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Exploring the Opportunities and Barriers of Implementing the Health Focused Physical Therapy Model

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Abstract

The Health-Focused Physical Therapy Model integrates lifestyle behavior management into physical therapy practice using a standardized care model and motivational patient interviewing. The purpose of this study was to identify the perceived opportunities and barriers physical therapists, physical therapist assistants, and rehab administrators may face when implementing the model. This study included a survey of 19 physical therapy clinicians, and interviews with four rehabilitation administrators from one healthcare system. All participants attended a continuing education course covering the model and then completed a survey detailing their perceptions. Participants included female (100%), physical therapists (78.9%) and physical therapy assistants (21.1%), with variable educational degrees, and at least 16 years of clinic experience (73.7%). Four rehabilitation administrators, 100% female with at least 11 years of PT practice, participated in a semi-structured interview. Survey analysis revealed participants were confident in their understanding of the model and believed the model would positively impact the health of patients. However, over half perceived time limitations as a barrier. Meanwhile, three themes from the interview emerged

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including holistic care, implementation barriers, and needed resources. This study demonstrated time limitations and productivity standards could limit the implementation of health-focused physical therapy care. Future research should analyze opportunities and barriers of the model with broadened participant sampling methods and triangulation across healthcare practitioner roles to guide implementation and realistic practice standards.

Keywords
Health focused care; lifestyle behavior; holistic; rehabilitation; barriers; opportunities; physical therapy practitioner

1. Introduction

The Health-Focused Physical Therapy Model (HFPTM) provides a structured framework for physical therapists (PTs) to integrate health promotion into traditional clinical care [1, 2]. This framework was validated [2], and it has been recommended for physical therapists use [2]. However, the literature that validated the HFPTM was performed in a non-clinical setting without clinical physical therapy or administrator input. Therefore, this study's purpose is to determine the feasibility of implementing the HFPTM using clinician and administrator perceptions.

Finding ways to implement the HFPTM is desirable because it provides PTs with a means to incorporate health-focused care into a more traditional physical therapy plan of care [1]. Health-focused care can address the need to modify unhealthy lifestyle behaviors like smoking, poor nutrition, obesity, physical inactivity, stress, poor sleeping habits, and alcohol abuse [1]. Addressing these behaviors may prevent noncommunicable diseases (NCDs) like heart disease, stroke, chronic obstructive pulmonary disease, cancer, and diabetes—all leading causes of mortality and morbidity worldwide [3]. Utilizing the HFPTM may also help PTs increase patient physical activity and improve body mass index (BMI) to enhance overall health and reduce risk of joint replacement [4].

The HFPTM provides a clear framework to implement lifestyle behavior changes into clinical practice. It consists of five steps including:

1. needs analysis
2. determination of patient needs for change
3. patient collaboration
4. lifestyle behavior changes interventions
5. outcomes assessment [2]

A key tenet of the HFPTM is lifestyle behavioral change through patient and clinician collaboration (step 3). This collaboration is often achieved through motivational interviewing (MI). MI is a goal-focused communication style designed to enhance a person's motivation to change through identification of a reason for change in an accepting environment [5]. Previous work concluded MI was a superior method of communication compared to traditional methods of advice giving—with increased effectiveness in multiple patient encounters [6]. MI improved patient engagement, self-efficacy, body weight, death rate, substance use, and sedentary behavior [7, 8]. Through MI, clinicians assisted patients to create realistic goals and self-monitoring strategies that improved confidence and solidified their belief to maintain a healthy lifestyle [5, 6].

Once individual patient needs are identified using MI, it is critical to measure a patient's readiness for change [2, 9, 10]. Patients who appear ready to incorporate lifestyle changes should continue through the five steps. The therapist should incorporate patient-centered lifestyle behavioral change interventions that are reasonable and measurable followed by standardized outcome assessment to determine if implementing the HFPTM was beneficial [2]. Patients who don't appear ready should be acknowledged and respected for their decision [2, 9] and the therapist should establish a traditional plan of care using the International Classification of Functioning, Disability, and Health framework, focusing on body function/structure, activity limitations, and participation limitations [11].

