

TITLE: Building a Bridge to the Community – An Integrated Knowledge Translation Approach to Improving Participation in Community-Based Exercise for People after Stroke

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Background. People with stroke living in the community have low levels of physical activity, which reduces their functional capacity and increases risks of developing secondary co-morbid conditions. Exercise delivered in community centers may address these low levels of physical activity; however, implementing evidence-based programs to meet the needs of all community stakeholders is challenging.

Objectives. The objective of this study was to determine implementation factors to facilitate participation in relevant exercise and physical activity for people with chronic health conditions, like stroke.

Design. The design consisted of a qualitative observational study using an integrated knowledge translation approach.

Methods. Supported by an integrated knowledge translation approach, a series of focus groups—with stakeholder group representation that included people with stroke and care partners, community organizations (ie, support groups, community center staff), healthcare providers, and exercise deliverers—was conducted. During the focus groups, participants provided perspectives on factors that could influence implementation effectiveness. Focus groups were recorded, transcribed, and thematically analyzed.

Results. Forty-two stakeholders participated. Based on the themes, a new implementation model that describes the importance of relationships between community centers, clinicians, and people with stroke is proposed. The development of partnerships facilitates the implementation and delivery of exercise programs for people with ongoing health needs. These partnerships address unmet needs articulated in the focus groups and may fill a gap in continuity of care.

Conclusion. Data from this study support the necessity for the community sector to offer a continuing service in partnership with the health system and people with

chronic health needs. It indicates the potential of clinicians to partner with people with chronic health conditions and empower them to improve participation in relevant health behaviors, like community-based exercise.

People with stroke are the most sedentary of all chronic disease populations¹; people after stroke consistently report activity levels that are less than half of their age-matched counterparts.² As with many chronic cardio-metabolic conditions, regular and targeted physical activity or exercise for people with stroke, produces de-conditioning that places people at further risk for developing or exacerbating secondary health conditions. This downward spiral reinforces poorer health and disease progression. The evidence for the benefits for regular physical activity on primary and secondary disease prevention is irrefutable.³

Many people with stroke are discharged from acute care with considerable health needs.⁴ Outpatient or home based rehabilitation after acute stroke has been identified as one way of sustaining continuity of care after inpatient services have finished⁵ however access to such community health services vary considerably across different health services and are time limited. The gap in service provision at the completion of rehabilitation is well documented by people with stroke⁶ and health professionals.⁷ Only a few examples exist of exercise programs for people with complex health needs delivered in general community centers.⁸

Community-based exercise for people after stroke produces multiple physical benefits⁹⁻¹¹ and improves social participation.¹² Exercise has the potential to reduce

the chance of having another stroke and is a key component of secondary disease prevention.¹³ Given the high-level evidence supporting community-based exercise for people after stroke,^{9,11,14,15} it is timely to develop effective processes to move this research to practice addressing social factors such as availability and personal factors like motivation. This process, which identifies evidence and applies it in practice, is known as knowledge translation.¹⁶

We have chosen to use an integrated knowledge translation (IKT) approach to understand the perspectives of relevant stakeholders as the preliminary step towards implementation.¹⁶ IKT is defined as a collaboration between researchers and people who are influenced by the research, which includes a range of decision-makers.¹⁶ This approach ensures that stakeholder voices are heard and enable development of programs that can be sustained outside of a research framework.

The aim of this study was to determine perspectives of all stakeholders in enhancing implementation of evidence-based exercise in the community for people with stroke. Specifically the objectives are to determine the desired content and structure of an exercise program, and implementation factors including local contextualisation, adoption, evaluation, sustainability and fidelity that will affect uptake and ongoing participation in relevant exercise and physical activity for people with multiple health conditions, using stroke as a model of chronic disease.

[Head 1] Methods

This observational cross-sectional study used semi-structured focus groups and interviews as the main means of data collection. Participants provided perspectives on implementation factors to optimize adoption commitment. The study has been reported based on the Standards for Reporting Qualitative Research guidelines.¹⁷

Ethical approval for this project was provided by the University of British Columbia and the Vancouver Coastal Health Research Institute. Informed written consent was obtained from all participants.

