Appendix 1: Overview of recruitment of patients and project flow (short)

**Recruitment of patients**

- Gentofte Hospital: $n=10$
- Frederiksberg Hospital: $n=10$

**Project flow**

- **Procedure**
  - Hospital Ambulatory rehab, $n=10$
  - Virtual rehab, $n=10$

- **Progress**
  - Test from base line
  - Follow-up after 8 weeks, 3 months, and 6 months

- **Effect**
  - $x + y < 1 = x' + y'$
Appendix 2.2: Overview of project flow (extended)
Appendix 2.3: Overview of project flow (extended)
Appendix 2.4: Overview of project flow (extended)

**5 months**

**Objective Test:**
- FVC (FVC6)
- FVE1
- Oxygen saturation
- resting Puls
- BMI
- BP%
- MM%, FFMI
- Up&Go test
- ISWT
- ESST
- 6min Walk
- R-S-S-T standard

**Subjective test:**
- CSER
- IADL
- EuroQol
- SGRQ
- HADS

**Test**

---

**8 months**

**Objective Test:**
- FVC (FVC6)
- FVE1
- Oxygen saturation
- resting Puls
- BMI
- BP%
- MM%, FFMI
- Up&Go test
- ISWT
- ESST
- 6min Walk
- R-S-S-T standard

**Subjective test:**
- CSER
- IADL
- EuroQol
- SGRQ
- HADS

**Test**

---
Appendix 3: Overview of data collection I & II

Overview of data collection I

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Measuring Instruments</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing exercises improves the dilatation of the bronchi increasing the VC (vital capacity) during expiratory maneuvers and in this case decreasing the FVC.</td>
<td><em>FVC (FVC6)</em> Forced Vital Capacity -</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Bronchopulmonary hygiene techniques and bronchiectasis clean the mucosa obstructing the bronchi increasing the VC (vital capacity during expiratory maneuvers) and in this case decreasing the FVC.</td>
<td><em>FVC1/FVC or Index</em>,</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Breathing exercises improves the dilatation of the bronchi increasing the FVC (forced vital capacity) during expiratory maneuvers and in this case increasing FVC and the Index.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchopulmonary hygiene techniques and bronchiectasis clean the mucosa obstructing the bronchi increasing the FVC (forced vital capacity) during expiratory maneuvers and in this case increasing FVC and the Index.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Aerobic and strength training improves (decreases) recovery time O2-saturation&quot;. Saturation of O2 during the training decreases but the recovery time from such saturation after aerobic training to patient’s normal saturation values decreases as well if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training. &quot;Breath technical training improves (increases) rest O2-saturation&quot;</td>
<td>Oxygen saturation</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>&quot;Aerobic and strength training improves (decreases) Heart Rate recovery- and rest time&quot;. HR increases during the training but the recovery time from HR after aerobic training to patient's normal HR decreases as well if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training. The same happens with the resting HR it becomes lower than usual. &quot;Breath technical training improves (decreases) HR rest time&quot;</td>
<td>PULS Monitors the hearth rate /minute</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic training for patients that are at least overweight decreases their BMI if the patient is involved in an intensive physical rehabilitation period with aerobic training.</td>
<td>BMI Body Mass Index</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients that are at least overweight decreases their BF% if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>BF% Body Fat Percentage</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Strength training for COPD individuals increases their MM% if the patient is involved in an intensive physical rehabilitation period with strength training.</td>
<td>MM% Muscle Mass %</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Strength training for COPD individuals increases their FFM and decreases mortality (in subjects with normal BMI) if the patient is involved in an intensive physical rehabilitation period with strength training. The FFM will be higher after the training period.</td>
<td>Fat Free Mass Index (FFMI)</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients decreases their time to perform the test if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>Up&amp; Go test</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients increases their walk endurance if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>Incremental shuttle walk test (ISWT)</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients increases their walk endurance if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>Endurance shuttle walk test (ISWT)</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients increases their walk distance if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>6min Walk</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Aerobic and strength training for patients increases the nr of repetitions if the patient is involved in an intensive physical rehabilitation period with aerobic and strength training.</td>
<td>R S S T standard, times / 30 sec</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
</tbody>
</table>

Overview of data collection II

<table>
<thead>
<tr>
<th>The other Hypotheses</th>
<th>Measuring Instruments</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-efficacy, activities of daily living and health-related quality of life are better after virtual rehabilitation compared with conventional rehabilitation</td>
<td>COPD Self Efficacy Scale (CSES) Instrumental Activity of Daily Living (IADL) EuroQol, Saint George Respiratory Questionnaire (SGRQ)</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
<tr>
<td>Less prevalence of anxiety and depression by virtual hospitalization compared with conventional hospitalization</td>
<td>Hospital Anxiety and Depression Scale (HADS)</td>
<td>from base line, 8 weeks, 5 and 8 months</td>
</tr>
</tbody>
</table>
Appendix 4: Conventional Rehab Program

The program lasts for 8 weeks with 2 sessions of approx. 2 hours per week. Associated with various activities for the program both before and after, as outlined below:

1- Selection of patients
COPD patients stage 4 (gold standards (35)).