Although some patients may not be ready for change, the HFPTM and MI may allow PTs to assess readiness with a standardized tool and begin potentially difficult patient conversations when appropriate. While the HFPTM has many benefits, potential barriers to implementation include not all entry-level physical therapy programs use benchmarks for health promotion within their curriculum [1], lack of time or awareness by the patient, feeling that other health care providers will deliver these services, lack of education, lack of reimbursement, and lack of resources [9]. This study set out to determine if the PT clinicians and administrators of an orthopedic outpatient medical system in the Midwest identified similar barriers, and to assess their perceived opportunities associated with the HFPTM.

2. Materials and Methods

2.1 Design

This research was based on the interpretivism paradigm; a qualitative method used to collect various interpretations through a researcher-participant construct in their natural environment [12]. This research paradigm allowed the investigators to use a survey and semi-structured interviews to collect data on participants' understanding and interpretation of HFPTM implementation.

The study was formally approved by a private university Institutional Review Board (IRB) (#1607) and the involved health care system IRB (#22-079).

2.2 Participants

A sample of convenience was used, purposively selecting relevant stakeholders, including physical therapists, physical therapy assistants, and administrators of a Midwest regional health care system. Participants included members of the outpatient physical therapy division. In all, 200 clinicians and administrators were invited to the HFPTM educational session; 40 attended resulting in an attendance rate of 20%. Of the 40 attendees, 19 provided informed consent as required for protection of human participants for response analysis and inclusion in the study resulting in a 47.5% response rate. This study's response rate is similar to prior research on health promotion beliefs in therapy which reported a response rate of 45.6% [13].

Survey participant demographics revealed 19/19 (100%) female, 15/19 (78.9%) physical therapists, 8/19 (42.1%) graduate degree holders, and 14/19 (73.7%) practicing 16 or more years. In addition, four administrators provided informed consent as required for the protection of human participants and completed the semi-structured interview. Interview participants included 100%

female sex, 75% master's degree holders, and at least 11 years of physical therapist practice. See Figure 1 for a diagram representing the flow of participants.

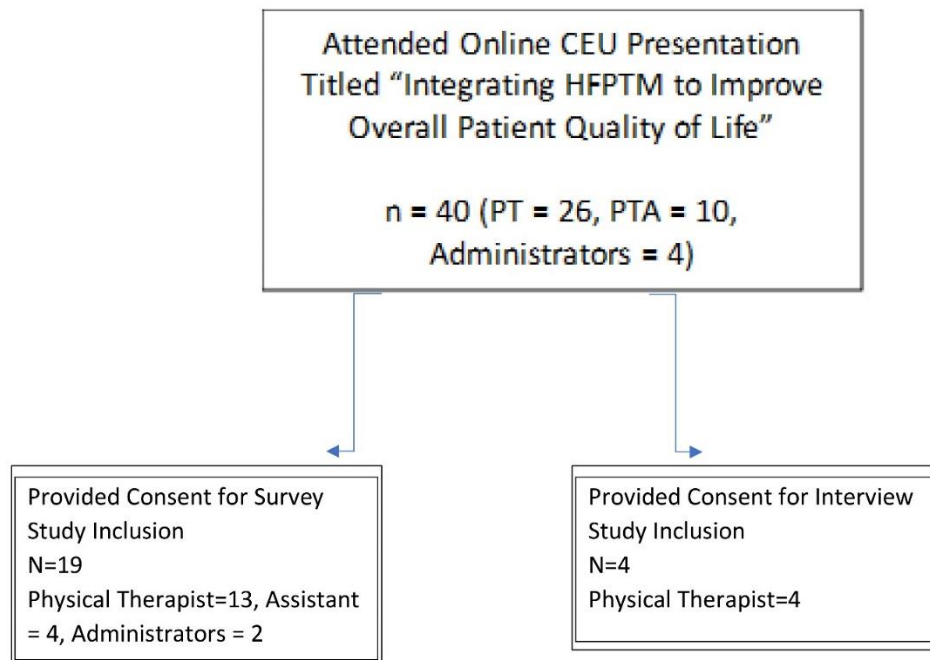

Figure 1 Diagram of Participant Flow.

