PJHRD Philippine Journal of Health Research and Development

RESEARCH ARTICLE

Readiness of clients in returning to face-to-face therapy in an outpatient rehabilitation clinic during the COVID-19 pandemic: A preliminary study

Jaymilyn Catangay Ombao*, Charlemaine Deane A. Perez, Audrey Anne D. Esguerra, Ferdiliza Dandah S. Garcia, Czarina Camille A. Lazaro, Michael P. Longno, Mariam Lujain J. Anwar Bahraq, Angelika Marie R. Gonzales, Jen Aebriel DC. Leynes, Kyla Kristiana F. Lu, Maria Inez Corazon T. Recto, Maria Blanquita M. Salvador, Regina Ariane DR Tayag

*Corresponding author's email address: jvcatangay@up.edu.ph

College of Allied Medical Professions, University of the Philippines Manila, Manila, Philippines

ABSTRACT

Background: The Clinic for Therapy Services (CTS) has considered reverting to face-to-face service delivery due to the downward trend in COVID-19 cases in the Philippines. However, the clinic has yet to investigate the willingness of the clients to this mode as a basis for its effective implementation.

Objectives: The study described the readiness of CTS clients in returning to face-to-face therapy amidst the pandemic. It also discussed the factors affecting readiness based on a survey.

Methods: Fifty-five screened survey responses on the readiness of clients in returning to face-to-face therapy were gathered from January 30 to February 28, 2021. These underwent retrospective data analysis. Eight prospective online key informant interviews were conducted for clarifications in May 2022. This study utilized a descriptive analysis of quantitative categorical variables and a thematic content analysis of qualitative data.

Results: The majority of the respondents (35) stated readiness to attend face-to-face therapy followed by those who answered "No" (11), "Maybe" (5), and others (4). Factors that may have affected readiness included travel, characteristics of face-to-face therapy, health conditions, vaccine, and COVID-19 concerns. Frequently preferred health and safety strategies were the provision of hygiene products, disinfection, limited people inside the clinic, separate therapy areas, and ventilation.

Conclusion: Most of the respondents expressed willingness to receive face-to-face therapy in April or May of 2021. Feasibility of travel and decreased number of COVID-19 cases may have encouraged willingness to attend. Those who were hesitant reported concerns with traveling, characteristics of face-to-face therapy, health conditions, the COVID-19 situation, and the vaccine.

Keywords: *rehabilitation, face-to-face therapy, readiness, COVID-19*

Introduction

The COVID-19 pandemic was a global health crisis that disrupted aspects of health, economy, and society [1,2]. In the Philippines, non-pharmaceutical health measures such as quarantines and lockdowns were implemented to control transmission [3]. the provision of rehabilitation services such as occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP) shifted to telehealth modalities [4,6]. The University of the Philippines Manila College of Allied Medical Professions (UPM-CAMP) responded by creating protocols for the Clinic for Therapy Services (CTS) in delivering OT, PT, and SLP services through online and remote means (*e.g.*, messaging, voice, and video calls). These measures were based on interim guidelines set by the professional organizations [4,6]. Consequently, service provision overcame the geographic, physical, and cognitive barriers brought about by the pandemic [7,8]. Since employing this setup, clients and providers have adapted and appreciated its convenience, safety, and comparability to face-to-face service delivery [7,9-11]. However, limitations such as access to hardware, software, and internet connectivity

persist. Also, conducting physical examinations and treatment procedures were infeasible. The CTS may soon need to return to face-to-face therapy services to accommodate procedures that need to be delivered in-person.

There are various human, organizational, and technical challenges to telerehabilitation in the Philippines [12]. The resistance of parties involved with telerehabilitation, inadequate proficiency in e-health, and data privacy concerns were identified as human-related factors that contribute to challenges in remote delivery of therapy services [12]. Larger issues such as the absence of national policies and laws on virtual healthcare practices were recognized as organizational challenges influencing telerehabilitation [12]. Technical challenges, especially internet connectivity in the Philippines, were the primary obstacle to adaptation to e-health [12]. The use of appropriate medical devices for specific patient needs was also restricted [13]. Evidently, the implementation of telerehabilitation in developing countries still has its impediments [12]. The return of OT, PT, and SLP services to face-to-face delivery can address these problems.

Since October 2020, experts have reported a decline in the number of newly-recorded cases [14], albeit inconsistent due to fluctuations in the following months. A clear downward trend in the number of COVID-19 cases was stated by the OCTA Research Group [15] in late January 2022 after an abrupt increase in cases in December 2021, which peaked in early January 2022 [16]. In the succeeding months, the Department of Health (DOH) of the Philippines observed that the daily number of COVID-19 cases nationwide plateaued at 200-plus-level [17].

Because of the decreasing trend in COVID-19 cases and the advantages of gradually returning to face-to-face therapy services for clients, CTS has performed assessment measures on the available structures and facilities for in-person therapy. Concurrently, UPM-CAMP has implemented systems in preparation for phased return to onsite academic activities, including the deployment of OT, PT, and SLP interns to face-to-face therapy sessions as part of internship. Safety guidelines were established and retrofitting of CTS was conducted as part of the preparation for phased re-opening. Despite these preparations, client perspectives have yet to be obtained. Further probing is necessary to gauge their readiness in terms of accessibility of geographical location, presence of caregivers during sessions, and other safety concerns. Understanding the intentions of the clients is crucial in identifying the factors that influence their perspective and likelihood of returning to the face-to-face setup.

The process of gathering the CTS clients' readiness for face-to-face therapy was essential in determining their intentions to receive onsite therapy services in congruence with the Theory of Planned Behavior (TPB) [18]. The TPB, as presented in Figure 1, states that the strength of an individual's intentions (*e.g.*, readiness to return to face-to-face therapy) determines the likelihood of performing the behavior (*i.e.*, attending face-to-face therapy) [18]. Given the nature of this study, the theoretical framework of TPB was deemed an appropriate guide for identifying various factors during the COVID-19 pandemic that impact the readiness of the clients of CTS in returning to face-to-face therapy. Further support for this decision is provided by multiple studies that applied TPB in exploring health behaviors such as using face masks [19] and receiving COVID-19 vaccination [20].

