Physiotherapy Extended-Role Practitioner for Individuals with Hip and Knee Arthritis: Patient Perspectives of a Rural/Urban Partnership

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ABSTRACT

Purpose: To explore the perspectives of people with hip and knee arthritis regarding a physiotherapy extended-role practitioner (ERP) model of care in a rural setting. **Method:** Using semi-structured interviews, a qualitative descriptive case study was undertaken with 13 participants from a rural family practice located in the province of Ontario, Canada, who had all been assessed by an ERP. Transcribed interviews were analyzed for emergent themes. **Results:** Three main themes were identified: (1) timely access to care, (2) distance as a factor in seeking care, and (3) perceptions of the ERP model of care. **Conclusions:** Participants reported many positive experiences with the physiotherapy ERP rural model. Processes related to minimizing travel required to access care are important for those in rural communities. An ERP model of care offers competent care that includes musculoskeletal diagnosis as well as time for educating patients and addressing questions.

Key Words: access to health care; arthroplasty; rural health.

RÉSUMÉ

Objectif : Explorer les perspectives des personnes qui ont de l'arthrite dans la hanche et le genou en ce qui concerne un modèle de soins basé sur le rôle élargi du professionnel de la physiothérapie (REP) en contexte rural. **Méthode :** Nous avons entrepris une étude de cas descriptive qualitative basée sur des entrevues structurées menées auprès de 13 participants d'un cabinet de médecine familiale en milieu rural dans la province d'Ontario, au Canada, qui avaient tous été évalués par un professionnel à rôle élargi. Nous avons analysé les entrevues transcrites pour en dégager des thèmes émergents. **Résultats :** Nous avons dégagé trois grands thèmes : (1) l'accès rapide aux soins; (2) la distance comme facteur de la recherche de soins; (3) les perceptions du modèle de soins basé sur le rôle élargi du professionnel. **Conclusions :** Des participants ont signalé de nombreuses expériences positives du modèle rural REP en physiothérapie. Les moyens de réduire au minimum les déplacements pour avoir accès aux soins sont importants pour les membres des communautés rurales. Un modèle de soins basé sur le rôle élargi du professionnel offre des soins compétents qui incluent la capacité de poser un diagnostic de l'appareil locomoteur et du temps pour l'éducation et pour répondre aux questions.

In 2009 it was estimated that 4.2 million Canadians and 1.8 million Ontarians were living with arthritis.¹ Osteoarthritis is the leading cause of disability and illness in Canada, affecting approximately 1 in 8 Canadians.²⁻⁴ As the number of people suffering with arthritis increases, so does the need for total joint replacement (TJR).⁵

Wait times for total hip and knee replacements were identified as a national concern at the First Ministers'

Conference in 2004, and the Ontario Ministry of Health and Long-Term Care subsequently announced a strategy to decrease wait times in five areas, including TJR.⁶ In Ontario, strategies were put in place to increase the number of surgical procedures performed, standardize best practices to ensure improvements in patient flow, and report accurate and current wait times.⁶ As of July 2010, the average wait time for a total hip replacement (THR) in Ontario was 172 days, surpassing the 182-day

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target set in 2004, but the average wait time for a total knee replacement (TKR) was 186 days, failing to meet the specified target.⁶ These numbers represent provincial averages, and smaller rural centres often experience longer wait times;⁶ for example, at the time of study, the average TJR wait time in the rural Ontario community in our study was 415 days, whereas the wait time at the urban hospital was 71 days.⁶ There is also a lack of physicians practising in rural areas and a lack of current research on the needs of people who live in these areas. Increased wait times for rural residents can potentially lead to deterioration in health status;^{7,8} numerous studies have shown that people who wait longer than 6 months for a TJR experience a decrease in health-related quality of life^{7,9–11} relative to those with shorter wait times.⁹

As part of the effort to reduce wait times for TJR, initiatives have been undertaken in Ontario to increase the competencies of some physiotherapists by creating extended-role practitioners (ERPs). ERPs have an extended scope of practice that allows them to take on roles beyond traditional physiotherapist duties.¹² For example, using medical directives, ERPs can order and interpret diagnostic tests and can make a diagnosis in their field of practice.¹² The Advanced Clinician Practitioner in Arthritis Care Program, associated with the Department of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto, was created to provide a mechanism for training physiotherapists and occupational therapists to work in extended or advanced roles of triage, education, and management of people with osteoarthritis and inflammatory arthritis.¹³ Several hospitals have also created their own procedures to train and evaluate ERPs.¹²