The first author conducted the interviews and focus groups with an assistant focus group moderator. Data analysis was performed by two researchers independently (M.L.B. and W.B.M.). The first author (M.L.B.) is a physiotherapist and clinical researcher, with experience in qualitative data collection. The second author (W.B.M.) is an occupational therapist with experience in qualitative research, ageing and disability studies. Prior to the study, these researchers were not known to the participants. Authors 3-6 (F.C., N.A., K.H., and J.Y.) are advisory group members, who represent each of the stakeholder groups (people after stroke, clinicians and community organizations). The final author (J.E.) has developed several interventions to improve functional ability and mobility in community dwelling people after stroke.

Three separate groups of stakeholders were invited to two one-hour focus groups under the direction of the advisory committee. Stakeholders with an experience of stroke were invited from a list of people who had previously consented to be contacted as part of research projects. Purposive sampling was undertaken by approaching organizations who represent people with stroke and community center staff, where the community centers had expressed interest in providing exercise for people after stroke. A convenience sample of clinicians was recruited through established professional networks. Recruitment continued until saturation was achieved.

Normalization Process Theory (NPT) provided a foundation for the questions within the interview guide for the focus groups.¹⁸ The interview guide was circulated to the advisory group for review at one of the meetings. The NPT framework is useful for health care implementation projects for people with complex co-morbid conditions (Figure), by providing a working model that focuses on sustained practice change. There are four constructs to this model; Coherence is the sense-making work that people do when operationalizing new practices, Cognitive Participation what people do to build relationships and sustain practice change, Collective Action is the operational work that people do to enact a set of practices and Reflexive Monitoring is the assessment that people do to understand the ways that a new set of practices affect them.¹⁸

For the purpose of the focus groups, the four constructs of NPT (coherence, cognitive participation, collective action and reflexive monitoring) were divided in half. Questions around coherence and cognitive participation, were utilized in the first round of focus groups. Data collated from the first round was presented back to the groups in the second round of focus groups, with the intention of using collective action to describe how an innovation could be implemented, in addition to reflexive monitoring to describe ongoing evaluation of the implementation (interview guide for participants with stroke provided in the Appendix).

Data from the hour-long focus groups were audio recorded and transcribed for analysis. To protect participant's anonymity all data files were password protected and stored on a secure server. Transcripts were not returned to the participants. To address the question of the preferred class exercise components and structure, content analysis was performed on all available data.

To address our objectives, inductive thematic analysis was used by two authors (M.L.B. and W.B.M.) to refine and conceptually distinguish between the themes.¹⁹

These authors familiarized themselves with the data through reading and re-reading the transcribed responses. Manual preliminary coding was undertaken collaboratively to identify important features of the data and to describe the meaning of the data. Candidate themes were generated after codes were re-examined and combined.

A post-positivist paradigm was used in the analysis, where we recognise that a data collection and interpretation is influenced by the researcher's experience and worldview.²⁰ We used three main trustworthiness strategies to corroborate findings and account for this. Reflexivity was used by the research team, who met frequently to discuss any issues regarding data collection and interpretation and journaling. A video blog of the first author's reflections on the codes and the relationship between them was kept during the analysis. This allowed us to better understand the influence of bias and changing researcher attitudes during interpretation. Data extracts for each theme were re-examined for consistency with the theme and discussed in team meetings. All themes were considered within the context of the narrative and with an understanding of the group dynamics and the researchers' own bias. Triangulation of the perspectives of the research participants from different stakeholder groups was the second strategy used. Data were explored for negative cases. In the text that follows all proper nouns were replaced by pseudonyms to protect the identity of participants.