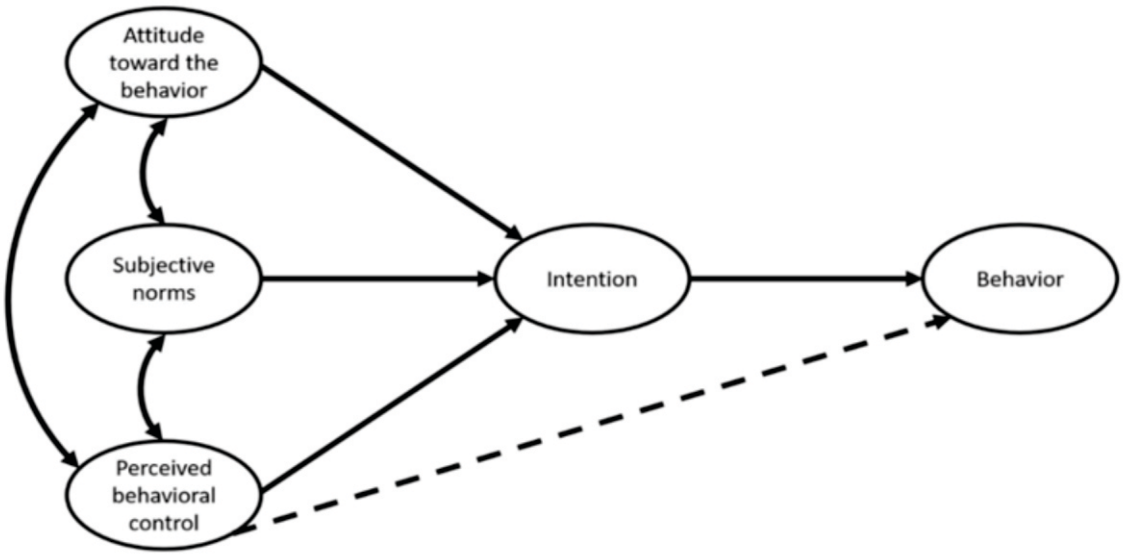


Figure 1. *Theory of Planned Behavior model*

Centered on the TPB framework, the study aims to describe the readiness of CTS clients in returning to face-to-face therapy as influenced by a variety of factors that are based on the results of a readiness survey conducted in January to February 2021. The results of this study will serve as a guide for CTS in its preparations and administrative decision-making for the resumption of face-to-face therapy. Specifically, this study will help identify the different concerns clients have with regard to returning to face-to-face therapy and the corresponding solutions (*e.g.*, appropriate health and safety protocols) to address these. Study findings may also benefit other similar outpatient rehabilitation clinics and institutions offering the same services for similar clientele as they shift to face-to-face therapy.

Methodology

Study Design and Sampling

The researchers conducted a blend of retrospective data analysis of existing recorded responses to an online readiness survey on returning to face-to-face therapy sessions generated between January 30, 2021 to February 28, 2021, and prospective online synchronous key informant interviews (KIIs) conducted from May 13, 2022 to May 26, 2022. The 100 target respondents (i.e., clients or caregivers of clients who were receiving or about to receive telerehabilitation OT, PT, and SLP services in CTS) were determined through purposive sampling.

Data Criteria

The researchers reviewed 67 responses from all (1) adult clients (*i.e.*, 18 years old and above) and (2) caregivers of pediatric and adult clients of the clinic to an online survey that was conducted from January 30, 2021 to February 28, 2021.

In reviewing the recorded responses, the researchers included data from clients who were receiving telerehabilitation services in the clinic at the time of the survey, regardless of their medical condition. The researchers included recorded responses even if open-ended questions (*i.e.*, reason for not being able to attend face-to-face therapy sessions, conditions that would encourage attendance, and questions or comments) were unanswered. The researchers also included responses in both English and Filipino but excluded duplicate responses from the review of records and data analysis.

Respondents who provided vague, inaccurate, and contradicting answers were considered candidates for a maximum of 60-minute online synchronous KIIs from May 13, 2022 to May 26, 2022 to clarify their responses. On the other hand, unanswered questions in Sections 1 to 4, as well as the open-ended question in Section 5 of the survey, did not warrant an interview.

Procedures and Data Collection

The survey was conducted using an online questionnaire developed using Google Forms (see Appendix A). It gathered information about the clients' demographic information (*i.e.*, age, sex, geographical location), the status of therapy, and the type of therapy received. The survey also collected data on (a) likelihood of attending face-to-face sessions, (b) accessibility to transportation (i.e., means of travel, length of time of travel, availability of companion when traveling, the relation of the companion to the client), (c) reason for not being able to attend face-to-face therapy sessions, (d) conditions where clients would consider attending face-to-face therapy sessions, (e) agreement with health and safety strategies planned by the clinic that would encourage attendance to face-to-face therapy, and (f) other questions and comments. The aforementioned data were collected through questions answerable by multiple choices, checkboxes, as well as short and long answers in the text.

The survey was distributed through email and online messaging applications to all clients receiving or decked for telehealth OT, PT, or SLP sessions at that time. The survey responses were followed up through text messages and phone calls. There were a total of 67 survey responses gathered.

Data reviewing was commenced after the researchers obtained approval from the UPM-CAMP Technical Review Committee and the University of the Philippines Manila Review Ethics Board (UPMREB 2021-0666-01). The researchers acquired permission from the Dean of UPM-CAMP on the use of recorded data for research purposes because of involvement of the CTS Program Head in the study. The respondents' consent to use their clinic records for research purposes has been gained upon referral to the clinic. A statement of consent integrated into the introduction section of the online form was also provided to the respondents upon accessing the survey. The statement explained that answering the form would reflect their agreement to the use of their responses for clinic services improvement, face-to-face therapy preparations, and research purposes of the clinic. There was no risk of harm to the survey respondents in this study. There were no physical interactions (*i.e.*, assessment or intervention procedures) with the survey respondents at any point in the study.

The researchers gained exclusive and temporary access (*i.e.*, from May 2, 2022 to June 15, 2022) to the recorded survey responses through a secured Google Drive folder only after pseudonymization and de-identification of data were performed by the administrative staff of the clinic. The administrative staff has sole access to the identities of the assigned pseudonyms.

The researchers screened the responses based on the inclusion and exclusion criteria. Initially, four duplicates and seven ineligible respondents who were not receiving services were excluded. The raw data from the remaining 56 responses were organized using a data extraction instrument via a secured Google Sheets file. The researchers coded survey responses involving quantitative categorical data from the respondents' demographic information and responses to close-ended questions. In addition, qualitative data were collected from recorded responses to the open-ended survey questions. The cells of the Google Sheets file were protected to prevent any accidental alterations in the data.

A data collection instrument via a secured Google Sheets file was utilized to summarize the clarity and completeness of the responses in each section of the survey. After evaluation, 12 respondents were considered candidates for the KIIs. Two of them did not respond to the close-ended question in Section 5 (i.e., agreement with health and safety strategies planned by the clinic) while three respondents provided contradicting or inaccurate answers on their access to transportation (i.e., duration of travel, availability of a companion when traveling, and relation of the companion to the client). The other seven respondents provided vague reasons for not being able to attend face-to-face therapy sessions and conditions that would encourage their attendance. The researchers provided the administrative staff with the pseudonyms of the candidates for the KIIs. The candidates were invited through the official email address and telephone number of the clinic. A letter of consent and informed consent were obtained from the respondents prior to the interview. Out of the 12 candidates, eight were interviewed via Zoom teleconferencing platform on May 13, 2022, May 17, 2022, and May 26, 2022 for not more than 60 minutes to clarify their survey responses. The interviews were recorded using Zoom and were uploaded to a secured Google Drive folder. Each video was transcribed and anonymized by a researcher (i.e., not the interviewer) in a secured Google Sheets file and was validated by a different researcher for accuracy. Only the researchers were given access to the recordings and transcription files, which were only used for this research study. Four candidates were not interviewed due to the unavailability of contact information, family emergency, and refusal to participate. One of the interviewees was excluded from the data analysis as he stated that he was not receiving online CTS services; this contradicted his initial response in the survey.

Data Analysis

Upon screening of the data, the researchers excluded four identified survey duplicates and eight respondents who were not receiving therapy services at the time of the survey. The 55 remaining data were organized and checked to ensure accuracy.

The researchers assigned codes to the quantitative categorical variables (*i.e.*, demographic information, status of therapy, type of therapy received, likelihood of attending face-to-face sessions, accessibility to transportation, agreement with health and safety strategies). To ensure proper data management and accuracy, the researchers kept a master list of codes and checked each other's coding. The raw data from recorded responses, the master list of codes, and the coded electronic data in the data extraction form are stored in a password-protected thumb drive inside a secured and locked cabinet in CTS until 10 years after the completion of the study. The researchers interpreted the coded quantitative data using descriptive analysis through frequencies, mean, and/or standard deviation in Google Sheets. The researchers then generated charts and graphs to present the results.