While the participant sample is limited, particularly for the interview, it is important to note the sample is reflective of the national physical therapist workforce data. See Table 1 for a comparison of survey and interview participant demographics to national data.

Table 1 Demographics.

	Survey Population	Interview Population	National Workforce
Gender	100% female	100% female	65-68% female [14]
Percentage of physical therapists and assistants	78.9% PT	100% PT	71.76 PTs/100 people 33.53 PTAs/100 people [14]
Degree	42.1% Graduate Degree	75% Graduate Degree	69.8% Graduate [15]

2.3 Survey

An online survey was sent to all 40 participants of the online continuing education course. The survey included 14 closed ended questions using a five-point Likert scale for quantitative analysis and six open ended questions for qualitative analysis to support and glean additional depth to the quantitative analysis. Questions were derived from codes identified in the five steps of the HFPTM or associated literature, assessed participant understanding of the HFPTM, and examined their perceived benefits and barriers to implementation. To ensure validity, four content experts completed multiple iterations of the survey to ensure accurate representation of the HFPTM and responses to negatively and positively phrased questions were similar. An expert in survey and

qualitative research found the survey was appropriately constructed, supported the research question, and the open-ended questions (15-20) provided additional depth to the quantitively analyzed questions (1-14). A list of the survey questions can be found in Table 2.

Table 2 Survey Questions. Questions 1-14 are 5-point Likert scale questions from (Strongly Disagree—Strongly Agree). Questions 15-20 are open ended questions.

Question Number	Survey Question	Question Reference
1	I have a good understanding of the Health Focused Physical Therapy Model following this presentation.	1,2,9
2	I feel confident performing a needs analysis to perform the Health Focused Physical Therapy Model.	HFPTM Step 1: Needs Analysis [2]
3	I feel confident determining patient needs for lifestyle behavior change related to physical activity.	HFPTM Step 2: Determination of patient needs for change [2]
4	I feel confident collaborating with my patient about their physical activity lifestyle behavior change needs.	HFPTM Step 3: Patient Collaboration [2]
5	I feel confident in my ability to conduct motivational interviewing with my patient.	HFPTM Step 3: Patient Collaboration [2]
6	I feel confident in my ability to assess patient readiness to change physical activity behaviors.	HFPTM Step 2: Determination of patient needs for change [2]
7	I feel confident providing lifestyle behavior change interventions related to physical activity.	HFPTM Step 4: Lifestyle behavior change interventions [2]
8	I feel confident collaborating with other health care professionals (e.g. registered dieticians, exercise physiologists) regarding patient interventions related to physical activity.	HFPTM Step 4: Lifestyle behavior change interventions [2]
9	I feel confident in my knowledge of community resources to improve patient physical activity.	HFPTM Step 4: Lifestyle behavior change interventions [2]
10	I feel confident assessing lifestyle behavior change outcomes (e.g. Physical Activity Vital Sign-PAVS).	HFPTM Step 5: Outcomes assessment [2]
11	I feel confident implementing the Health Focused Physical Therapy Model will not impact my daily productivity.	9
12	I feel confident implementing the Health Focused Physical Therapy Model will positively impact the general health of my patients.	1,2,9
13	I feel confident there will be sufficient time during an initial evaluation to implement the Health Focused Physical Therapy Model.	2,9
14	I feel confident there will be sufficient time during a daily treatment to implement the Health Focused Physical Therapy Model.	2,9

15	Describe how the Health Focused Physical Therapy Model will positively or negatively impact your patient intervention?	1,2,9
16	What are some potential barriers you see with implementing this model?	2,9
17	Do you believe this model would be beneficial to integrate with every patient, or should only certain patient populations be targeted? Please explain.	2,9
18	What would be the best balance between conventional therapy intervention and health focused therapy?	1,2,9
19	What resources would you need from your employer to implement this model?	2,9
20	What resources are already available to you that would help you implement this model?	2,9

2.4 Interview

Rehab administrators from the healthcare system were invited to participate in semi-structured interviews using Zoom video software with video and audio two weeks after the continuing education presentation. The purpose of the interviews was to discuss perceived benefits and barriers of HFPTM implementation. To enhance validity, interview questions were developed from "*a priori*" codes identified in previous literature [16] and were triangulated with secondary research [1, 2, 9] to demonstrate a current need for answers to these questions. While seven administrators agreed to interview participation, only four provided consents to analysis of interview results. Each interviewee participated in an interview lasting approximately 45 minutes. To ensure consistency in the interview process, the same questions were asked to each participant in the same order. See Table 3 for interview questions.

