

Therapist Perspectives on Adoption of a Telehealth Self-Management Walking Program for Individuals With Lower Limb Amputation

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PURPOSE: Stakeholder engagement is essential to guide the development and adaptation of self-management programming for large-scale clinical implementation. The purpose of this study was to identify barriers and facilitators to occupational and physical therapist adoption of the Dysvascular Amputation Self-management of Health (DASH) program. DASH is a telehealth-delivered behavior-change program designed to maximize sustained daily physical activity.

DESIGN: We used a generic qualitative design and a general inductive qualitative approach to identify themes related to DASH program adoption.

METHOD: Participants were actively practicing physical or occupational therapists who identified as treating medically complex adult populations. Participation included a 30-minute orientation to the DASH program, followed by a 1-hour focus group. Semi-structured focus group questions elicited feedback on DASH program components, and barriers and facilitators to clinical implementation during the outpatient prosthetic rehabilitation phase. All focus groups were audio recorded and transcribed verbatim. Two team members participated independent coding using deductive (barrier/facilitator) and inductive codes, consistent with general inductive qualitative analysis, until consensus was reached and a final codebook applied to all transcripts. Thematic analysis consisting of an iterative process was used to group coding categories, and identify emergent themes and subthemes of factors that influence potential clinical implementation of the DASH program. Finalized themes, definitions, and raw data examples were provided to a peer reviewer separate from the initial coding process to enhance trustworthiness.

RESULTS: Thematic saturation was met after five focus groups with 24 participants. Participants were on average 34 years old [range 27-52], and the majority were female (n = 19, 79%), physical therapists (n = 17, 71%), and practiced in an outpatient setting (n = 12, 50%). Within deductive barrier and facilitator themes, three implementation domains emerged: facility, clinician, and patient. In the facility level, participants discussed the amount of telehealth support as either a barrier or facilitator depending on access/connectivity, and affordability. The facility's level of care coordination would also likely influence DASH implementation. For example, fluid referral systems to mental health or social work would facilitate ease of adoption and clinician comfort with the program. At the clinician level, comprehensive training on the DASH program was deemed essential, including explanation of behavior-change theory. Conversely, clinicians were familiar with many of the DASH program elements within standard of care (e.g., goal setting, self-monitoring), and also thought the personalized approach would create a strong therapeutic alliance. At the patient level, an individual's starting self-efficacy was something participants thought would influence their likelihood to follow the DASH protocol. Correspondingly, factors associated with a complex health condition (e.g., cognitive status), could reduce patient ability to follow the program and therapists mentioned that should be considered thoroughly beforehand. Yet strong patient social support may bolster participation from a physical activity habit formation perspective.

CONCLUSION: Occupational and physical therapists identified factors within facility, clinician, and patient levels that would influence clinical implementation of the DASH program and must be considered at this phase of program design.

IMPACT STATEMENT: Telehealth behavior change programs are critical for physical activity promotion and considering therapist perspectives early on could maximize program adoption during future t.

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