The researchers employed an inductive thematic content analysis of the responses from the open-ended survey questions and from the KIIs. Inductive thematic content analysis of qualitative data aided in describing the emergent phenomena related to the inability to attend face-to-face therapy sessions, the conditions that would facilitate attendance, and questions and comments related to clinic operations amid a pandemic [21]. The researchers transcribed the qualitative data and conducted an initial and repeated coding in a secured Google Sheet file. From the initial codes, the researchers identified sub-themes, which were used to generate general themes that represented the participants' perspectives on returning to face-to-face therapy sessions. The researchers consulted with each other regularly to decrease the probability of bias in interpreting the data. The researchers then generated tables to represent the results of the thematic content analysis.

Results

The data presents the readiness of CTS clients to return to face-to-face therapy and the related factors to this behavior. Among the 67 respondents, only 55 were included in the quantitative and qualitative (i.e., thematic content analysis) data analysis. The four duplicates and eight individuals who were not CTS clients at the time of the survey were excluded.

Demographics

Table 1 shows that the majority of the survey respondents were pediatric clients represented by their caregivers, followed by adult clients represented by themselves or their caregivers.

Out of 55 survey respondents, 40 (72.7%) were male while 15 (27%) were female. There were 43 respondents (78%) residing in Metro Manila, Philippines when the survey was conducted, while 12 (21.81%) were living in farther cities and provinces.

Type of Therapy Received

Half of the clients represented by the survey respondents were predominantly receiving only remote SLP services (n=28, 51%), as shown in Figure 2. Nineteen out of 55 (35%) respondents were seen for two or more telerehabilitation services (e.g., both OT and PT).

Table 1. *Age of respondents*

Age Range (years)	Frequency	Percentage
0-17 (Pediatric)	41	74.54%
≥18 (Adult)	14	25.45%

Likelihood for Attending Face-to-Face Therapy

Out of the 55 respondents, most (n=35, 63.6%) were likely to attend face-to-face therapy, while some were unwilling (n=11, 20%) and a few (n=5, 9.1%) had reservations (See Figure 3). Four respondents (7.3%) did not indicate their likelihood of attending but provided clear conditions in the short-answer survey question.

Readiness of Clients for Attending Face-to-face Therapy

Among the respondents who expressed readiness for face-to-face therapy (n=35), 26 (74.28%) would use public transportation, followed by private vehicles (n=8, 22.86%), then hired vehicles (n=1, 2.86%) to go to the clinic (See Table 2). The majority of respondents' (n=27, 77.14%) travel time to the clinic was 60 minutes or less (See Table 3).

Among the 35 respondents who expressed readiness to attend face-to-face therapy in the clinic, 28 (80%) would have a companion. Figure 4 shows that most respondents would be accompanied by a parent. One respondent who stated that they had a companion did not specify their relationship with the person. For respondents who selected "Other", their companions include their spouse and relatives. One respondent answered "Other" despite expressing the unavailability of their companion on the preceding question. This contradiction was not clarified due

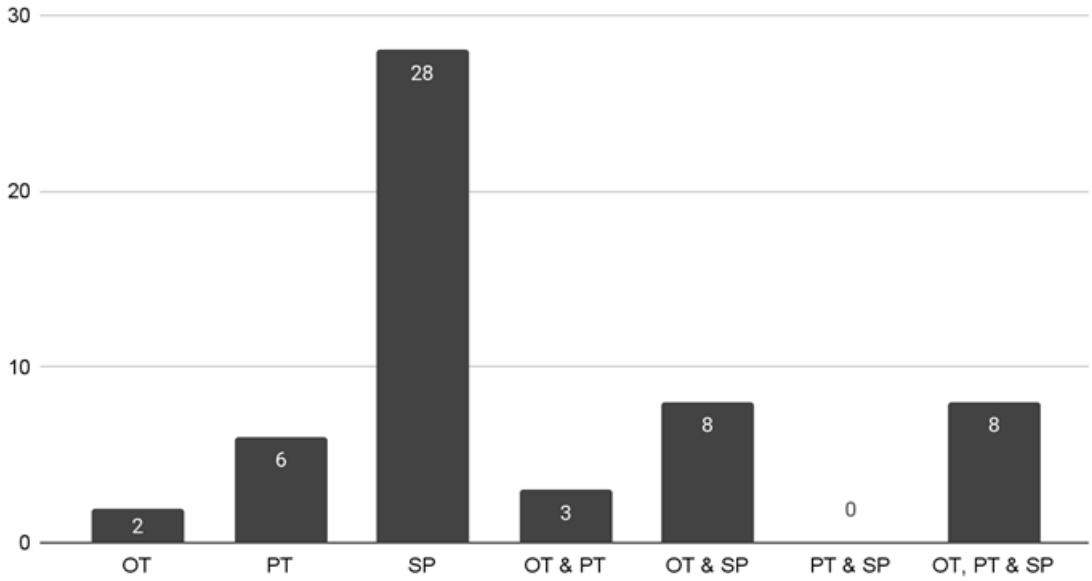


Figure 2. *Type of telerehabilitation services received by the respondents in CTS*

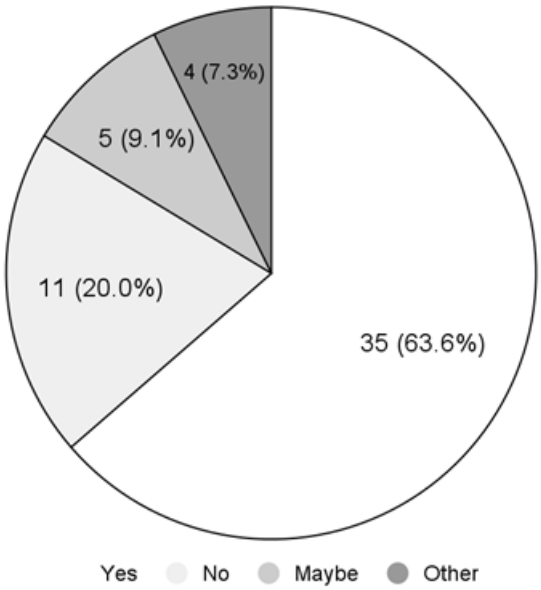


Figure 3. *Likelihood of Attending Face-to-Face Therapy in April or May 2021*

Table 2. *Means of transportation of respondents*

Means of Transportation	Frequency
Public	26
Private	8
Hired	1
Other	0

Table 3. *Duration of travel of the respondents*

Average Duration of Travel (mins.)	Frequency
0-30	12
31-60	15
61-90	2
91-120	3
121-150	0
150+	3

to the respondent's unavailability for an interview. Overall, there were seven respondents (20%) who would have no available companion to the clinic.

Through inductive thematic content analysis, the responses from open-ended questions of the survey and KIIs were explored to probe the respondents' reasons behind refusal and the preferable conditions for attending face-to-face therapy in May 2021. A total of 90 codes were generated from 68 excerpts. Five themes were generated on the reasons behind refusal to attend face-to-face therapy, three themes on preferable conditions for attending face-to-face therapy, and seven themes from comments and suggestions related to face-to-face therapy service delivery. Each of these themes comprised a variety of subthemes in Table 4. Other examples of the coded excerpts for each subtheme are also provided in Appendix B

Reasons for Not Attending Face-to-face Therapy

Most respondents expressed that the COVID-19 pandemic situation at the time of the survey was the main reason for their hesitation to return to face-to-face therapy. They shared concerns regarding exposure to health risks, difficulties abiding by health protocols, and issues with attending therapy due to quarantine restrictions for minors. Another recurring reason for not agreeing to face-to-face therapy included the health condition (*e.g.*, medical diagnosis) of both the client and the caregiver. Some respondents reported problems with travel due to unavailability of transportation and a companion. Others had lengthy travel times and far residence from the clinic. A few respondents had indicated the vaccine unavailability and age restrictions (*e.g.,* no vaccine for minors) as their reason for hesitancy. The least common factor observed was the short duration of face-to-face therapy.