2- Initial assessment
Prior to embarking on a rehabilitation program for a COPD patient, conducted a survey of symptoms and physical and mental functional status. The presence of complicating diseases to be mapped. You must describe how COPD develops in the patient, and how the disease affects social functions, which need help in everyday life should be described. The aim should be to identify the impact disease has on the individual patient in order to assess the need for assistive devices and help in specific situations. It should also clarify how much knowledge the patient has of his illness and the extent to which the patient is characterized by anxiety and depression.

Each patient has a journal where the lung specialist can follow up the process of rehabilitation where the results of the test performed will be collected as:

a. height; b. weight; c. lung function; d. medication; e. resting status; b. MRC dyspnea questionnaire; g. Borg dyspnea index; h. The SGRQ questionnaire
(above measurements performed by a nurse)

Then the patient will get tested his physical abilities based on 3 timed tests the patient must perform:

a. a walk test with increasing speed (sample test - incremental shuttle walking test (incrSWT))

b. a walk test with increasing speed (real test - incrSWT)

c. a walk test at the same time speed = endurance test (endurance shuttle walking test (endSWT))

From these tests one can calculate the patient's fitness and find the training level the patient must use as the basis for the daily training in the rehabilitation program.

Walk Test performed by physiotherapists.

3- Rehabilitation Program
The program consists of a total of 16 sessions with 2 sessions (2h. each) every week of an 8 week program.

The selected program may be considered a prototype of a rehabilitation program consisting of well-documented, evidence-based elements. Individualization of elements at patient level will be necessary, which is quite common and legal in the rehabilitation context and necessary to adapt dialogue, education and training for the individual patient.

Teams may not be too large, and a number of 8 patients seem appropriate. Initially start the group with 10 patients per team since experience shows that one can expect a drop in individual sessions (illness, hospitalization, etc...)

At each of the 16 sessions, the physical training will be a recurring element. Patients should be here learning and practicing the right walking speed and learn to handle their breathlessness in connection with the physical exertion.

There are 2 persons present at these sessions (physiotherapist and nurse) which lasts a total of 1 hour. The sessions will include:

a. Warming up in group
b. Individual workout
c. Individual ergo bike training
d. Relaxation

e. ... (continued)

Out of the 16 sessions the program consists on, there are 11 sessions where the group of patients receives teaching in extension from the physical training. The 11 subject areas to learn are:

1. Introduction to rehabilitation and rehabilitation program
2. Disease understanding
3. Smoking and COPD
4. Treatment
5. Nutrition Guide
6. Living with COPD 1 (most of everyday, breathing techniques, dyspnea management, etc.)
7. Living with COPD 2 (anxiety, stress, everyday life, social networks, sexuality, etc...)
8. Occupational therapy / assistive
9. Social Counseling (support, regulatory, patient associations, etc...)
10. Exacerbations (etiology, management and planning)
11. Followup, summary

Teaching is carried out by relevant resource persons including doctors, nurses, physiotherapist, dietician, occupational therapist, social worker, psychologist and possibly a priest.

There are allocated 1 hour for each teaching session.

The patient is encouraged to exercise at home twice a week with a specific home training program during the whole intervention. A diary is handled to the patients in order to register the degree of their home training.

4- End and repetition of the initial assessment
After last self training session the program is completed and a repetition of the initial assessment is performed.