Results:

Thirty-six people participated in nine group focus groups while six participated in individual interview sessions (11 people with stroke, 3 caregivers, 22 clinicians and 12 people from community organizations including managers and exercise deliverers). All participants attended in two sessions. The average age and mean time since stroke (SD) of the participants with stroke was 64(11) years and 32(15) months. Two participants, who were less than 50 years old, represented the young person with stroke perspective. Program management staff from three community centers participated in the data collection. The people delivering exercise were exercise physiologists, kinesiologists or fitness instructors from four different sites. Five health service sites were visited, and the professions represented included neurologists, physiatrists, speech and language pathologists, physical therapists, exercise physiologists, recreation therapists and occupational therapists. Clinicians worked in a range of settings including acute medical and neurological services, inpatient and outpatient rehabilitation and community. Table 1 provides more details of participant characteristics.

Pragmatic information about components of the exercise intervention from both focus groups and interviews are included in Table 2 presented as frequency data and percentages. Twenty-seven people provided explicit information on the content of classes.

Our thematic analysis identified three themes. When retrieving quotations to use in this manuscript, people with stroke and their care partners are coded S; community organizations (managers and exercise deliverers) are coded C; and clinicians from

the health service are coded H. Different people within these groups were identified by a number indicating the chronological sequence of data collection.

[head2] Theme 1: A NEW WEB OF RELATIONSHIPS

This theme included relationships that demonstrated a “belonging to a new community” and included those between the stroke participants themselves and with clinicians and community center fitness instructors. Participants identified a strong sense of “belonging” as driving participation in stroke-specific classes, as illustrated by one participant; “The beautiful thing is that we are all in the same boat” (S1). This sense of community was so strong that people with stroke identified that they preferred a “stroke only” constituency to exercise classes (where possible) and were not concerned about the functional level of other people in the class. One person with stroke indicated, “You know, I think, even though my stroke didn’t result in a physical disability, I still identify with all the people in wheelchairs” (S9).

About half of the people with stroke described that they had developed a relationship with their health professional and exercise providers that demonstrated a sense of trustworthiness. They valued the advice and programs that these professionals delivered. For example, one participant with stroke said “my [physical therapist]...said the information that they had would be appropriate for me” (S14). In one situation trust between the health professional and the person with stroke led to over reliance. She said “because every step I had taken was so closely supervised (in rehab), I did not feel able to do anything by myself” (S12). The importance of the skills and knowledge of people delivering exercise in the community was also high. There was one example of a participant who goes to community exercise, and does

so because of the skill and experience of the instructor was important; “He’s a graduate from there (University) so he has lots of experience” (S2).

Both clinicians and stroke participants suggested that the clinicians should support the exercise deliverers, with general agreement when a participant said “I think the physiotherapist should be involved in the training [Sounds of agreement]” (H5). In fact, an ongoing relationship between the trained instructor and the physiotherapist was seen as a possible solution to the fact that the evidence around exercise for people with stroke is continually evolving. One stroke participant stated; “a physical therapist who’s keeping abreast of all the new research going on, because it’s moving along quite quickly, I understand” (S10). As well, fitness trainers valued an ongoing relationship between the health professional for the fidelity of the program; ‘If you could in the community, (have a) familiar therapist, or whoever’s running it, keeping you accountable, you got that relationship with them” (C4).

[head 2] Theme 2: IN THE FACE OF CHANGING NEED

This theme covered the need for exercise that was relevant to participants, but unexpectedly also identified that people needed more information to help them manage their new life after stroke. People from each stakeholder group identified an urgent and immediate need for stroke-specific exercise that was described as “There is a need like there is no tomorrow” (C7) by a fitness instructor. Clinicians also identified that their clients’ needs might not be addressed with generic classes (ie, not specific to a particular disease), described by one clinician as missing the mark, “we’re just finding that nobody was getting the benefit because it was too easy for the higher level, and it was too daunting for the lower levels” (H1). As well as a lack

of opportunities, there was a lack of information about available opportunities, as illustrated with the statement “I think that’s one of the big things that’s missing, is that even if they wanted to do things like this, the people in the community don’t know where to get it” (H11).

