Supporting Information

Supplementary results

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Dawson R, Pinheiro M, Oliveira J, et al. The Telephysiotherapy for Older People (TOP-UP) program for improving mobility in people receiving aged care: a hybrid type 1 effectiveness–implementation randomised controlled trial. *Med J Aust* 2025; doi: 10.5694/mja2.70004.

Supplementary results

Table 1. Individual component ordinal scores for the Short Performance Physical Battery Test, 0-4

Outcome	Control		Intervention	
	Baseline	6 months	Baseline	6 months
Number of participants	122	100	120	92
Sit to stand				
0	52 (43%)	49 (49%)	65 (65%)	33 (36%)
1	31 (25%)	20 (20%)	22 (22%)	25 (27%)
2	21 (17%)	10 (10%)	19 (19%)	9 (10%)
3	10 (8%)	14 (14%)	8 (8%)	11 (12%)
4	8 (7%)	7 (7%)	6 (6%)	14 (15%)
Balance				
0	10 (8%)	49 (49%)	12 (10%)	33 (36%)
1	20 (16%)	20 (20%)	38 (32%)	25 (27%)
2	33 (27%)	10 (10%)	34 (28%)	9 (10%)
3	25 (21%)	14 (14%)	14 (12%)	11 (12%)
4	34 (28%)	7 (7%)	22 (18%)	14 (15%)
Gait				
0	2 (2%)	3 (3%)	0 (0%)	1 (1%)
1	28 (23%)	24 (24%)	43 (36%)	18 (20%)
2	48 (39%)	23 (23%)	46 (38%)	17 (18%)
3	26 (21%)	20 (20%)	12 (10%)	15 (16%)
4	18 (15%)	30 (30%)	19 (16%)	41 (45%)

Table 2. Individual component ordinal scores for the mobility Goal Attainment Scale at six months follow up

Outcome	Control	Intervention
Number of participants	100	92
Level of mobility goal achieved		
-2: much less than expected	85 (85%)	17 (18%)
-1: somewhat less than expected	8 (8%)	27 (29%)
0: achieved the expected level	4 (4%)	20 (22%)
+1: somewhat more than expected	3 (3%)	12 (13%)
+2: much more than expected	0	16 (18%)

CONSORT 2025 Checklist for Reporting the TOP-UP Trial

Note: The page numbers in this checklist refer to the submitted manuscript, not to the published article or its Supporting Information file

	Section/topic	No	CONSORT 2025 checklist item description	Reported on page no.
	Title and abstract			
	Title and structured abstract	1a	Identification as a randomised trial	3
		1b	Structured summary of the trial design, methods, results, and conclusions	13
	Open science			
	Trial registration	2	Name of trial registry, identifying number (with URL) and date of registration	4
	Protocol and statistical analysis plan	3	Where the trial protocol and statistical analysis plan can be accessed	6
	Data sharing	4	Where and how the individual de-identified participant data (including data dictionary), statistical code and any other materials can be accessed	9
	Funding and conflicts of interest	5a	Sources of funding and other support (eg, supply of drugs), and role of funders in the design, conduct, analysis and reporting of the trial	9
		5b	Financial and other conflicts of interest of the manuscript authors	9
	Introduction			
	Background and rationale	6	Scientific background and rationale	4, 5
	Objectives	7	Specific objectives related to benefits and harms	4
	Methods			
	Patient and public involvement	8	Details of patient or public involvement in the design, conduct and reporting of the trial	4
	Trial design	9	Description of trial design including type of trial (eg, parallel group, crossover), allocation ratio, and framework (eg, superiority, equivalence, non-inferiority, exploratory)	4
	Changes to trial protocol	10	Important changes to the trial after it commenced including any outcomes or analyses that were not prespecified, with reason	NA
	Trial setting	11	Settings (eg, community, hospital) and locations (eg, countries, sites) where the trial was conducted	4
	Eligibility criteria	12a	Eligibility criteria for participants	4,5
		12b	If applicable, eligibility criteria for sites and for individuals delivering the interventions (eg, surgeons, physiotherapists)	5
	Intervention and comparator	13	Intervention and comparator with sufficient details to allow replication. If relevant, where additional materials describing the intervention and comparator (eg, intervention manual) can be accessed	5
	Outcomes	14	Prespecified primary and secondary outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome	5,6
	Harms	15	How harms were defined and assessed (eg, systematically, non-systematically)	6
	Sample size	16a	How sample size was determined, including all assumptions supporting the sample size calculation	6
		16b	Explanation of any interim analyses and stopping guidelines	6
	Randomisation:			
	Sequence generation	17a	Who generated the random allocation sequence and the method used	5
		17b	Type of randomisation and details of any restriction (eg, stratification, blocking and block size)	5
	Allocation concealment mechanism	18	Mechanism used to implement the random allocation sequence (eg, central computer/telephone; sequentially numbered, opaque, sealed containers), describing any steps to conceal the sequence until interventions were assigned	5