Table 3 Interview Questions for Rehab Administrators.

Question Number	Question
1	What barriers do you perceive to implementing the HFPTM?
2	What benefits do you perceive to implementing the HFPTM?
3	Do the perceived benefits outweigh the barriers? Please explain.
4	What resources do you perceive to be needed to implement the HFPTM?
5	What resources are already available to you to implement the HFPTM?

HFPTM, Health Focused Physical Therapy Model.

Additional techniques were utilized to ensure consistency including active listening, listening to the participant "inner voice", listening while being aware of the process, and asking for concrete details ([17], p.81-82). This interview was focused on rehab administrators tasked with the productivity and financial success of a clinic, so the ability of the investigator to identify what the administrator was truly saying without guarding, or the "inner voice" was important to obtain accurate data collection.

2.5 Data Analysis

2.5.1 Survey

Survey data was analyzed using Microsoft Excel version 16.83 to assess participant demographics and survey responses. The Likert scale rating for each survey question 1-14 was recorded and an assessment of those responses with a majority was reported.

2.5.2 Interviews

Interviews were transcribed and data analysis was performed using a three-step process of reading, structural analysis, and interpretations [18]. An iterative coding process was used in which "start codes" were identified in MAXQDA data analysis software and revised after reading two interview transcripts [16]. Generated codes were validated via three qualified researchers. Interpretation of the codes developed themes that answered the research question, were exhaustive and mutually exclusive, sensitive, and conceptually congruent [16]. Interview responses were triangulated with currently available research and expounded upon in the discussion.

3. Results

3.1 Survey

The survey data consisted of 14 Likert scale questions, with responses ranging from "strongly disagree" to "strongly agree." The results of the survey found participants expressed a high level of understanding of the HFPTM, with 100% responding "agree" or "strongly agree" to the statement, "I have a good understanding of the Health Focused Physical Therapy Model." Additionally, 100% "agree" or "strongly agree" they felt confident performing a needs analysis to implement the HFPTM, determining patient lifestyle behavior change needs, and their ability to assess patient readiness to change.

Meanwhile, 18/19 (94.7%) of respondents felt they "agreed or strongly agreed" they were confident in their abilities to collaborate with the patient and other health care providers about the lifestyle change, to conduct motivational interviewing, and to provide interventions to create change. Concerning confidence in knowledge of community resources and the ability to assess behavior change outcomes like the Physical Activity Vital Sign (PAVS), 16/19 (84.2%) "agreed or strongly agreed". Additionally, 17/19 (89.5%) of participants "agreed or strongly agreed" the HFPTM would positively impact patient health, but only 7/19 (36.8%) of participants felt there was sufficient time during a patient evaluation, and 12/19 (63.2%) felt there was sufficient time during a patient treatment to implement the HFPTM.

Overall, the survey results reveal physical therapists, physical therapist assistants, and rehab administrators felt confident they had a good understanding of the HFPTM and how to implement during patient care including how to interview, how to refer, and how to assess patient behaviors and readiness for change. However, physical therapy practitioners were less confident there would be sufficient time to implement this model during an initial patient evaluation or treatment. A visual representation of the survey responses can be found in Figure 2.