Stroke participants repeatedly identified that they needed new information to support them and help them manage their new life after stroke. One example was “After you had a stroke, there isn’t much information for me and I really found it difficult” (S4) and another was “I think for knowing myself and another stroke patient, we’re always looking for additional information and people to connect with” (S7). One person recalled that the information provided in rehabilitation was useful; “we heavily relied on the resources that was given to us [at the rehabilitation center]” (S1), but many felt they needed more. After discharge, people used a variety of sources to try to find information on their own; however, it was described as difficult to find and not relevant. Some people used the internet; “When you Google ‘yoga’ ‘stroke’, nothing [useful] came up” (S2). People with stroke discussed the idea that other people with stroke could provide support and information in a way that allowed them to connect. This was spoken of multiple times as something they were still searching for;

“one of the things that I have been looking for is the commonality, a place where you can maybe talk to each other to find out things, or maybe people that you could talk to find out more answers” (S8).

Further, as part of their recovery, stroke participant needs were constantly (and sometimes rapidly) changing. The sudden onset of stroke symptoms heralded in a period of ongoing change, as one clinician pointed out; “(They) were going to work the day before and then they have a stroke, and all of a sudden they’re like, new

reality” (H14). These changes continued after discharge, as described by another clinician, “They really need a lot of guidance and education at that stage, plus that’s a stage of recovery (in the community) when there’s still a lot of changes going on” (H15).

[head 2] Theme 3: CONTINUUM OF CARE

This theme described the capacity for the community sector to offer a continuing service to address issues with the availability of medical services. A gap in care after rehabilitation was felt by multiple stakeholders. Commonly this was reported from people with stroke with statements like “with a pat on the head (keep up the good work) and a kick out the door ...” (S12). The magnitude of this issue was described by another participant as “the gap seems to be repeated again and again” (S7).

The clinicians identified a bridge between the health service and community might facilitate communication between the two; “So, I mean, it might be communication between the public health system and the community centers” (H11). A better integrated relationship was proposed by another clinician who suggested; “It almost seems like there needs to be a collaboration with the [community center] and the [health service]” (H12). There were potentially multiple positive benefits described from such a partnership. One clinician provided an example of a rural community outreach program that delivered services that helped to reduce the workload within the health service;

“That’s been a really good (community based) program, it has really helped with discharge. It’s ironically made more referrals in patient (numbers), but it’s actually reduced the length of stay [from the hospital]” (H10).

Participants identified that trust with their health professionals had potential to produce benefits to individual health through personal empowerment and motivation. This was described by one participant with stroke as “That kind of empowerment that people actually need to take control of their own journey” (S7). Another participant thought that their general medical practitioner may have an important role to motivate them because “clients and patients listen to doctors” (H6).

Navigation to community services was described as an unmet need; “I was not directed to any type of rehab program” (S6). However, some people identified that having an advocate that was part of their support network was one way in which they were able to navigate their way through the health system. Stroke participants identified that both their partners and children acted as advocates following the interactions with the health system. Clinicians were supportive, but indicated that they needed information to assist with the referral process, for example; “these are the type of people we should definitely refer” [send to community programs] (H15).

Community support groups were identified as effective for providing for a range of needs. In addition to providing information, there were multiple benefits to these groups as they “bring in a lot of speakers who have been doing research or providing services too, you know, in the community ... which I find really useful” (S8) and “I mean there’s a social benefit and an emotional benefit ...? [Sounds of agreement.]” (H8).

Examples provided by the participants that indicate support for the different implementation factors are provided in Table 3.

[head1] Discussion

The strength of this study is the novel method of data collection where we used an integrated knowledge translation approach to drive the methods within the NPT framework. By using a two-staged approach to the focus groups, the stakeholders had input into the design and identified important components and characteristics of the program, and then met again to determine the local contextualization, which is required for implementation success. By having such a significant role in generating this information, we anticipate the adoption commitment of the stakeholders will be enhanced.²¹

This study aimed to determine stakeholder perspectives on implementation factors for community based exercise. The development of partnerships between stakeholders has potential to meet identified gaps in availability of community-based exercise and establish a referral pathway between the health service and community centers. Equally important is the relationship between the clinicians and the patients, and having this relationship develop into a partnership that will foster independence and self-management in the patient as they move to no longer being a patient or client, but a community member.