	Implementation	19	Whether the personnel who enrolled and those who assigned participants to the interventions had access to the random allocation sequence	5
	Blinding	20a	Who was blinded after assignment to interventions (eg, participants, care providers, outcome assessors, data analysts)	5
		20b	If blinded, how blinding was achieved and description of the similarity of interventions	5
	Statistical methods	21a	Statistical methods used to compare groups for primary and secondary outcomes, including harms	6
		21b	Definition of who is included in each analysis (eg, all randomised participants), and in which group	6
		21c	How missing data were handled in the analysis	6
		21d	Methods for any additional analyses (eg, subgroup and sensitivity analyses), distinguishing prespecified from post hoc	6
	Results			
	Participant flow, including flow diagram	22a	For each group, the numbers of participants who were randomly assigned, received intended intervention, and were analysed for the primary outcome	7, 12
		22b	For each group, losses and exclusions after randomisation, together with reasons	7, 12
	Recruitment	23a	Dates defining the periods of recruitment and follow-up for outcomes of benefits and harms	4
		23b	If relevant, why the trial ended or was stopped	NA
	Intervention and comparator delivery	24a	Intervention and comparator as they were actually administered (eg, where appropriate, who delivered the intervention/comparator, how participants adhered, whether they were delivered as intended (fidelity))	5, 7
		24b	Concomitant care received during the trial for each group	5
	Baseline data	25	A table showing baseline demographic and clinical characteristics for each group	13
	Numbers analysed, outcomes and estimation	26	For each primary and secondary outcome, by group: ● the number of participants included in the analysis ● the number of participants with available data at the outcome time point ● result for each group, and the estimated effect size and its precision (such as 95% confidence interval) ● for binary outcomes, presentation of both absolute and relative effect size	12, 14,15
	Harms	27	All harms or unintended events in each group	77
	Ancillary analyses	28	Any other analyses performed, including subgroup and sensitivity analyses, distinguishing pre-specified from post hoc	8,16
	Discussion			
	Interpretation	29	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	8, 9
	Limitations	30	Trial limitations, addressing sources of potential bias, imprecision, generalisability, and, if relevant, multiplicity of analyses	9

Citation: Hopewell S, Chan AW, Collins GS, Hróbjartsson A, Moher D, Schulz KF, et al. CONSORT 2025 Statement: updated guideline for reporting randomised trials. BMJ. 2025; 388:e081123. https://dx.doi.org/10.1136/bmj-2024-081123

*We strongly recommend reading this statement in conjunction with the CONSORT 2025 Explanation and Elaboration and/or the CONSORT 2025 Expanded Checklist for important clarifications on all the items. We also recommend reading relevant CONSORT extensions. See www.consort-spirit.org.

Intervention description using the template for intervention description and replication (TIDieR) checklist

1.Brief Name	Telehealth physiotherapy-led exercise (TOP UP) Study to improve mobility in older people receiving aged care services.
2.Why	Older people receiving aged care services have a high prevalence of mobility disability and a high rate of falls. Physiotherapy-led exercise programs that increase leg strength and challenge balance are proven to improve mobility and reduce falls. Telehealth is emerging as an effective method to deliver physiotherapy to improve access in regional areas and during COVID-19.
3.What materials	Participants allocated to the TOP UP exercise program will be provided with a mobile tablet with internet connectivity to access Zoom, online exercise videos and the StandingTall app. Participants will receive a booklet comprising descriptions of their home exercise program based on the Otago exercise program, an exercise and falls calendar, ankle weights (one and two kg), details on how to access and connect to the online exercise programs, and balance support such as a sturdy dining chair, kitchen bench, parallel bars or wall bar.
4.What procedures	TOP UP physiotherapists will deliver balance and strength exercise prescription advice and health coaching using telehealth. Participants will be supported to access zoom to videoconference with a physiotherapist and aim to exercise for two hours per week supported by TOP UP Coaches (trained care staff of the participant's aged care service provider). The research team will provide the physiotherapists and TOP UP Coaches with a two-hour training session on the study protocol at the beginning of the study.
5.Who provides	The intervention will be conducted by either the research team's physiotherapists or other registered physiotherapists employed by the study's aged care partners. All physiotherapists will have 3 years+ experience in working in aged care supervising care staff. TOP UP Coaches will be selected by the aged care service providers from their interested pool of care workers.
6.How	TOP UP Coaches will support the participant to gain access to the technology for the Zoom physiotherapy sessions, lead group exercise classes in residential aged care, and supervise weekly the individual exercise programs using the participant exercise booklet, online exercise videos, and app. Participants allocated to the wait-list control group will receive a similar three-month intervention once the trial is completed.
7.Where	The TOP UP Study will be delivered in the participant's home or in the residential aged care facility where they live. Participants will be recruited from aged care service providers that deliver residential and home care services across metropolitan and regional areas in Australia.
8.When and how much	The six-month intervention will include ten zoom sessions where the physiotherapists will devise moderate-intensity exercise program and use health coaching principles to encourage participants to exercise for two hours per week. The participants can follow their exercise program via exercise sheets in the participant booklet, follow 20–30-minute exercise videos on the TOP UP website, attend group exercise programs, or follow the StandingTall app. The program will focus on standing balance and strength exercises. Participants will be provided with 30 min of supervised exercise with their TOP UP Coach each week to support the program dose and safety.
9.Tailoring	The exercise program will be tailored to the individual's capabilities and comorbidities by a physiotherapist at assessment and subsequent assessment. The physiotherapist will introduce supervised and unsupervised exercise and introduce online exercise resources that challenge balance and lower limb strength when appropriate.

Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ 2014; 348: g1687.

Consensus on Exercise Reporting Template (CERT) for the TOP-UP trial

Item No.	Category	Item Description	TOP-UP trial
1	WHAT: materials	Type of exercise equipment	Participants used ankle weights (1–2 kg), chairs, and tablet devices to access exercise videos and online tools.
2	WHO: provider	Qualifications, teaching/supervising expertise, and/or training of the exercise instructor	Physiotherapists had 3+ years of aged care experience and received 2-hour protocol training from the research team.
3	HOW: delivery	Whether exercises are performed individually or in a group	Exercises were performed individually (in homes and in residential aged care).
4	HOW: delivery	Whether exercises are supervised or unsupervised	Exercises were supervised by trained support workers in-person with unsupervised prescribed by physiotherapists.
5	HOW: delivery	Measurement and reporting of adherence to exercise	Adherence was tracked via diaries and calendar logs completed by participants and support workers.
6	HOW: delivery	Details of motivation strategies	Motivational strategies included health coaching, goal setting, and use of the COM-B model.
7	HOW: delivery	Decision rules for progressing the exercise program	Physiotherapists reviewed participants every 2–3 weeks to progress the exercise program, using clinical assessments of strength, balance, mobility, pain, exercise tolerance, and confidence to ensure exercises were performed at a moderate intensity.
8	HOW: delivery	Each exercise is described so that it can be replicated (e.g., illustrations, photographs)	Exercises described in detail in booklets and videos (TOP-UP website-based routineshttps://www.top-up.net.au/).
9	HOW: delivery	Content of any home program component	Participants were supported to complete exercises at home using printed materials and online resources.
10	HOW: delivery	Non-exercise components	Physiotherapists delivered non-exercise components, including behavioural support, motivational interviewing, and education on exercise safety.
11	HOW: delivery	How adverse events that occur during exercise are documented and managed	Falls, pain, and adverse events were monitored via diaries, care staff reports, and audit of health records.
12	WHERE: location	Setting in which exercises are performed	Exercises conducted in-home or at aged care facilities depending on participant location.
13	WHEN, HOW MUCH: dosage	Detailed description of the exercises (e.g., sets, repetitions, duration, intensity)	Two hours per week of seated and standing strength and balance exercises based on the Otago Exercise Program were prescribed (e.g. 2–3 sets of 10 repetitions), performed at moderate intensity as defined by a Borg Scale rating of 12–14.

14	TAILORING: what, how	Whether exercises are generic or tailored to the individual	The program was tailored to physical and cognitive capacity using Otago-based progression and input from support workers.
15	TAILORING: what, how	Decision rule that determines the starting level for exercise	Starting level determined by initial assessment of strength, standing balance, gait speed, self-report exercise tolerance mobility, cognition, and readiness.
16	HOW WELL: planned, actual	Whether the exercise intervention is delivered and performed as planned	Fidelity monitored via diary audits, support worker logs, physiotherapist notes, and exercise session tracking.

Adapted from Slade SC, Dionne CE, Underwood M, et al. Consensus on exercise reporting template (CERT): modified Delphi study. Phys Ther 2016; 96: 1514-1524.CERT is a 16-item checklist designed to improve the reporting of exercise interventions. The following table summarises the items according to their category.