Research on the effectiveness of ERP models of care suggests that ERPs help reduce wait times, have high levels of competency (with orthopaedic surgeons as the gold standard) in diagnosing and referring people for TJR surgery, and achieve high rates of patient satisfaction.^{12,14–20} Studies investigating the level of agreement of diagnoses between surgeons and ERPs have found at least 90% agreement between the two professions.^{16–18} A Toronto programme using an ERP model of care for people who required THR and TKR surgery found that ERPs provided enhanced education throughout the continuum of care, resulting in more efficient delivery of services.¹⁵ Another Ontario study found that using an ERP decreased wait times both between referral and consultation and between consultation and surgery.¹⁶ The same study also found that those individuals requiring conservative care could be managed sooner as they did not have to wait for a physician's referral to rehabilitative care once surgery was deemed unnecessary.¹⁶

An urban-based study that examined patient satisfaction with ERPs in roles traditionally performed by orthopaedic surgeons found that people were satisfied with

the long-term follow-up after THR and TKR provided by ERPs.¹⁹ To our knowledge, satisfaction and experiences with ERP models of care for rural people with hip and/or knee arthritis have not been examined. Such perspectives can help us understand how models of care affect the lives of the participants and the impact of such programmes as a whole.

OBJECTIVES

Our study addressed two key objectives: (1) ascertaining participants' perspectives on how an ERP model of care affected their ability to access services for hip and knee arthritis and (2) ascertaining participants' perspectives on the quality of care they received through an ERP model. A priori, we postulated that, overall, participants would provide positive feedback on both the impact of an ERP model of care on access to services and the quality of care received. The research team was independent of the clinical team providing the health care and was therefore in an objective position to conduct the research.

METHODS

Study setting

The study was conducted in Ontario and examined a partnership between a rural community health centre (RCHC) and an urban teaching hospital (UTH) in a large city. The names of the centres are pseudonyms. RCHC, a family practice consisting of two family physicians, a pharmacist, and a privately funded physiotherapist, is based in a village of approximately 300 people and serves surrounding communities within a geographical radius of approximately 120 km. The partnership involved an ERP service-delivery model to address the needs of people with hip and/or knee arthritis in the rural community. This partnership was instituted in January 2010 and involved an ERP travelling from UTH to RCHC on a monthly basis. In this model, after a referral from one of the family physicians at RCHC for TJR assessment, the first point of contact for an individual with hip or knee arthritis is an ERP at RCHC for assessment and triage for either conservative or surgical management. If conservative management is indicated, the ERP provides various recommendations. If the individual is a potential candidate for TJR, the ERP reviews the patient's history, clinical findings, and imaging results with a surgeon upon returning to UTH; if the surgeon agrees with the recommended care pathway, the patient is put on a wait list for surgery at UTH, where the patient attends the preadmission clinic (including assessment by the orthopaedic surgeon), undergoes surgery, and receives post-operative acute care. The individual is discharged home with publicly funded home-care physiotherapy and can choose to receive follow-up care with the ERP at RCHC or with the surgeon at UTH. This model of health care delivery differs from the traditional care pathway for

Table 1 Participant Demographics

Participant	Pseudonym	Intervention	Sex	Age, y	Wait time, d
1	John	C	M	69	
2	Olivia	S	F	64	54
3	Sarah	C	F	69	
4	Susan	S	F	57	216
5	Debbie	C	F	69	
6	Michael	S	M	58	14
7	Noah	S	M	65	168
8	Trudy	S	F	73	104
9	Sheila	S	F	73	112
10	Beatrice	C	F	79	
11	Thomas	S	M	78	22
12	Katherine	S	F	65	113
13	Danielle	S*	F	46	58

C = conservative management; M = male; S = surgical intervention; F = female.

* Osteotomy.

persons with hip and/or knee arthritis. For example, these individuals would typically be referred to an orthopaedic surgeon by their family doctor. After a variable waiting time, they would then be assessed by the orthopaedic surgeon who would determine appropriateness for TJR. Following this stage, if appropriate for TJR, persons with hip and/or knee arthritis would then be put on a wait list for surgery. Following surgery, follow-up visits, including clinical and radiographic review, would be conducted by the attending orthopaedic surgeon.