Conditions for Attending Face-to-face Therapy

Vaccines and travel were the most frequent factors influencing the likelihood of attending face-to-face therapy

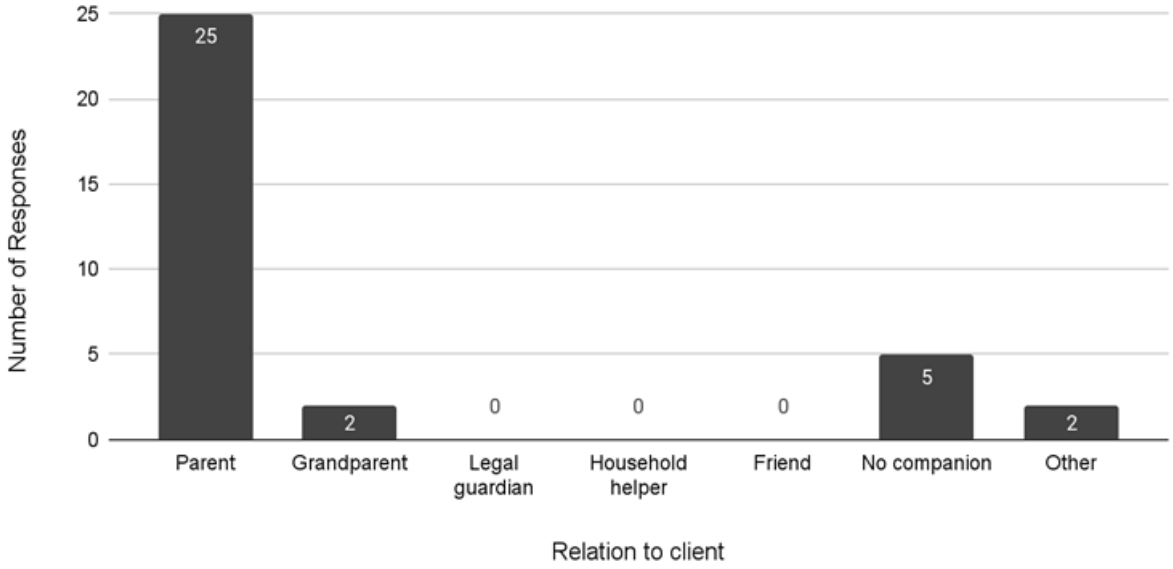


Figure 4. *Relation of the available companion to respondent in face-to-face therapy*

for the respondents who answered "Maybe." When the survey was conducted, some of them were unvaccinated either due to unavailability or existing age restrictions. Moreover, the respondents' available mode of transportation and distance from the clinic also potentially impacted their decision. Lastly, the COVID-19 pandemic situation was the least frequently mentioned reason for their conditional return. They raised unspecified concerns related to COVID-19, not including reasons involving health risks, protocols, and restrictions.

Additional Suggestions, Questions, and Comments

Additional questions and comments indicated by the respondents were predominantly about access to therapy. Some respondents shared their preference for online remote therapy while others had further concerns regarding the availability of online or face-to-face therapy services and the scheduling and implementation of face-to-face sessions. Comments and questions regarding the characteristics of the probable face-to-face therapy services (i.e., duration, client requirements, clinic equipment, clinic protocols) provided by CTS were then raised. Respondents listed projected health risks brought about by the pandemic and IATF quarantine restrictions that may influence attendance in face-to-face sessions. Some respondents also added particular concerns regarding unavailability and restrictions related to COVID-19 vaccination and travel logistics (i.e., mode of transportation). Only one additional concern specific to a client's difficulties with expressive language secondary to their medical diagnosis was recorded. The remaining respondents did not have any further questions or comments.

Agreeable Clinic and Health Safety Strategies

The five most frequently preferred health and safety strategies implemented according to 45 to 49 respondents (83%-90.74%) were on availability of hygiene products (HyP), regular disinfection of materials (DInf), limited number of people in the clinic (LNP), separate therapy areas aligned with physical distancing protocols (STA), and proper ventilation of therapy area (Ven) (See Figure 5). Orientation for patients and caregivers regarding the clinic safety protocols (Orie), availability of foot mat/bath in the clinic entrance (Foot), health and safety signages around the clinic (Sign), implementation of physical distancing protocols in the clinic's waiting area (Wait), completion of contact tracing form (CTF), and use of acrylic barriers for sessions (AcB) were next preferred conditions by 34 out of 54 respondents (62.96%). Shorter duration of therapy sessions (Dur) was the least frequently preferred strategy (13 out of 54 respondents). Additionally, five respondents (9.26%) suggested other strategies such as vaccination, one-hour duration of therapy, preferred time of the session (e.g., at night), and a system wherein the therapist escorts the client from outside the therapy room. One respondent had not answered this section. However, their preferences for the health and safety strategies were not determined due to their unavailability for an interview.

Table 4. *Themes from responses in open-ended survey questions and KIIs*

Reasons for Not Attending Face-to-face Therapy					
General Themes	**Frequency (%) (n = 36)**	**Subthemes**	**Descriptions**	**Frequency (n = 36)**	**Examples**
Vaccine	4 (11%)	Unavailability	Lack of available vaccines	3	Kami po ay nag-aalala at nababahala hangga't **wala pa pong vaccine.**
		Restrictions	Age-restrictions regarding vaccination	1	Kasi yung time na yun marami pa ring cases tapos hindi pa pati vaccinated si [name of child] so wala akong naiisip na pwede niyang panlaban just in case na…sinagot ko doon talaga na sa ngayon parang hindi ko alam kung may sinagot ako sa ngayon **hindi ko pa siya mapapayagang mag-face-to-face dahil hindi pa siya vaccinated at saka yung time na yun parang wala pang ina-announce na vaccination sa mga bata.**
Travel	7 (19%)	Transportation	Available mode of transportation going to the clinic	3	**Mahihirapan po kami sa pag commute.**
		Companion	Availability of client's companion going to the clinic	2	**Walang maghahatid sa pasyente.**
		Duration	Length of travel going to the clinic	1	Mother: Kung one hour lang yung session o less than… Father: **Matagal pa yung biyahe.** Mother: Yung effort po **mas matagal po.**
		Distance	Distance of the client from the clinic	1	**Malayo po kami, taga-Laguna pa po kami. Mahirap pa po ang biyahe** at isa pa po, delikado po sa pasyente dahil ito ay special child. Yun lang po.
COVID-19 Pandemic Situation	13 (36%)	General	Unspecified or vague concerns regarding the pandemic not including reasons involving health risks, protocols, and restrictions	4	**Hindi pa rin po ako kampante sa sitwasyon** at mahirap ang transportation.
		Health Risks	Projected health risks brought about by the pandemic	7	**Dahil po sa pandemic mahirap isugal ang kalusugan ng aking anak** lalo na sa kanyang kondisyon.
		Protocol	Difficulties abiding to the protocols set during the pandemic	1	Since may **DS [Down Syndrome]** nga po siya **na may autism,** hindi po siya compliant na lumabas po nang **naka-face mask.**
		Restrictions	Inter-Agency Task Force (IATF) quarantine restrictions	1	Bale po kasi nung time na 'yun dito sa Lipa yung **COVID cases po. Nag-alert level 3 po ata dito, level 2.**
Health Conditions	11 (31%)	Client	Medical diagnosis, symptoms, and health- related status of the client	10	Since may **DS [Down Syndrome]** nga po siya **na may autism,** hindi po siya compliant na lumabas po nang naka-face mask.
		Caregiver	Health status of the caregiver accompanying the client to the clinic	1	**Buntis** po kasi ako 4 months. Medyo hassle po sakin magbyahe. Ako lang po ang nag-aalaga sa anak ko po.
Characteristics of Face-to- Face Therapy	1 (3%)	Duration of Therapy	Length of face-to-face therapy	1	Mother: Tapos kung **one hour lang nga po, ang feeling namin parang hindi na applicable?** Father: Matagal pa yung biyahe. Mother: Yung effort po mas matagal po.