Class content and context were identified using an integrated knowledge translation approach to ensure that the program is delivered in a way that meets the needs of stakeholders. Having “stroke only” groups with stroke specific exercise and the social support of peers are both known facilitators of group exercise in this clinical population.²² Social networks are documented as important for management of chronic health conditions.²³ We anticipate that it is more likely for this program to be successfully adopted and sustained as representative stakeholder groups identified

program components to be included. Firstly, having a person-centered approach to program development has been shown to improve exercise adherence.²⁴ Secondly, exercising with a group of peers has been demonstrated to improve ongoing participation in physical activity programs.²⁴ Previous researchers have reported that de-medicalized programs led by suitably trained non-clinicians is attractive to people after stroke.²⁵ Multiple participants discussed how this program would be meeting a gap, improving capacity of people after stroke to be active, which is a key aspect of improving health behaviors.²⁴

There was a strongly articulated need for more information and self-management skills for people after stroke around “managing life” as well as physical activity and exercise.²⁶ Recent literature suggests that people with chronic health conditions are becoming more active in their own care than previously.²⁷ Peers, care partners, the internet, community support groups, and clinicians were identified in this study as real or potential knowledge sources. Information provided clearly by health professionals can minimise anxiety and increase perceived control.²⁸ Expansion of the roles of clinicians to work in partnership with people after stroke to work on changing beliefs around exercise can have a positive effect on health service delivery.²⁹ Such partnerships with patients have potential to impact physical activity self-efficacy beliefs and subsequently impact on participation in physical activity by people with stroke, with ongoing participation facilitated through social support.³⁰ The health system at present does not focus on the role that clinicians can have in supporting health decisions about physical activity, despite a documented role to play in changing physical activity levels and beliefs.³¹

Information about what individuals can safely do after discharge was an identified gap. Health professionals like physical therapists are ideally placed to provide

information on safe exercise and promote physical activity.²⁴ However, the lack of access to community based programs affects uptake in multiple chronic diseases such as people with osteoarthritis,³² pulmonary disease³³ and diabetes³³ as well as stroke. Recent literature suggests that most physiotherapists do not provide their patients with information on community based exercise, with half citing a lack of suitable programs.³⁴

Health professionals have a valuable role to play in assisting their patients to navigate out of the health system as community integration is occurring. Our clinicians felt that part of this referral role was to give 'permission' to people with a chronic health condition to participate in relevant exercise and be active without supervision.³⁵ A partnership between the community centers and the health service sector would allow development of referral pathways that could be established with an understanding of local contexts. The IKT approach allowed recognition of local needs and this recognition has been documented as a positive basis on which to establish relationships.³⁶ Our data suggest that clinicians should play a role in empowering people after stroke to make more decisions about their physical activity and health. This may address health care system burden by improving self-management of people with chronic diseases. Improved self-management is associated with reduced health care utilisation and cost-benefits in people with chronic health conditions.³⁷ Engaging end-users is a well-documented strategy to assist in changing clinician behavior.³⁸

A review of nineteen papers that examined sustainability of community based exercise for people after stroke, found only one study that identified a model for clinicians developing partnerships with community centers.³⁹ Our study provides further justification for this model based on voices from stakeholders. The current

study adds to the published literature by identifying that people after stroke want to be considered as partners in their interaction with the health system and in developing community based exercise programs that meets their needs.

Data generalizability is limited to more mobile participants or those confident in phone communication as people with stroke who were not able to attend focus groups or participate in phone interviews did not provide perspectives.

Generalizability is also limited to the presented perspectives of participants recruited from a large metropolitan center. Although the data were collected in stakeholder groups with a focus on stroke as a clinical condition, many of the issues raised here may be generalizable to different populations of people living in the community with chronic health conditions.

[head 2] Conclusions

The study data supports the need for, and defines characteristics of, implementation of exercise programs in community centers for people with stroke. Gaps in opportunities, information delivery and continuity of care were common. We learned that the development of partnerships may facilitate implementation and delivery of exercise programs for people in the community with stroke and that this model may be useful for a wide number of other chronic health conditions. Data from this study indicates the potential of clinicians to empower people after stroke, through partnering with them and community centers to assist in relevant referral of people to community based exercise. The potential of clinicians to change the physical activity beliefs of people with stroke may address an important gap in practice.