Study design

Our study used a qualitative descriptive case-study design^{21–24} consisting of semi-structured interviews with people who experienced the ERP model of care at RCHC to explore perceptions of the programme. We chose this study design to provide a comprehensive summary of events in everyday terms as described by participants.^{21–24} A qualitative descriptive design allows researchers to stay close to the data when evolving their interpretations rather than draw on formalized theory or generate new theories. Sandelowski^{22(p.335)} notes that qualitative descriptive studies

...do not require researchers to move as far from or into their data ... [and] do not require a conceptual or otherwise highly abstract rendering of data.... Although no description is free of interpretation, basic or fundamental qualitative description, as opposed to, for example, phenomenological or grounded theory description, entails a kind of interpretation that is low-inference, or likely to result in easier consensus among researchers.

Specifically, our research design allowed us to compile a firsthand account of details related to the programme being offered at RCHC and provided an understanding of the impact of the programme on those involved. For our study, the case is the ERP model of care at RCHC, and the unit of analysis²⁴ is the perspective of each participant. Ethical approval for this study was obtained

from research ethics boards at the UTH and the University of Toronto.

Participants

Patients of RCHC who were assessed and/or treated by the ERP between January 2010 and January 2011 were eligible to participate in the study. Programme staff generated a list of all people assessed during this period; to ensure a range of perspectives, this list of 40 eligible participants was stratified according to gender and surgical versus conservative management. Sampling was purposive (potential participants were systematically contacted by administration staff at RCHC) to identify information-rich cases. Administration staff booked a total of 14 interviews for two interview dates set by the researchers in February and March 2011. Of the potential participants contacted by the administrative staff, none refused. Participants scheduled for interviews were sent information letters outlining the study details, including the researchers' contact information. One participant scheduled for the March interview date cancelled on the day of the interview due to an emergency; therefore, a total of 13 participants were interviewed for the study (Table 1). Although there are no standard sample-size guidelines for qualitative studies, a sample of 12–20 participants is generally considered sufficient to achieve saturation of themes with a relatively homogenous group.²¹ In our study, saturation of data was achieved with 13 participants, and therefore no further dates were scheduled for interviews.

Data collection

Individual face-to-face interviews took place over 2 days at RCHC in February and March 2011, using a semi-structured interview guide (Appendix 1) consisting of six core open-ended questions with potential probes, which we had previously piloted with two participants in a similar ERP programme in an urban setting. The research team consisted of five student researchers and

three physiotherapy faculty advisors with qualitative research experience. Two students and one advisor participated in the interviews; the students alternated between lead interviewer and observer roles, while the advisor was present to provide training to ensure adequate coverage of the topic areas. The spouse of one participant, Sheila (see Table 1), was included in her interview to provide additional information because she had experienced temporary memory difficulties post-surgery. After each interview, the interview team debriefed to discuss the interview and to make note of additional probes and modifications to the interview guide as new information emerged. This process allowed the interview content to evolve as the study progressed to reflect issues raised by participants. Modification of interview guides is standard in qualitative research; a key principle is that data collection and analysis are conducted concurrently so that new information can be incorporated into further data collection. This method increases the richness of the data, focuses inquiry on emerging concepts (anticipated and emergent), and strengthens the overall rigour of the research.²⁵ All interviews were audio-recorded and transcribed verbatim for subsequent analysis; the original lead interviewer checked the transcripts to ensure accuracy.

Data analysis

We analyzed the data using methods outlined by Carpenter and Suto.²³ All five student researchers, individually and independent of each other, reviewed each transcript to record their initial impressions and then independently coded two transcripts using a line-by-line review method.²³ The entire research team then met to discuss the codes and develop a flexible codebook for coding subsequent transcripts. Codes were derived from inductive analyses of the texts to address research objectives. Two student researchers then independently coded the remainder of the transcripts. Codes were added and revised as analysis proceeded. After coding was complete, the team met to review and finalize the coding and discuss emerging interpretations. Coded data were imported into QSR NVivo 8 (QSR International [Americas] Inc., Cambridge, MA), a qualitative data software programme, for further management. Cross-case coding reports were generated, and the team met to discuss impressions and identify themes. Codes were grouped into broader categories, and multiple interpretations, outliers, and negative cases were reviewed and discussed using an iterative process.²³ Data analysis was considered complete when no new themes were identified (indicating saturation), inconsistencies in interpretations had been identified and reconciled, and the research team was satisfied that the objectives of the study had been met.²⁶

RESULTS

Three main themes were identified: timely access to care, distance as a factor in seeking care, and percep-

tions of the ERP model of care. In the excerpts quoted below, participant names are pseudonyms (see Table 1).