5- Follow up
All patients will be followed up with the initial assessment parameters after 3 and 6 months from the completion of the program.
Appendix 5: **Knowledge base in the DSS**

<table>
<thead>
<tr>
<th>ID</th>
<th>Rules in Song B et al (37) with an ergometer bike</th>
<th>In the proposed study</th>
</tr>
</thead>
</table>
| 1  | If: SO2 < 90%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  |
| 2  | If: SO2 < 80%  
   Then: stop training  
   Then: stop training  
   Then: stop training  
   Then: stop training  |
| 3  | If: HR > maximum HR  
   Then: stop training  
   Then: stop training  
   Then: stop training  
   Then: stop training  |
| 4  | If: HR increase > 5 beats per minute in the last 5 minutes  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  |
| 5  | If: HR > coefficient × maximum HR  
   (coefficient = 72% for A-Intensity, coefficient = 80% for B-Intensity, coefficient = 86% for C-Intensity)  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  |
| 6  | If: systolic BP ≥ 220 mmHg or diastolic BP ≥ 180 mmHg  
   Then: stop training  
   Then: stop training  
   Then: stop training  
   Then: stop training  |
| 7  | If: systolic BP increase > 5 mmHg in the last 3 measurements  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  |
| 8  | If: systolic BP > 180 mmHg  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  
   Then: reduce performance by 15%  |
| 9  | If: HR < 65% of the maximum HR  
   Then: increase performance by 10%  
   Then: increase performance by 10%  
   Then: increase performance by 10%  
   Then: increase performance by 10%  |

**Appendix 6: Flow chart**

- Suitable and consecutively enrolled patients for this study project that meets all inclusion criteria and none of exclusion criteria
- 20 randomized
- **Intervention Group:** Virtual Rehabilitation
- **Control Group:** Conventional Rehabilitation
**Appendix 7.1: Test Methods**

<table>
<thead>
<tr>
<th>Test</th>
<th>Normal Rates</th>
<th>KOL</th>
<th>What tell us such test</th>
</tr>
</thead>
<tbody>
<tr>
<td>(38) FEV1% predicted</td>
<td>&gt;80% of predicted = normal</td>
<td>1-60% to 79% = Mild</td>
<td>It is a marker for the degree of obstruction in the lungs that is calculated based on individuals FEV1. FEV1% predicted is compared to reference material from healthy population.</td>
</tr>
<tr>
<td>(The maximal amount of air you can forcefully exhale in one second compared with healthy population)</td>
<td>2-40% to 59% = Moderate</td>
<td>3-&lt;40% = Severe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-&lt;30% = Very Severe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*FVC (FVC6)*

Forced Vital Capacity - Maximum volume expired after maximum inspiration in 6 seconds. The volume change of the lung between a full inspiration to total lung capacity and a maximal expiration to residual volume. The measurement is performed during forceful exhalation; the preceding maximal inhalation need not be performed forcefully.

The exhalation curve tends to finish quickly. The volume assessed is the forced expiratory vital capacity (FEVC), commonly called forced vital capacity (FVC)

The exhalation curve tends to be endless because the air is obstructed in its way out.

The FVC is useful for detecting restrictive diseases, since lower than expected results may be a sign that the lungs cannot inflate as fully as normal. The FVC may also be reduced in severe obstructive diseases. Maximum volume expired after maximum inspiration. It estimates the total lung capacity.

*FEV1/FVC or Index, is a calculated ratio used in the diagnosis of obstructive and restrictive lung disease (39; 40)*

Normal values are approximately 80% (41; 41) Predicted normal values can be calculated online and depend on age, sex, height, weight and ethnicity as well as the research study that they are based upon.

The diagnosis of COPD is made when the FEV1/FVC ratio is less than 70%. (42)

It represents the proportion of the obstruction.

**Oximetry**

Monitors the oxygen saturation of a patient’s blood arriving in distal tissues. Normal oxygen saturation values are 97% to 99% in the healthy individual

Baseline saturation of 90% or less is a good screening test for exercise desaturation (43)

It is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement

**Puls**

Monitors the heart rate / minute

For an adult, a normal resting heart rate ranges from 50 to 70 beats a minute.

Resting pulse is varies often over 70 beats/min.

It is an indicator of heart work load

**BMI**

Body Mass Index is defined as the individual’s body weight divided by the square of his or her height

Normal from 18.5 to 25 but can have some changes depending on the race.

Underweight from 16.0 to 18.5

Overweight from 25 to 30

Obese Class I from 30 to 35

Obese Class II from 35 to 40

Obese Class III over 40 but can have some changes depending on the race.

