include insufficient technical equipment (either on the patient’s side or at the healthcare facility), and the lack of a quiet space for providing therapy [32]. A rather surprising and comforting finding was that only a few patients in our study reported technical difficulties during telerehabilitation. Most issues occurred only during the initial connection and setup. In the vast majority of cases, these were resolved with the advice of a therapist or the help of a family member (often the patient’s children. This contrasts with previous studies, which have identified technical difficulties as a common barrier to the implementation of telerehabilitation [27,33]).

In our survey, 42% of participants rated the telerehabilitation program as effective, being comparable to conventional physiotherapy. Similarly, studies evaluating the per-

ception of telerehabilitation in other different countries, such as Australia [25], United States [30], Kuwait [34] and Brazil [29], have reported positive patient evaluations. Our facility does not use any specialized software for telerehabilitation; instead, we relied on common communication platforms for online sessions. Microsoft Teams and Zoom were the participants' most preferred platforms. This is probably due to the fact that up to 45 min can be used for free. Their popularity is also probably linked to experience during the COVID-19 pandemic, when these platforms were widely used in the Czech Republic for online school lessons and other work communications. We consider the most interesting findings to be the comparison of what respondents missed most about personal contact with a physiotherapist (if anything). They most frequently mentioned the lack of manual correction during exercises or the absence of a pleasant human touch. Less frequently, they mentioned the therapist's professional expertise or the limited ability to clearly see how the exercise was being performed during online sessions. We find it interesting that there was no difference in this regard between groups with lower and higher levels of neurological disability, nor by age. These findings may be useful for future planning of telerehabilitation interventions. Previous studies have reported that after completing a telerehabilitation program, participants perceived an improvement in physical function and positive effects on psychosocial health [35]. Systematic reviews have also found that various telerehabilitation interventions for people with MS can improve certain symptoms as effectively as conventional therapy [9,36]. Consistent with findings from international questionnaire surveys of people with MS, our feedback suggests that the hybrid model (i.e., partly face-to-face and partly telerehabilitation option) is the preferred approach [37]. Overall, telerehabilitation appears to be well received and in high demand among people with MS. This contrasts with experiences of telemonitoring, which can also be followed by people with MS in the long term. However, some patients perceive telemonitoring as an unwelcome obligation for medical oversight of their condition, which they do for the sake of medical research rather than as an intervention that clearly benefits their condition [38,39].

However, provision of telerehabilitation care requires not only technical skills but also a range of other competencies and skills from rehabilitation professionals. First, therapists must carefully consider patient's medical conditions, which may limit their ability to perform exercises without manual in-person guidance. Furthermore, therapists should have a knowledge of privacy regulations (especially with regard to group forms of therapy) and possess sufficient technical skills to assist patients with any IT-related difficulties.

In addition, creativity and good communication skills are also very important, as establishing effective communication and building a therapeutic relationship is more difficult when providing services remotely [40]. These skills are just as important for therapeutic success as in face-to-face therapy—perhaps even more so, as therapists must rely heavily on verbal communication online, given that they cannot use nonverbal cues or rely on close observation of patient's facial expressions [41].

Trust between patient and therapist is also very crucial, in the sense, for example, that a patient's recordings of their exercises should not be shared online, something which can be a problem not only for people with limited IT literacy [33]. A potential factor that may also make communication and interaction between therapist and patient more difficult may be the lack of contextual cues [30].

In addition to limited technical equipment, the main obstacle to the broader adoption of telerehabilitation is the lack of established institutional support and established mechanism for health insurance reimbursement, both factors that therapists often cite as significant obstacles [42]. We believe that this feedback can help in planning future telerehabilitation programs.

5. Limitations

This study has several limitations. First, participants in our study did not follow a single standardized rehabilitation protocol. However, all participants performed active exercises for at least 30 min twice a week, either under the direct supervision of a physical therapist or by following recorded videos if they were unable to attend a live online exercise session. They also had weekly personal contact with the therapist via phone or online. Slight differences in rehabilitation protocols may have influenced their perceived benefits and satisfaction. However, all telerehabilitation sessions used common, commercially available communication tools and patients' own technical equipment, which should have minimized these differences. Participants were also offered telerehabilitation in addition to usual in-person care and always had the option to choose a classic face-to-face alternative, so no one was forced to use the remote option.

Furthermore, no sensitive health information was transmitted during telerehabilitation sessions. Prior to each telerehabilitation session, there was at least one initial face-to-face meeting with their therapist, to conduct the necessary baseline examinations and obtain all the necessary personal information from the patient. During subsequent telerehabilitation sessions no data transfer took place apart from the usual conversation and exercise instructions. Thus, we considered the risk of information leakage to be minimized. Nevertheless, we recognize that the use of ordinary non-medical communication platforms is not ideal. In the future, communication via special dedicated medical software would be more appropriate. A possible alternative could be the loan of a communication device to the patient by the healthcare facility.

Another limitation is that no previously published questionnaire was used to assess participants' experiences, making it difficult to compare our results with previous other studies. We chose instead to use a semi-structured interview to better capture the original experience of the participants. A further limitation is that only patients who successfully completed the telerehabilitation program were invited to provide feedback. This may have introduced bias as we did not capture the views of those who were not satisfied with the telerehabilitation program and did not complete it.

Although these findings are based on experience from a single institution, we believe they offer new and interesting insights into the patients' experiences that can help in better planning future telerehabilitation programs.

6. Conclusions

Individuals with multiple sclerosis (MS), with varying degrees of neurological disability and across different ages, generally evaluated the telerehabilitation experience positively. While the specific perceived benefits varied among patients (some appreciate time saving, others time flexibility). Very few participants had minor technical difficulties. A commonly mentioned limitation was the absence of direct personal and hands-on contact with the therapist. Despite this, most participants expressed interest in continuing telerehabilitation either as a standalone option or in combination with traditional in-person physiotherapy. This feedback could help in planning future telerehabilitation programs.

Supplementary Materials: The following supporting information can be downloaded at <https://www.mdpi.com/article/10.3390/sclerosis4030016/s1>, Supplementary File S1: Evaluation of the telerehabilitation experience.

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Informed Consent Statement: Informed consent was obtained from patients before the study began.

Data Availability Statement: Data are available upon request from the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

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