Timely access to care

The overarching theme that arose was that wait time for initial assessment and subsequent surgery was an important determining factor in choosing the ERP model over other pathways. Even though this programme would require participants to travel further for their surgery, the perceived shorter waiting time for TJR surgery was identified as one of the main reasons for participation: "I could have gone to [the local hospital], it was closer, but it was going to take me a year to get in there, so I opted to go to [UTH]" (Trudy).

All participants waited less than 1 month for their first assessment with the ERP. For example, Katherine commented on how quickly she could be seen by the ERP: "Oh, it was wonderful—there was no waiting with the [ERP]." Many of the participants were impressed by how short the wait times to receive a TJR were through the programme. Those who were surgical candidates had an average wait time of 96 days from initial ERP assessment to TJR, which participants suggested was much shorter than expected. Michael compared his experience with that of a relative who underwent TJR surgery locally: "What was interesting ... was that I have my older sister ... going through the same process, and she went the other route and she had been waiting for almost ... 2 years."

Participants appreciated that the scheduling of their surgery was flexible as well as timely. For example, two participants were working up until the time of their surgeries, and flexible scheduling allowed them to plan surgery for times that were optimal for them and their employers: "I could have had the surgery in December, but it wasn't a good time for my employer ... I called and said I [couldn't] get time off and she said okay, we will put you off until ... you're ready to do it" (Danielle).

Distance as a factor in seeking care

All participants voiced concerns about travelling from their rural communities to the urban centre for surgery and subsequent follow-up appointments. Many participants felt that having to travel to a large urban centre was a deterrent to seeking health care. Although some appointments took place in their own community, participants had to travel to the city for a preoperative appointment and for surgery. Some participants expressed concerns about the driving distance and traffic congestion, as well as anxieties about being in an urban centre and away from home: "I was a little leery about being so far away from home—[the local hospital] doesn't seem so far away from home as being in ... the city. I was uneasy about that" (Michael).

Overall, participants recognized that living in a rural community creates many challenges concerning access to health care services. Katherine noted that rural residents often defer addressing health issues: "I think up

here you find people put things off because ... they are going to have to go to [the urban centre], and they don't want to. People seem to put their aches and pains off."

Although travelling to an urban centre created some anxieties before surgery, many participants found it more manageable than initially perceived. Participants also identified a variety of strategies to overcome travel barriers, including assistance from friends, family, or publicly funded community supports: "So I just called up one of the fellows [from a local community agency] that took me there ... He picked us up, he waited and brought us home, it was worth it" (Sheila).

The ERP model of care helped address the concerns about travelling from the rural community to UTH by reducing the number of trips required. Although participants had to travel to the urban centre if surgery was required, the programme reduced the need for multiple trips for follow-up appointments after TJR because the follow-up visits could be completed by the ERP at RCHC. Participants lived within a 5- to 40-minute drive from RCHC, and all reported this to be more convenient than driving approximately 2.5 hours to UTH: "What was good for me was living so far away and not having to travel to see the doctor [for follow-ups] because I think that's detrimental to my condition. I'd have to get out of the car once an hour ... so it's been wonderful for me" (Sheila).

Participants also talked about the convenience of making only one visit to UTH for all of their preoperative appointments, which reduced their travel time and the associated costs. Within one visit they were able to meet with the entire health care team that would be involved in their care, including the orthopaedic surgeon. Michael contrasted his experience with that of his sister, who had to attend many separate appointments before surgery: "The fact that preoperative appointments were made so that you met all of the professionals at one time ... was incredible because my sister made several trips to different people at different times."

Participants felt that the programme significantly decreased the challenges of accessing health care services in a rural community by offering services closer to home while expediting surgery. Danielle described the programme's substantial effect on the community: "It has enhanced our community beyond belief. It truly has. I had watched patients in so much pain [who] truly, truly needed the surgery, and in our area you can't get it and ... in 4–6 weeks, it just totally changes their life."