The BMI is generally used as a means of correlation between groups related by general mass and can serve as a vague means of estimating adiposity
## Appendix 7.2: Test Methods

<table>
<thead>
<tr>
<th>Test</th>
<th>Normal Rates</th>
<th>KOL</th>
<th>What tells us such test</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM% Muscle Mass %</td>
<td>The average athletic person will be about 60% water. The more muscle you have, the greater your water % (muscle retains water). Assuming 70% water, if you are 10% body fat, that leaves about 20% for OTHER tissues. All lean tissue makes up that 20% as liver, kidneys, brain. 10% muscle mass is a lot for a well trained person.</td>
<td>An study by (44) testing the muscle mass of the tight of COPD individuals measured directly by computerized tomography scan arrives to the conclusion that the muscles of the lower extremity, are particularly affected in patients with COPD.</td>
<td>It is an indicator of the percentage of Muscle mass in the body.</td>
</tr>
<tr>
<td>BF% Body Fat percentage</td>
<td>Essential fat is 3%-5% in men, and 8-12% in women. There are different body fat index depending on the race.</td>
<td>Storage body fats starts over above the essential fats.</td>
<td>It is an indicator of the percentage of body fat in the body.</td>
</tr>
<tr>
<td>Fat Free Mass Index (FFMI)</td>
<td>A fat free mass index of 25 is pretty much an upper limit for someone who does not use steroids. A fat free mass of 19 is the average for males.</td>
<td>16.0 kg/m² for women and 18.7 kg/m² for men</td>
<td>It is an indicator of the percentage of lean body mass.</td>
</tr>
<tr>
<td>Up &amp; Go test (45)</td>
<td>For men in an older between 60-64 the test normally measures 5, 6 to 3, 8 seconds. For woman in same older range the test normally measures 6, 0 – 4, 4 seconds.</td>
<td>Risk zone More than 9 seconds</td>
<td>Assess agility/dynamic balance, which is important in tasks that require quick maneuvering, such as getting off a bus in time or getting up to attend to something in the kitchen, to go to the bathroom or to answer the phone.</td>
</tr>
<tr>
<td>Shuttel Test: Incremental shuttle walk test (ESWT) (46)</td>
<td>It depends on older and activity level</td>
<td>It depends on COPD stage</td>
<td>Assess the maximum working capacity. Typically, on this basis determine the walking speed the patient should use for training.</td>
</tr>
<tr>
<td>Shuttel Test: Endurance shuttle walk test (ESWT) (46)</td>
<td>It depends on older and activity level</td>
<td>It depends on COPD stage</td>
<td>Determines the endurance (walking distance) by sub maximal working capacity.</td>
</tr>
</tbody>
</table>
### Test Methods

<table>
<thead>
<tr>
<th>Test</th>
<th>Normal Rates</th>
<th>KOL</th>
<th>What tell us such test</th>
</tr>
</thead>
</table>
| **6min Walk:(45)**                | For men in an older between 60-64 the test normally measures 610 – 735 yards. For woman in same older range the test normally measures 545 – 660 yards. | Risk zone  
Less than 350 yards for men and women  
assess aerobic endurance, which is important for walking distances, stair climbing, shopping, sightseeing while on vacation, etc. Description  
Number of yards/meters that can be walked in 6 minutes around a 50-yard (45.7 meter) course. (5 yds = 4.57 meters)  
RISK zone  
Less than 350 yards for men and women |  
Description  
Number of yards/meters that can be walked in 6 minutes around a 50-yard (45.7 meter) course. (5 yds = 4.57 meters)  
Risk zone  
Less than 350 yards for men and women |
| **R-S-S-T standard, times / 30 sec:(45)** | For men in an older between 60-64 the test normally measures 14 – 19 no. of stands. For woman in same older range the test normally measures 12 - 17 no. of stands. | Risk zone  
Less than 8 unassisted stands for men and women  
assess lower body strength, needed for numerous tasks such as climbing stairs, walking and getting out of a chair, tub or car. Also reduces the chance of falling. Description  
Number of full stands that can be completed in 30 seconds with arms folded across chest. |  
Description  
Number of full stands that can be completed in 30 seconds with arms folded across chest. |
Appendix 8: The questionnaires to test the various secondary hypotheses.

Self efficacy refers to an individual's belief in being able to perform certain acts in relation to a given situation (47). COPD Self Efficacy Scale consists of 34 fields used for assessment of patient's performance in the handling of respiratory distress. Each area is divided into five subscales, which deals with negative effects, intense emotional exposure, physical exertion, weather / environment and behavioral risk factors. Patients respond to each area on a 5 point Likert scale, ranging from 5 (very safe) to 1 (not sure) in the belief that they can handle or avoid problems with breathing in certain circumstances. The higher the score the more familiar the patients to manage or avoid breathing problems. An average of 3 or more indicates some degree of confidentiality in dealing with respiratory problems. The form has been validated and tested for test-retest reliability. It is translated into Danish and validated in a Danish COPD sample (48).