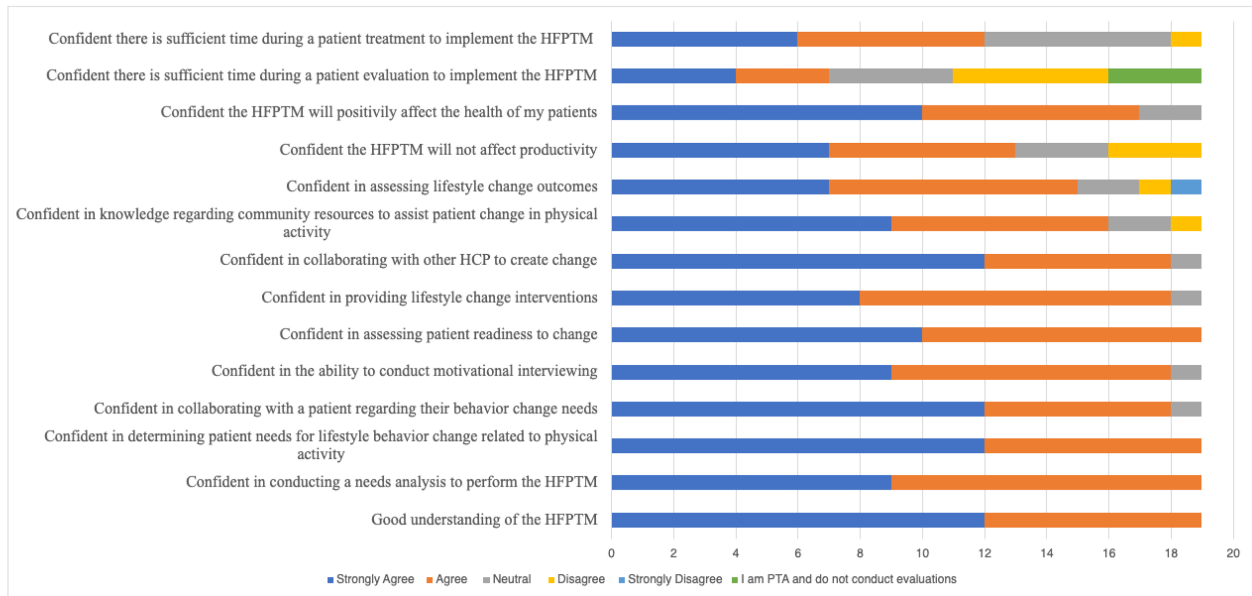

Figure 2 Survey Likert Scale Responses.

3.2 Interview

Using previously established criteria [16] resulted in the generation of three themes central to rehab administrator perception of the HFPTM: “therapist perception of the HFPTM as holistic care,” “patient motivation and productivity barriers to implement the HFPTM,” and “resources needed to implement the HFPTM.”

3.3 Therapist Perception of the HFPTM as Holistic Care

Rehab administrators consistently identified ways the HFPTM was beneficial to patients. Interestingly, all the benefits mentioned were for the patient, but no benefits were identified for the rehab administrator or clinician. Rehab administrators felt the HFPTM would result in both physical and financial benefits to the patient. For example, data analysis revealed “better health of the patient” was a frequent “*in-vivo*” code [16]. Multiple interviewees explained adopting a practice model focusing on the entire patient's health instead of only one body part is more beneficial to the patient. The HFPTM was described as “holistic” and “preventative.” Several interviewees verbalized the HFPTM will improve physical activity and decrease the risk of comorbidities, thus improving patient health. A second benefit to the patient was “decreased cost of healthcare.” The interviewees correlated the HFPTM and decreased comorbidities with decreased financial burden, a significant benefit to the patient. For example, one interviewee stated,

> “We will decrease the cost of healthcare by decreasing non-communicable disease rates in physical therapy patients. Less incidence of things like diabetes and heart disease will mean fewer visits to the doctor and less medications prescribed; ultimately improving their health and finances.”

3.3.1 Patient Motivation and Productivity Barriers to Implement the HFPTM

The interview discussion included a review of the hurdles physical therapists, physical therapist assistants, and rehab administrators face when trying to incorporate this model into their typical practice. Identified barriers could be grouped into patient care and productivity. The main patient care barriers included patient readiness to change and physical therapist or physical therapist assistant education. The interviewees discussed how physical therapists and physical therapist assistants want patients to change their lifestyles, but the patient may not have the time or energy to change. For example, one interviewee stated,

> "The biggest barrier will be from a patient care standpoint. For the physical therapist to identify if and when the patient is ready to participate in the model. Patients lead busy lives—do they have time and energy to change? Most often they may not."

While rehab administrators felt patient unwillingness to change is a large barrier to implementing the HFPTM, they also felt that a lack of physical therapist and physical therapist education could halt this model's implementation. Interviewees felt lack of education could be a barrier because "Physical therapists are not comfortable providing information they aren't knowledgeable on." Administrators identified specific topics that physical therapists and physical therapist assistants may need more education including nutrition, bowel/bladder habits, and menstrual cycles.