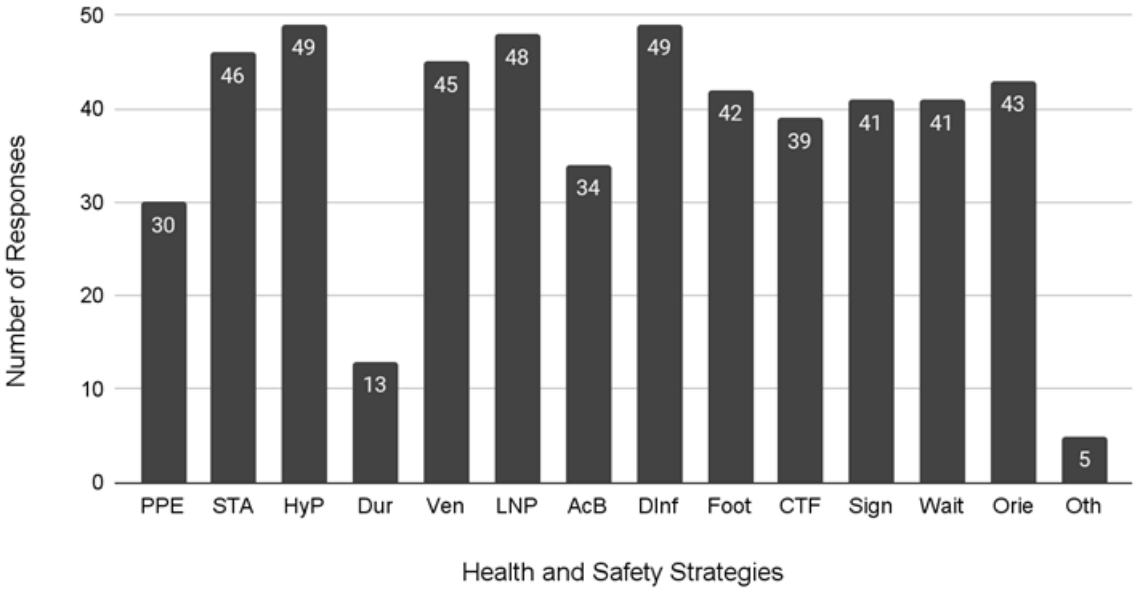
Table 4. *Themes from responses in open-ended survey questions and KIIs (continuation)*

Conditions for Attending Face-to-face Therapy					
General Themes	**Frequency (%) (n = 10)**	**Subthemes**	**Descriptions**	**Frequency (n = 10)**	**Examples**
Vaccine	4 (40%)	Unavailability	Lack of available vaccines	3	**Kapag may vaccine na po lahat**
		Restrictions	Age-restrictions regarding vaccination	1	Unless clear from COVID, less exposure. Kasi **ang vaccine ay hindi pa para sa edad ng anak ko.**
Travel	4 (40%)	Transportation	Available mode of transportation going to the clinic	3	**Kung meron po kami masasakyan**
		Distance	Distance of the client from the clinic	1	**Depende po sa location**
COVID-19 Pandemic Situation	2 (20%)	General	Unspecified or vague concerns regarding the pandemic not including reasons involving health risks, protocols, and restrictions	2	Hindi po sigurado **depende sa sitwasyon**
Additional Suggestions, Questions, and Comments					
General Themes	**Frequency (%) (n = 44)**	**Subthemes**	**Descriptions**	**Frequency (n = 44)**	**Examples**
Vaccine	2 (5%)	Unavailability	Lack of available vaccines	1	**Vaccination.**
		Restrictions	Age-restrictions regarding vaccination	1	**Para sa patient below 15 na hindi pa allowed sa vaccine**, mas better po sana via electronic communication na lang muna, less exposure po para sa kanila, especially my son. He's only 5. Although nagma-mask naman siya and face shield, hindi pa rin natin masabi ang safety sa kanila. Thank you po.
Travel	2 (5%)	Transportation	Available mode of transportation going to the clinic	1	Sana po para po sa mga hindi makakapunta, sana po maituloy pa rin po ang online. Mas safe po ang pasyente. Saka po kasi mahirap pa po ang biyahe sa iba pa pong mga probinsya kaya hindi ko po masabi kung magiging safe po ba kami pagpunta sa therapy lalo na po yung mga **nagko-commute lamang.**
		Distance	Distance of the client from the clinic	1	Sana po para po sa mga hindi makakapunta, sana po maituloy pa rin po ang online. Mas safe po ang pasyente. **Saka po kasi mahirap pa po ang biyahe sa iba pa pong mga probinsya** kaya hindi ko po masabi kung magiging safe po ba kami pagpunta sa therapy lalo na po yung mga nagko-commute lamang.
COVID-19 Pandemic Situation	5 (11%)	Health Risks	Projected health risks brought about by the pandemic	4	Sana po para po sa mga hindi makakapunta sana po maituloy pa rin po ang online. Mas safe po ang pasyente. Saka po kasi mahirap pa po ang biyahe sa iba pa pong mga probinsya kaya hindi ko po masabi kung **magiging safe po ba kami pagpunta sa therapy** lalo na po yung mga nagko-commute lamang.
		Restrictions	Inter-Agency Task Force (IATF) quarantine restrictions	1	Hindi po namin sigurado **kung papayagan na lumabas ang mga bata pagdating ng April.**

Table 4. *Themes from responses in open-ended survey questions and KIIs (continuation)*

Additional Suggestions, Questions, and Comments					
General Themes	**Frequency (%) (n = 44)**	**Subthemes**	**Descriptions**	**Frequency (n = 44)**	**Example**
Health Conditions	1 (2%)	Client	Medical diagnosis, symptoms, and health-related status of the client	1	Kung maari, sana online pa din po. Mahirap makisalamuha sa ibang tao lalo na sumasakay lang kami ng pampublikong transportasyon. Minsan kahit anong ingat, ang ibang tao naman ay matigas ang ulo, hindi sumusunod. Bilang magulang, takot ako mahawa o magkasakit ang aking anak. Gayundin sa akin, **dahil sa kalagayan niya na hindi mai-express ang kanyang saloobin.**
Access to Therapy	15 (34%)	General Therapy Service Availability	Request for therapy slots, unspecified if face-to-face or online	3	**Kung muli pong mabibigyan ng pagkakataon ang anak ko na maka-avail ng therapy program**, ngayon pa lang po nagpapasalamat na ako.
		Scheduling of Face-to-face Therapy	Concerns regarding the scheduling of face to face therapy	3	Sana at least nasa 2 hours ang session or baka pwede na **mag request din ng OT na kasama para yung punta sa Manila sulit.**
		Implementation of Face-to-face Therapy	Comments, insights, and/or concerns regarding the implementation of face to face therapy	4	**Kailan po magi-start yung face-to-face po** kasi po ayun po yung sabi po ni mama bago siya umalis sa bahay po eh.
		Preference for Telerehabilitation	Caregivers or client prefer to continue with the current online remote therapy set-up	5	**Sana po may online services pa din.**
Characteristics of Face-to- face Therapy	9 (20%)	Duration of Therapy	Length of each face- to-face therapy session	2	**Sana at least nasa 2 hours ang session** or baka pwede na mag request din ng OT na kasama para yung punta sa Manila sulit.
		Client Requirements	Prerequisite requirements for face-to-face therapy, such as vaccination status, medical certificate, and COVID-19 testing	3	If ever ba po kung may face-to-face, **we need po ng rapid antigen po before magpunta?** Mga ganoon po?
		Clinic Equipment	Request for additional materials (e.g., facilities, equipment) for face-to- face therapy in the clinic	1	Pwede naman pong mag exceed more than one hour para po hindi mabitin sa therapy at sasabihing home program after therapy session at kung pwede po magkaroon ng **rubber mattress sa loob ng therapy** session para po maiwasang madulas mga bata since sabik lang mag-explore due to or during pandemic pero paki-sanitize at cleanse na lang po kahit once a week. Maraming salamat po and God bless.
		Clinic Protocols	Request for implementation of health strategy protocols in the clinic including disinfection (e.g., sanitation of materials) and regular changing of PPE	3	**Siguro po every after therapy, magpapalit ng damit yung therapist** and magdi-disinfect sa loob bago yung next na bata.
Other Comments	10 (23%)	No further questions/concerns	Respondents had not raised any additional questions or concerns	10	**Wala** po.