Instrumental Activity of Daily Living (IADL) questionnaire consists of seven questions related to shopping, housework, cooking, walks, money management, handling of medications and use of telephone. Both patients and their closest relatives (mostly spouses) reply form. For each of the seven questions indicates a score of 0 is no need for help, 1 indicates something needs 2 indicates unable to perform an activity without assistance. A total score is calculated on a scale from 0 to 14 Higher scores indicate greater dependence (49). The form has been translated into Danish and used among Danish surgical patients (50).

Hospital Anxiety and Depression Scale (HADS) (51,52) consists of 14 questions with four possible answers, which elucidates patients' level of anxiety and depression respectively. The scales for anxiety and depression are designed so that high scores reflect high levels of anxiety or depression.

The EuroQol or EQ-5D™ (53) is a standardized instrument for use as a measure of health outcome. Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status. The EQ-5D-3L essentially consists of 2 pages - the EQ-5D descriptive system and the EQ visual analogue scale (EQ VAS). The EQ-5D-3L comprises the following 5 dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 3 levels: no problems, some problems, extreme problems.

SGRQ-C (54) is a shorter version of the The St. George's Respiratory Questionnaire (SGRQ), derived from the original version following detailed analysis of data from large studies in COPD. The SGRQ-C has been developed using COPD data only, being valid for this disease. The validity for its use in other conditions has yet to be established, but it is unlikely to perform very differently from the SGRQ. The SGRQ is a disease-specific measure used to assess patients with mild to severe airway disease. Developed by Paul Jones at St. George's Hospital in London in 1990, this measure is a disease-specific instrument designed to measure impact on overall health, daily life, and perceived well-being. It was developed for use by patients with fixed and reversible airway obstruction. The measure consists of 50 (76 responses) items that produce three domain scores and one overall score measuring: Symptom (frequency and severity); Activity (activities that cause or are limited by breathlessness); and Impacts (social functioning, psychological disturbances resulting from airways disease). It is important to note that Section I (Symptoms) contains items on a five-point Likert scale; Sections II (Activity) and III (Impacts) are dichotomous (yes/no) items.
Appendix 9: Time Plan

Year 1- Develop a virtual exercise program for patients with severe COPD:
Here I am going to perform interviews with patients and health professionals in order to establish knowledge for the further planning and development of the virtual exercise program. Then I will include few patients with COPD for a pilot study using patient centred design and human computer interaction until the final virtual exercise program is ready. At the same time I will assist to 15 ECTS PhD courses.

Year 2- Test the telerehabilitation program on COPD patients:
Here I am going to start and follow up a 20-patients-pilot randomized study to collect descriptive statistics for a later planning of a large scale study and assist to 10 ECTS PhD courses.

Year 3- To evaluate and discuss the results of the testing phase and to publish these results:
Here I am going to evaluate and discuss the results of my pilot-randomized study and publish these results in international scientific journals. At the same time I will assist to the last 5 ECTS PhD courses.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2011 – July 2012</td>
<td>Preparation and writing of protocol and applications for funding.</td>
</tr>
<tr>
<td>April 2012</td>
<td>Obtaining approval from the Data Inspectorate and the Ethics Committee</td>
</tr>
<tr>
<td>April 2010</td>
<td>Ph.D. study is initiated. Participation in relevant courses</td>
</tr>
<tr>
<td>June 2013</td>
<td>The COPD remote training system is being designed.</td>
</tr>
<tr>
<td>July 2013</td>
<td>The COPD tele rehabilitation system is ready designed to be tested</td>
</tr>
<tr>
<td>August 2013</td>
<td>The first patient included in the study (total of 20 patients to participate).</td>
</tr>
<tr>
<td>April 2014</td>
<td>Prepare regular 2, 5 and 8 months follow-ups in study</td>
</tr>
<tr>
<td>May 2014</td>
<td>The database is closed and the processing of the data begins.</td>
</tr>
<tr>
<td>October 2014</td>
<td>Stay abroad at another relevant research center.</td>
</tr>
<tr>
<td>November 2014–July 2015</td>
<td>Data processing and ending of publications (study results as well as the 2, 5</td>
</tr>
<tr>
<td>August 2013</td>
<td>and 6 months of follow-up studies)</td>
</tr>
<tr>
<td>August 2013</td>
<td>Thesis and completion of Ph.D. study.</td>
</tr>
</tbody>
</table>