Perceptions of the ERP model of care

Overall, participants expressed satisfaction with the ERP model of care for hip and knee arthritis and highlighted the programme's positive effect on their lives. Key positive features of the ERP model of care, including how these features contributed to an overall successful experience, are described below.

Time spent with the ERP

Participants told us that the ERP was easily approachable, able to spend more time with them than other health care providers in their experience, and personalized their health care:

She took the time. I think that was definitely a plus. She took the time to examine me, to answer my questions, and I answered her questions ... I felt like I was important to her. She wanted to get to the bottom of things and I was quite relaxed with her and very comfortable. (Debbie)

Knowledge and competence of the ERP

Participants commented that they were satisfied with the care provided by the ERP, including her ability to diagnose. They specifically noted the consensus between the ERP and the surgeon in both diagnosing and referring for surgery: "She told me exactly what ... the doctors had already told me. She hit the nail on the head—[she knew] exactly what was wrong" (Danielle).

Education provided by the ERP

Participants noted that education they received from the ERP was very helpful, allowing a better understanding of their conditions, including mental and physical preparation for surgery: "She explained the whole process. She was excellent. Every question I needed answering she [answered] before I even had to ask" (Trudy).

Participants told us that information about their conditions and prognosis was essential to their decision-making and described how the ERP provided additional resources if needed:

[The ERP] gave us a lot of information verbally ... and also [told us] where we could look for more information because there was a lot to absorb in a very short period of time. We were given the opportunity to talk through some of it, but ... we could [also] go and look at it in writing and really mull it over. (Michael)

Overall effect of the programme

Overall, programme participants were very satisfied with the ERP model of care. Many participants discussed difficulties that they had experienced in day-to-day living before intervention and the treatment's positive impact on their level of function. A participant working as a teacher discussed the importance of mobility in his life and how much the programme and surgery had contributed to his improved quality of life:

I needed to be mobile, pain-free mobile, and that wasn't happening ... I was impressed with the whole process and extremely thankful that I've been through it. And [my] quality of life is incredibly different now—I am] much more positive. I know that it has made a world of difference in terms of me ... being mobile as quickly as I was. I was back in the classroom full time ... at the start of September and have been ever since. (Michael)

Participants strongly recommended the programme to others, which indicates their overall satisfaction with the ERP model of care: "I would do it this way. I would recommend it to anybody, I really would. I think [the ERP] has set up a good programme" (Katherine).

However, some participants suggested that this model of care would have been even better if it was based out of their local hospital so that preadmission appointments and surgery would take place closer to home, further saving them travel time and costs. They also suggested that having care closer to home would reduce anxieties about unfamiliar urban settings.

DISCUSSION

Our study contributes to a better understanding of the perspectives of people with hip and knee arthritis, including those with TJR, on how an ERP model of care affects access to care, as well as the quality of care received, in a rural setting. Specifically, early access, minimal travel, and care provided by a health care professional with the knowledge base, clinical assessment skills, and time to address questions and provide information were reported to be important. While strategies have been put in place across Canada to reduce wait times in priority areas, including TJR, wait times remain longer than anticipated in many regions across the country, most notably in rural areas.⁶⁻⁸ Related to the first theme, timely access to care, the interviews demonstrated that participants valued the reduced wait times associated with the ERP model. Previous research suggests that those who wait longer than 6 months experience clinically important losses in functional mobility and health-related quality of life.^{7,9-11} Consistent with these findings, many participants discussed how long waiting periods for TJR surgery leads to inactivity and weight gain, which can cause complications with surgery and poorer outcomes. The average wait time for TJR for people involved in the ERP model of care in this study was 96 days, much less than the average wait time of 418 days in surrounding regions.⁶ Adoption of similar programmes using ERP models of care has the potential for a positive impact on the musculoskeletal health of Canadians.

The second theme that emerged from the interview data related to travel distance for care. The ERP model allowed participants to have initial assessments and follow-up visits within their own community. A recent study reported that for people in rural communities, a travel distance of within 80 kilometres of one's residence is a key factor when choosing a hospital for total knee replacement.²⁷ Similarly, while our study participants generally had positive views of the ERP model of care, they told us that having to travel to a large urban centre several hours from home for preadmission and surgery was a significant barrier. Minimizing travel to UTH for care (including initial assessment and follow-up visits) appears to have been a determining factor for patients

when deciding whether to wait for care in their community or access it more quickly via the ERP model of care.