Note. The words in bold are the examples of the coded excerpts



Note: PPE = therapists wearing personal protective equipment (PPE); STA = separate therapy areas aligned with physical distancing protocols; HyP = availability of hygiene products (e.g., alcohol, soap) in common clinic areas; Dur = shorter duration (e.g., less than one hour) of therapy sessions; Ven = proper ventilation of therapy area; LNP = limited number of people in the clinic, AcB = use of acrylic barriers for sessions; DInf = regular disinfection of materials, Foot = availability of foot mat/bath in the clinic entrance; CTF = completion of contact tracing form; Sign = health and safety signages around the clinic; Wait = implementation of physical distancing protocols in the clinic's waiting area; Orie = conducting an orientation for patients and caregivers regarding the clinic safety protocols; Oth = suggest other strategies

Figure 5. *Preferred health and safety strategies for implementation in face-to-face therapy*

Discussion

Centered on the TPB framework [18], the study found that positive variables related to transportation and capacity to travel to and from the clinic contributed to positive intentions and enhanced readiness of client respondents for face-to-face OT, PT, and SLP. On the other hand, negative behavior and uncertainty towards attending face-to-face therapy were contributed by identified issues with traveling, characteristics of face-to-face therapy, health conditions of client and caregiver, COVID-19 situation, and vaccine accessibility.

Readiness of Client Respondents for Attending Face-to-Face Therapy

All respondents willing to return to face-to-face therapy had transportation means to the clinic (i.e., public, private, or hired vehicles). A key factor that enhanced positive intentions for face-to-face therapy was accessibility to the clinic given that most of them reside in areas that are less than an hour away from the clinic. The respective residences of respondents also implemented increased leniency of community quarantine measures) that improved mobility within and outside communities. In addition, the availability of a companion in therapy influenced positive behaviors towards receiving onsite OT, PT, and SLP, especially among the pediatric clients. However, the positive attitudes of respondents with companions, especially caregivers of pediatric clients, were mixed with uncertainty due to unavailability of vaccinations for children with disabilities (See Figure 6). The adult client respondents, on the other hand, retained positive attitudes and expressed readiness towards face-to-face therapy because it may be feasible for them to travel without assistance and a companion. These may have positively impacted their decision regarding attending on-site therapy services.

Reasons and Considerations for Not Attending Face-to-face Therapy

The observed attitudes toward the intended behavior on readiness to face-to-face therapy were influenced by themes about concerns regarding the COVID-19 pandemic, health conditions of the client and caregiver, travel, and dislike of characteristics of face-to-face therapy. On travel, further sub-themes were identified, such as transportation accessibility, companion availability, trip duration, and distance from the clinic. Transportation issues reported by the respondents included commuting using public vehicles because of increased risks for acquiring COVID-19. Several identified the lack of a companion to be a hindrance; children without a guardian would experience difficulties in going to the clinic. Also, far distance from the clinic and a characteristic of face-to-face therapy (e.g., duration of a session) were deemed unfavorable as a session of less than

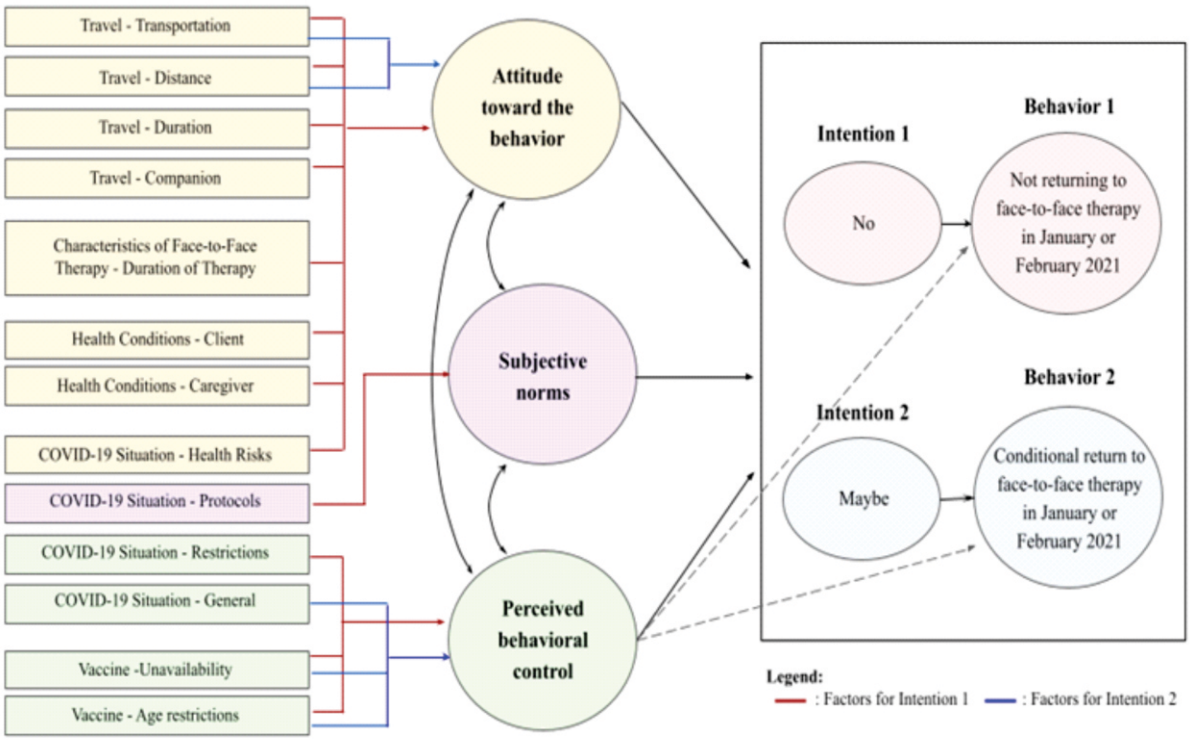


Figure 6. *Respondents' readiness based on the Theory of Planned Behavior [18]*

one hour is too short and not worth the lengthy travel time. For respondents who were uncertain about returning to face-to-face therapy, they identified the inconvenience of travel (*e.g.*, inconsistent availability of transportation means) as an unfavorable factor to consider.