Author Contributions and Acknowledgments

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Ethics Approval

Ethical approval for this project was provided by the University of British Columbia and the Vancouver Coastal Health Research Institute. Informed written consent was obtained from all participants.

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Disclosures and Presentations

The authors completed the ICJME Form for Disclosure of Potential Conflicts of Interest. B.W. Mortenson reports that he holds an investigator award from the Canadian Institutes of Health Research and grants from many funding agencies. N. Acerra reports that she was paid for her contributions to this research. J.J. Eng reports grant received to fund operations of work and an award scholarship offered to faculty to offset teaching so more research time is permitted. All other authors report no conflicts of interest.

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Figure Legend:

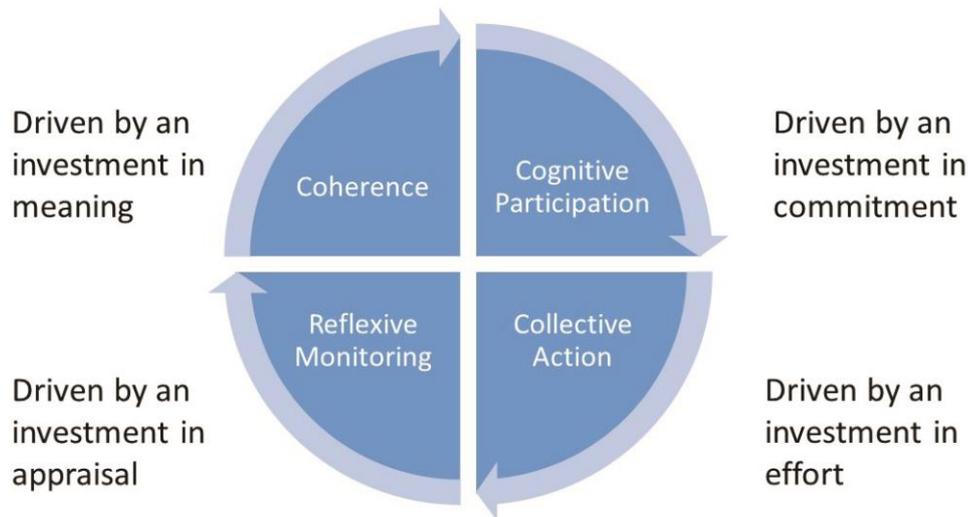


Figure. Constructs of the normalization process theory with drivers for implementation.

Table 1. Participant Characteristics (N = 42)

Stakeholder Type	Number
People with stroke and carers	
People with stroke	11
Carers	3
Age Mean (SD)	64 (11)
Time since stroke months Mean (SD)	32 (15)
Health Professionals	
Physical therapists	12
Occupational therapists	3
Speech and language pathologists	2
Recreation therapists	1
Medical Staff (neurologist/physiatrist)	4
Clinicians with >10 y of clinical practice	17
Clinicians in acute settings	12
Clinicians in rehabilitation or community settings	10
Community Center Staff	
Program managers	3

Exercise physiologists	2
Kinesiologists/fitness trainers	7
Exercise deliverers with > 5 y experience	8

Table 2. Components of the Ideal Exercise Intervention^a

Exercise Component	Number of People
Arm strength	56% (15)
Leg strength	63% (17)
Mobility	67% (18)
Tone	52% (14)
Balance	85% (23)
Posture	67% (18)
Sensation	67% (18)
Cardio	63% (17)
Other components (number of people who identified them)	Trunk, fine movements, outside exercise, flexibility (2) yoga (2) function (2) supported treadmill (1) walking (1) hand exercise (1) motor control (1)

^aFrom stakeholder perspectives.