Lastly, time and productivity standards were identified as major barriers to using the HFPTM; a sentiment echoed by all interviewees. A review of the discussion found most physical therapy practitioners have limited time with patients to address their primary complaint(s) and administrators felt the additional questions, testing, and patient education required of the HFPTM are not feasible in today's health care system which focuses on productivity and typically results in limited time spent with patients.

3.4 Resources Needed to Implement the HFPTM

The last theme identified resources needed by physical therapists and physical therapist assistants to implement the HFPTM. This included physical therapy practitioners need for themselves and the patients. The interview discussion primarily centered on the need for physical therapist and physical therapist assistant education as well as patient education. Physical therapist and physical therapist assistant education topics included those identified as potential barriers to model implementation: nutrition, bowel/bladder habits, and menstrual cycles were the most frequently mentioned. One interviewee stated these topics could be the focus of future continuing education seminars offered by the healthcare system to improve physical therapist and physical therapist assistant education. Additionally, while physical therapists and physical therapist assistants need referral resources to implement the HFPTM, a rehab administrator mentioned resources are available at all outpatient clinics of the healthcare system in the form of community healthcare provider lists and utilizing the social determinants of health framework. Interviewees stated most individual clinics possess a list of local primary care physicians, mental health counselors, transportation services, and nutritionists to allow them to make appropriate referrals. One clinic administrator stated the regional healthcare system encourages its employees to utilize the SDOH framework to treat all patients: meaning all patients must be approached from a viewpoint that

encompasses environmental, behavioral, social, and economic factors. Since this framework is holistic in nature and already utilized, they felt the HFPTM should be easy to implement.

Rehab administrators also identified the need for patient education. They reported a need for informational handouts patients can read at their leisure and hypothesized this delivery method could provide patients with necessary information while being mindful of limited treatment time. For example, one interviewee stated, “We need to give information to patients that they can look at on their own time. Especially on things that can improve their health, or access to healthcare, like transportation and nutrition services.” One interviewee summarized stating, “If all physical therapists had the same overall health education and we had informational handouts on things like physical activity, nutrition, and mental health, implementing the HFPTM would be much easier.” In-vivo codes related to the interview themes can be found in Table 4.

Table 4 In-vivo codes related to the interview themes.

Question	In-vivo Codes	
What barriers do you perceive to implementing the HFPTM?	“The biggest barrier will be from a patient care standpoint. For the physical therapist to identify if and when the patient is ready to participate in the model. Patients lead busy lives- do they have time and energy to change? Most often they may not”.	“Time to implement additional testing like aerobic capacity”.
What benefits do you perceive to implementing the HFPTM?	“We will decrease the cost of healthcare by decreasing non communicable disease rates in physical therapy patients. Less incidence of things like diabetes and heart disease will mean fewer visits to the doctor and less medications prescribed; ultimately improving their health and finances”.	“Preventative care- patients want to do what keeps them healthy to avoid using their deductible”.
Do the perceived benefits outweigh the barriers? Please explain.	“Clinicians think benefits outweigh the barriers, but patients may not feel the same”.	
What resources do you perceive to be needed to implement the HFPTM?	“Educational handouts for patients- nutrition, education to look at on their own time. Staff need to be comfortable with the resources they refer to. Having the types of resources and where to go available”.	“If all physical therapists had the same overall health education and we had informational handouts on things like physical activity, nutrition, and mental health, implementing the HFPTM would be much easier”.
What resources are already available to you to implement the HFPTM?	“List of providers in community”.	“Social Determinants of Health- It compiles community resource guides by county- we need to refresh and update. This is online and we need to

	educate staff on where it is and how to use it".