The anticipated health risks of the pandemic is another predominant theme that influenced negative attitudes of respondents towards face-to-face therapy. Respondents refrained from attending face-to-face therapy to avoid getting infected. Similarly, health conditions of the clients and caregivers, which increased their risks to the virus (e.g., pregnancy), were common considerations identified. Respondents' reluctance to return to face-to-face therapy due to their knowledge of the COVID-19 health risks is similar to the findings of Irfan *et al.* [19] that presented an increase in motivation to wear face masks among individuals who became aware of the harmful impacts caused by the pandemic on their health. The results of this study is also similar to the findings of Zhang et al. [20] that showed the impact of receiving negative information such as side effects of COVID-19 vaccine on the likelihood of individuals getting vaccinated.

Moreover, identified subjective norms had likely impacted the decision of the respondents to defer from returning to the face-to-face set-up. A major theme that surfaced was abiding by the COVID-19 protocols (e.g., wearing of face masks) that were being enforced by government agencies (*e.g.*, IATF-MEID). Wearing face masks also became an expected behavior in the Philippines, with the majority having no issues adhering to this health and safety measure [22]. Some respondents agreed with wearing PPE (*i.e.* face mask). A similar finding was reported in Irfan *et al.* [19], wherein the Pakistani society was observed to display strong regard for the opinions of the community (*e.g.*, friends, family) regarding the use of face masks which led to increased compliance. More participants were inclined to wear masks when their peers were also doing so. Additionally, Zhang *et al.* [20] reported that Chinese factory workers who had relatives in favor of being vaccinated were more likely to receive the COVID-19 vaccine. However, the health condition of the client can still contribute to decreased likelihood of attending to face-to-face therapy even if standard protocols have been established for public health and safety. For instance, a number of respondents shared that due to possible sensory issues brought about by their child's medical diagnosis (*e.g.*, Autism Spectrum Disorder), they experienced difficulties with tolerating wearing of face masks. Caregivers may have opted to continue with online therapy since decreased compliance to health protocols could result in increased health risks and negative social implications.

Recognized variables by the respondents on perceived behavioral control contributed to their refusal to attend face-to-face therapy. A number of responses centered on the theme of vaccination, with sub-themes of unavailability and age restrictions. At the time of the survey, the Philippine government had not yet distributed vaccines [23]. The lack of vaccines for children in the Philippines at the time was beyond the control of the respondents, similar to the unavailability of face masks and their unreasonable prices in Pakistan that discouraged face mask use [19]. Likewise, clients and caregivers were observed to be less motivated to return to face-to-face therapy as they were unable to receive vaccination due to external factors. The provision of vaccines from the government may contribute to positive behaviors towards onsite therapy.

Comparably, respondents had expressed their difficulty in returning to onsite therapy due to vaccine age restrictions. In February 2021, vaccines for the pediatric population were not yet available in the country. For most vaccine brands (*e.g.*, AstraZeneca), recipients needed to be between the ages of 18 to 59 [24]. Numerous caregivers believed that vaccines were important in protecting their children from the contraction of the COVID-19 virus. In relation, the IATF-MEID restrictions [25] were viewed to be beyond the control of the respondents, affecting their ability to participate in face-to-face sessions.

These considerations aligned with the responses of some clients on the KIIs regarding their readiness to participate in face-to-face therapy sessions in May 2022. While the same inconsistent factors (*i.e.*, the health condition of the client depending on the weather and availability of transportation means) were noted as reasons for the conditional return of a respondent, three respondents changed their intention as they have received at least one dose of vaccine.

Health and safety strategies

Overall, almost all health and safety strategies were deemed important by the respondents and would enhance their readiness in returning to face-to-face OT, PT, and SLP. Among the five most frequently chosen health and safety strategies, four are similar to the guidelines set by the Department of Trade and Industry and the Department of Labor and Employment [26]. These are the availability of hygiene products in common areas in the clinic, regular disinfection of materials, allotment of separate therapy areas for patients aligned with physical distancing protocols, and the presence of proper ventilation. Despite the authorization of the IATF-MEID [25] on the full capacity operation of rehabilitation clinics, most of the respondents still agreed that it is important to limit the number of people in the clinic. Some interviewees shared their rationale for choosing certain health and safety strategies that were aligned with guidelines set by the IATF-MEID [27] and institutions such as the Department of Education [28]. However, some interviewees also disagreed with some strategies, such as lessening the duration of the therapy sessions as this may compromise the opportunity for learning the target skills and for practical reasons.

Limitations of the study

The limitations of this study include the low number of respondents gathered from the survey questionnaire. This may affect its applicability and generalizability to populations that are similar to the survey respondents and to contexts that are parallel to CTS. It may not reflect the majority of the perceived readiness of clients within the clinic, the region, and the country who also received face-to-face therapy. In relation to this, most respondents reside within the NCR; thus, the results of this study may not be an adequate representation for other parts of the country. Although the analyzed data may not sufficiently reflect the readiness of all the clients of the clinic, the findings of this study will still aid in improving the retrofitting of the clinic, especially its policies for quality client care and health and safety.

In addition, the review of records also has inherent limitations such as potential inaccuracy in divulged information, incompleteness of data, and variability in the abstraction and data encoding. To address these, the research team underwent training on proper handling of incomplete data, accurate data abstraction and encoding, and management of varying data quality by a consultant with more experience in these skills. The data extraction instrument was also piloted by the research team using the first two responses to identify areas for improvement related to data abstraction and data encoding and to enhance reliability. Initially, the research team considered the involvement of a social scientist to aid in the study implementation and data analysis. However, the team did not pursue this since the gathered data no longer required the guidance of a social scientist.

Data obtained in this study can also be expounded as respondents who answered “Yes” for receiving face-to-face therapy services were not given the opportunity to explain the factors, other than those related to travel, that influenced

their decision. This hindered further analysis of factors that directly contribute to an increased likelihood of attending on-site therapy sessions as the influence of factors were studied only in relation to the "No" and "Maybe" responses.

Lastly, the COVID situation has shifted in the country since 2021. This puts into question the applicability of the data gathered and analyzed in the study.

Implications of the study

Although the majority of the respondents expressed their readiness for face-to-face therapy, some still had reservations due to various reasons. With TPB as the framework, it is important to take into account the factors that pose impacts on the intentions as this could determine the enactment of the behavior (*i.e.*, attending face-to-face therapy).

With this, CTS' plans for face-to-face therapy should incorporate client perspectives, particularly of those who are still hesitant. Concrete steps could be conducted to address recurrent concerns related to vaccine, travel, COVID-19 pandemic situation, health conditions, and characteristics of face-to-face therapy. Likewise, solutions can be discussed for other unique themes and subthemes generated from the additional questions and comments of the respondents. These include access to therapy (*e.g.*, general therapy service availability, scheduling of face-to-face therapy) and face-to-face therapy characteristics (*e.g.*, client requirements, clinic equipment).

To expound, CTS could reassess the vaccination status of the clients and its influence on their readiness for face-to-face therapy. As of February 7, 2022, the DOH commenced the "Resbakuna Kids" campaign to vaccinate children aged five to 11 years old [29]. Potential guidelines for face-to-face therapy could also consider the suggestions from the respondents such as extending the duration of therapy (*i.e.*, "Sana at least nasa 2 hours ang session…"), continuing online or implementing hybrid therapy wherein on-site sessions are lessened (*i.e.*, "Siguro po yung sinabi ko dati kung by month, once a month na lang po"), providing clinic equipment (*e.g.*, rubber mattress), and following strict clinic protocols (*i.e.*, therapy area disinfections, change of clothes for therapists). It is also imperative to employ the most frequently selected strategies by the respondents (*e.g.*, provision of hygiene products, disinfection), as these increased their motivation in availing face-to-face therapy services.