Finally, participants identified several advantages of an ERP model of care with respect to both access and quality of care received. One of the advantages was having adequate time with the ERP to discuss issues related to TJR. It was also evident that participants welcomed a physiotherapist with extended knowledge and skills in orthopaedics. In addition, participants commented on the ERP's ability to provide educational information and resources for further knowledge acquisition. These findings are consistent with previous research demonstrating that ERPs provide quality care for musculoskeletal conditions^{12,13,15,16} and concur with a previous study that recommended an all-inclusive educational package for people undergoing TJR.²⁸

While this study provides in-depth information on the perspectives of people who participated in an innovative programme for hip and knee arthritis, it has some limitations. Participants were all from a single programme, and therefore caution needs to be exercised when transferring or generalizing the results to other contexts. The ERP involved in the programme had previously lived in the small rural area where the study took place and continues to have family ties to that community; it may be that participants were more receptive to her than to an outsider because of her personal background.

CONCLUSION

Our data suggest that people with hip or knee arthritis who may need TJR believe that long wait times can adversely affect their lives by delaying the return to valued levels of activity. Overall, participants reported high levels of satisfaction with the ERP model of care; processes related to minimizing travel to access care for hip and knee arthritis, including TJR, are also important when developing models of care. Finally, personalized, competent care that includes opportunities for education, as provided by an ERP, is an important consideration when developing models of care for hip and knee arthritis.

This study highlights areas for potential change in health care delivery using models of care with ERPs. Although the partnership between RCHC and UTH had many advantages, our interviews made clear that participants would have greater access to such a programme if an ERP were partnered with hospitals locally. The study also provides a case example that can inform future research on rural programme delivery models, including partnering other rural communities with urban centres.

KEY MESSAGES

What is already known on this topic

Physiotherapists working in ERP roles have been shown to contribute to improved access to care for those with

musculoskeletal conditions, particularly in urban settings. ERPs are highly competent in care delivery when compared with orthopaedic surgeons as the gold standard, and patient satisfaction with ERP services is generally high.

What this study adds

Participant perspectives suggest that an ERP model of care is an effective means of decreasing wait times and providing competent, quality care for people with hip and knee arthritis living in rural communities. Important aspects of this model of care include adequate time to discuss issues, answer questions, and provide education related to TJR, as well as the physiotherapist's advanced knowledge and ability to make a musculoskeletal diagnosis. In rural communities, travel distance is a key factor when choosing a hospital for TJR.

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APPENDIX 1: Interview Guide

1. Could you please tell us a little about how you came to be assessed by the advanced practice physiotherapist?
 - a. When were you first referred?
 - b. Were you given other options?
 - c. How long did it take from the time you were referred until your first appointment?
 - d. Surgical—what happened at the hospital?
 - i. How many times did you go to [urban centre]?
 - ii. Did you meet with the surgeon? Advanced practice physiotherapist?
2. This is a new model of care—previously the appointment would have been with a surgeon and they would have determined your appropriateness for surgery. With this new model of care, an advanced practice physiotherapist did your initial assessment and determined if you were a candidate for surgery. Could you please describe a bit about your first appointment with the advanced practice physiotherapist?
 - a. Did she give you exercises?
 - b. Were X-rays done?
 - c. Did she give you any education—what was it?
 - d. Have you ever been seen by an advanced practice physiotherapist in the past?
 - e. Have you had previous experience being seen by a surgeon in the past?
 - i. How did their assessments compare?
3. Describe your experiences with accessing health care services both here at the clinic and at the hospital.
 - a. Is it difficult for you to get to the clinic?
 - b. If you had surgery was it difficult getting to [urban centre]?
 - c. How long after they decided you were to have a joint replacement did you have your surgery?
 - d. After the surgery did you have any follow-up appointments?
 - i. Who did your follow-up appointments?
4. How do you feel your treatment has improved your overall health?
 - a. Has it had any impact on your social life?
 - b. Are there things you can do now that you couldn't do before?
 - c. Have you found any changes in your mood since you received treatment?
5. Could you describe any advantages you have experienced as being part of the programme?
6. Do you see any disadvantages or things that could be improved?