4. Discussion

This mixed-methods study explored physical therapist, physical therapist assistant, and rehab administrator perceptions of the HFPTM. Through survey analysis, the investigators concluded physical therapists and physical therapist assistants felt the HFPTM would positively impact patient health (89.5% of respondents) and felt confident in their knowledge of health focused delivery (100%). Additionally, most physical therapists and physical therapist assistants (84.2%) felt confident in their knowledge of community resources to implement the HFPTM. However, a majority felt limited by time and productivity standards; only 36.8% of respondents felt there would be sufficient time to implement the HFPTM into a physical therapy evaluation. Interestingly, the results of the survey are substantiated by the themes derived from the rehab administrator interviews but with one difference; survey respondents who were practicing clinicians felt confident in their knowledge of resources needed to implement the HFPTM, while administrators stated further resources are needed for implementation. The investigators propose this could be due to the decreased patient care hours typical of administration- those not in direct patient care may not be familiar with resources available.

The three central themes derived from interviews with rehab administrators included: patients benefit holistically from health focused care, barriers may limit integration of health focused care, and further resources are needed for implementation. The administrators stated the patient would benefit both physically and financially from practicing health-focused care. Despite the clear benefits, they felt there were several barriers to implementing this model including clinician time constraints, lack of patient willingness or ability to change, lack of resources, and lack of clinician education. The investigators posit that these are all very real concerns preventing the integration of health-focused care in an outpatient physical therapy setting. To create change, the investigators encourage physical therapy education programs to implement health-focused care into curricula, clinics to create handouts providing contact information for local health and wellness providers, and rehab administration to ethically evaluate the effects of productivity standards on patient care. It would also be beneficial for individual clinicians to assess the quality of their interactions with patients during treatment. Specifically, clinicians should focus their conversations during treatment on health and wellness promotion topics instead of generalized "small talk" topics of conversation.

The investigators' call to action is based on this study's results and is substantiated by the findings in previous literature. For example, prior work has also found clinicians are confident in their abilities to implement health-focused care [19], but more patient resources are needed [2], and lack of time and productivity standards are a large barrier to implementation [10]. These commonalities suggest change in current practice is needed to propel the health-focused model forward.

4.1 Limitations

This study included four rehab administrators who volunteered for the interview and 19 physical therapists and physical therapist assistants from within the same healthcare system. While the investigators achieved saturation with administrative interview responses, the sample size was relatively small and homogenous limiting generalizability across healthcare settings, socioeconomic

structures, and geographical regions. All participants were female sex and 78.9% of survey responders were physical therapists limiting generalizability of the results, however, participants did have a variety of educational backgrounds. Participants may have introduced volunteer biased when completing the survey because of their interest in the topic, which could narrow population results. Future studies should broaden the interviewee selection and survey respondents to expand generalizability. Additionally, the interview portion of this study reflected only rehab administrators. This was done in attempts to gain unique insight into those financially responsible for the healthcare facility. Future studies could include interviews with physical therapist and physical therapist assistants alongside rehab administrators to triangulate the results of each group.

5. Conclusions

This study revealed physical therapists and physical therapist assistants understood the HFPTM, felt implementation would positively impact patient health, and administrators were aware of the holistic benefits of a health -focused model of care. However, physical therapists, physical therapist assistants, and rehab administration reported time limitations in a clinical setting could be a barrier to implementing the HFPTM. Physical therapists and physical therapist assistants also felt confident in their implementation of the HFPTM, but administrators felt more clinical resources like physical therapist and physical therapist assistant training was needed for successful clinical integration. The investigators encouraged further research investigating best practices to reduce barriers to health focused care, and a broader analysis of opportunities and barriers across healthcare settings and geographical areas to increase generalizability of results.

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Author Contributions

Angie Huber is the corresponding author. She was involved through conceptualization, data curation, formal analysis, investigation, methodology, project administration and resources, software, supervision, validation, visualization, writing and reviewing and editing. Nicole Schroeder is an author that was involved in conceptualization, data curation, lead on formal analysis, investigation, methodology, validation, visualization, writing and review and editing. Dave Verhoff is an author that assisted in investigation, data curation, methodology, supervision, validation, visualization, writing, and review and editing. Andrew Parsons is an author that assisted with data curation, investigation, project administration, resources, software, validation, visualization and review and editing draft.

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Competing Interests

The authors have declared that no competing interests exist.

Data Availability Statement

All data was managed and stored securely according to institutional guidelines and survey data was de-identified. Access has only been available in a password protected shared drive to investigators of this study.

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