As of writing, there is an unavailability of existing studies that are similar to the current research, hence comparisons may not be drawn. The findings of this study (*e.g.*, factors affecting readiness for face-to-face therapy, health and safety strategies) may contribute to baseline protocols for other outpatient rehabilitation clinics that are preparing to return to face-to-face therapy. Moreover, clinics could be prompted to design and distribute their own surveys or conduct interviews with their clientele as distinct concerns could help in planning for guidelines that are more applicable to their context. The findings of this study may also be used for a cross-sectional research to further describe possible changes in the readiness of clients over a period of time.

Conclusion and Recommendations

The readiness of clients to return to face-to-face therapy and the factors affecting this intent were explored to guide the planning of on-site service delivery in the clinic. This study found that the majority of survey respondents were willing to return to face-to-face therapy in April or May of 2021. Guided by the TPB, we found that variables related to travel (*e.g.*, proximity to the clinic, transportation) and the capability to travel to the clinic may have influenced positive attitudes and readiness of client respondents for onsite OT, PT, and SLP. However, identified issues with traveling, characteristics of face-to-face therapy, health conditions of client and caregiver, COVID-19 situation, and vaccine accessibility influenced negative behavior and uncertainty towards attending face-to-face therapy.

The main internal validity concerns of the study consisted of potential inaccuracy in divulged information, incompleteness of data, and the variability of abstraction and data encoding. Meanwhile, external validity issues included factors affecting the generalizability of the findings of the study (*e.g.*, small sample size, unequal representation of the population).

Despite these limitations, the findings of the study may aid CTS in providing solutions to the concerns raised by clients regarding face-to-face therapy. Likewise, other outpatient rehabilitation clinics could utilize relevant information discussed in the current research (e.g., factors affecting readiness for face-to-face therapy, health and safety strategies) as a basis for planning specific guidelines. Study findings may also contribute to further research studies about the readiness of clients in engaging in face-to-face therapy. Future studies can guide the formulation of updated health and safety measures in clinics following the IATF-MEID guidelines.

Acknowledgment

The authors would like to acknowledge the valuable contributions of Ms. Gerlie R. Ramirez in assisting the team during data collection. Moreover, the authors would like to express their sincere gratitude for the guidance and assistance provided by Ms. Alma V. Labro, MMBM in preparing the manuscript for submission.

Author Disclosure

We declare we have no competing interests and/or no financial competing interests, or other interests that might be perceived to influence the interpretation of this article.

References

1. Haleem A, Javaid M, Vaishya R. (2020) Effects of COVID-19 pandemic in daily life. Current Medicine Research and Practice 10(2):78-79. doi: 10.1016/j.cmrp.2020.03.011
2. World Health Organization. (2020) Impact of COVID-19 on people's livelihoods, their health and our food systems.
3. Esquivias D. (2020) Socio-Economic policy response amidst the Covid-19 situation in the Philippines ISSUE BACKGROUNDER. Retrieved from: http://doi:10.13140/RG.2.2.25546.72645
4. Philippine Physical Therapy Association. (2020) Interim recommendations on PT services during the COVID-19 pandemic.
5. Philippine Academy of Occupational Therapists, Inc. (2020) Interim guidelines on the practice of occupational therapy amidst the coronavirus disease (COVID-19) situation in the Philippines.
6. Philippine Association of Speech Pathologists. (2020) Guidelines for speech-language pathology practice in the Philippines during the COVID-19 pandemic.
7. Powell RE, Henstenburg JM, Cooper G, Hollander JE, Rising KL. (2017) Patient Perceptions of Telehealth Primary Care Video Visits. Annals of Family Medicine 15(3):225-9. doi: 10.1370/afm.2095
8. Galea MD. (2019) Telemedicine in Rehabilitation. Physical Medicine Rehabilitation Clinics of North America 30(2):473-83. doi: 10.1016/j.pmr.2018.12.002
9. Molini-Avejonas DR, Rondon-Melo S, Amato CA, Samelli AG. (2015) A Systematic review of the use of telehealth in speech, language and hearing sciences. Journal of Telemedicine and Telecare. 21(7):367-76. doi: 10.1177/1357633X15583215
10. Hung Kn G, Fong KN. (2019) Effects of telerehabilitation in occupational therapy practice: A systematic review. Hong Kong Journal of Occupational Therapy. 32(1):3-21. doi: 10.1177/1569186119849119
11. Eannucci EF, Hazel K, Grundstein MJ, Nguyen JT, Gallegro J. (2020) Patient satisfaction for telehealth physical therapy services was comparable to that of in-person services During the COVID-19 pandemic. Hospital for Special Surgery Journal. 16(Suppl 1):10-16. doi: 10.1007/s11420-020-09800-5
12. Leochico CFD, Espiritu AI, Ignacio SD, Mojica JAP. (2020) Challenges to the emergence of telerehabilitation in a developing country: A systematic review. Frontiers in Neurology. 11:1007. doi: 10.3389/fneur.2020.01007
13. Peretti A, Amenta F, Tayebati SK, Nittari G, Mahdi SS. (2017) Telerehabilitation: Review of the state-of-the-art and areas of application. JMIR Rehabilitation and Assistive Technology. 4(2):e7. doi: 10.2196/rehab.7511
14. Cable News Network Philippines. (2020) Despite Top 20 rank, PH among nations with decreasing COVID-19 cases – experts.
15. Montemayor MT. (2022) Covid-19 cases in Manila on 'clear' downward trend: OCTA.
16. World Health Organization. (2022) Philippines coronavirus disease (COVID-19) situation report #94, 31 January 2022.
17. de Villa K. (2022) DOH: Daily COVID-19 count hits plateau.
18. Ajzen I. (1991) The theory of planned behavior. Organizational Behavior and Human Decision Processes. 50(2):179-211. https://doi.org/10.1016/0749-5978(91)90020-T
19. Irfan M, Akhtar N, Ahmad M, et al. (2021) Assessing public willingness to wear face masks during the COVID-19 pandemic: Fresh insights from the theory of planned behavior. International Journal of Environmental Research and Public Health. 18(9):4577. doi: 10.3390/ijerph18094577
20. Zhang KC, Fang Y, Cao H, et al. (2021) Behavioral intention to receive a COVID-19 vaccination among Chinese factory workers: Cross-sectional online survey. Journal of Medical Internet Research. 23(3):e24673. doi: 10.2196/24673
21. Vaismoradi M, Turunen H, Bondas T. (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing

and Health Sciences. 15(3):398-405. doi: 10.1111/nhs.12048
22. Gita-Carlos RA. (2020) Palace happy with Filipinos' high face mask compliance.
23. United Nations Children's Fund. (2021) Philippines welcomes the arrival of COVID-19 vaccines via COVAX facility.
24. Health Technology Assessment Council. (2022) Pediatric vaccination for the prevention of COVID-19 for 5 to 11 age group.
25. Inter-Agency Task Force for the Management of Emerging Infectious Diseases. (2021) Omnibus guidelines on the implementation of community quarantine in the Philippines.
26. Department of Trade and Industry and Department of Labor and Employment. (2020) DTI and DOLE supplemental guidelines on workplace prevention and control of Covid-19.
27. Inter-Agency Task Force for the Management of Emerging Infectious Diseases. (2022) Guidelines for the implementation of alert level system for COVID-19 response.
28. Department of Education. (2021) Preparations for the pilot face-to-face expansion and transitioning to new normal.
29. Department of Health. (2022) DOH, NVOC, NTF launch 'Resbakuna Kids' campaign for 5 to 11 year olds.