Table 3. Implementation Factors

Implementation Factor	Example From Focus Group
Contextualization	“It’s a very local kind of thing, it will be tucked in a cross of systems” (H10).
Adoptability	“I was not directed to any type of rehab program” (S6). “They definitely need someone to be an advocate and to help coordinate some of that information for them” (H15).
Sustainability	“From rehab into a program, that kind of pathway’s important” (S1)
Fidelity	“I would think that [the exercise deliverers]... needs to be a physical therapist trained person because a physical therapist’s keeping abreast of all the new research going on, because it’s moving along quite quickly” (S10).
Evaluation	“We can approach this from a more of a systems perspective and look at, you know, do we have some clear criteria”H15 (Physiatrist)

Appendix. Interview Questions for Participants With Stroke

Coherence		
Dimensions	Outcome Questions	NPT Questions
Differentiation (Is your ideal program perceived to be different from traditional ways of working?)	What gap, if any, does proposed program fill?	How is this program different from what you can already get?
Communal specification (Does everybody understand and agree with your ideal program?)	Does doing an intensive community based exercise program make sense to the target group?	What would people like you think of the program you have described?
Individual specification (Does everybody understand what they have to do?)	Does an intensive community based exercise program meet client goals?	How important to you is attending a class that has lots of variety in content or one that has a core group of exercises to focus on? What do you think about exercising at home?
Internalisation (Does everybody think it is worth the effort?)		How worthwhile, if at all, do you think an intensive community based exercise program is?
Cognitive Participation		
Dimensions	Outcome Questions	NPT Questions

Initiation (Are there key individuals that advocate for an intensive community based exercise program?)	Are there key people driving the implementation of an intensive community based exercise program?	What involvement, if any, would your family or care network like to do to support you being involved in an exercise program? Would they want to come with you? Would you like that?
Enrolment (Have people “bought into” implementing an intensive community based exercise program in practice?)	Has there been sufficient involvement other than professions/trainers/program managers in developing this implementation framework for an intensive community based exercise program?	Who do you think should be involved in setting up and running a community based program? How big should the classes be (ie, number of people for each instructor)? Can people of different levels exercise together?
Legitimation (Are the right people doing the right tasks?)	Will anything get in the way of implementing an intensive community based exercise program?	What things may make it harder for you to start and keep coming to an intensive community based exercise program?
Activation (Is everybody ready to make an action plan?)	What will help in implementing an intensive community based exercise program?	What things may motivate you and make it easier for you to start and keep coming to an intensive community based exercise program?
Thank You		
Description of Consensus Program and Framework		
Collective Action		

Dimensions	Outcome Questions	NPT Questions
Interactional workability (Is the work involved in delivering this program able to be appropriately allocated?)	Are people prepared to come to this exercise program?	What problems, if any, do you think there will be implementing this exercise program?
Relational integration (Do staff trust each other's work and expertise in using this exercise program?)	Are people confident that this exercise program can be implemented as it should be?	Who developed this intervention? What, if any, changes or modifications would you suggest to how this exercise program will be implemented? What are the core elements or principles that need to be included?
Skill set workability (Can people perform the tasks that are being asked of them?)	Do people have the right skills and knowledge needed to implement this exercise program?	Who do you think are the best people to deliver this program? What training should be provided?
Contextual integration (Is this exercise program adequately supported by the host organization?)	Is there sufficient support from the community setting for implementing this exercise program?	Is there anything in particular that will support the implementation of the program for you?
Reflexive Monitoring		
Dimensions	Outcome Questions	NPT Questions
Systematizing (Do people find implementing an intensive exercise program a	Do you think it is worth using this exercise program?	Would you come to this exercise program? If this program is successful, what would that look like for you?

worthwhile venture?)		
Communal appraisal (Do people find implementing a new exercise program with this framework a worthwhile venture?)	What are the benefits of this intervention?	What, if any, benefits of this program are there for you? How will you know if this exercise program is working or not? Can you think of any negative consequences of a program like this?
Individual appraisal (Do individuals evaluate the new practice as worthwhile?)	Will you use this exercise program in practice?	What factors would influence you using and continue to use this program? Timing? Locations? Cost? People or exercises in the class??
Reconfiguration (Do people modify their practice in response to evaluations made?)	Do you think that this exercise program will be easy to implement?	Would you make any changes to this exercise program based on your experiences?