Primary Healthcare Professionals’ Perspectives Regarding Integrating eHealth into their Psycho-Oncological Care Practices: A Qualitative Interview Study

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Abstract

Background: Psycho-oncological (PO) care gradually shifts from secondary to primary healthcare to ensure greater accessibility and proximity for cancer patients. Integrating electronic health (eHealth) interventions, like Compas-Y—a mobile self-compassion intervention—into PO care practices appears promising but also challenging. Insight into the perceptions of primary healthcare professionals on successfully integrating eHealth into their PO care practices is needed.

Objective: To explore primary healthcare professionals' perceptions of integrating eHealth (Compas-Y in particular) into their PO care practices.

Methods: Twelve professionals, including practice assistants (POHs) and physio-, psychosocial, and occupational therapists, were recruited using purposive and snowball sampling strategies for digital semi-structured interviews. The interview questions explored current PO care in primary settings, practices and experiences with eHealth (both positive and negative), and the factors that facilitate or hinder the integration of Compas-Y. The Consolidated Framework for Implementation Research (CFIR) 2.0 was used as a theoretical framework for the latter part. Interview data were analysed with a combination of deductive and inductive approaches.

Results: PO care practices varied, with significant patient differences between oncology-specialised and other professions. Consultations usually last between 25 and 60 minutes and are performed in one-on-one sessions. Patient needs are diverse, and professionals offer generic and specific PO care. Challenges to providing PO care in primary care include poor information provision and coordination with secondary care and an imbalance in patient resource availability. Most professionals integrate eHealth into their practices, particularly in patient education, progress monitoring, and therapy tools. POHs use eHealth platforms, including Therapieland and Minddistrict (Evie), where physiotherapists use Physitrack for exercise programs. The most critical facilitators professionals experience when integrating Compas-Y into their PO care practices are the app's user-friendliness and acceptability, low costs for the organisation, supportive incentives for adoption, high status of eHealth use, motivation and interests, training and education, and patient-centred care. The most critical barriers are time and agenda constraints and low digital awareness among patients and professionals.

Conclusion: PO care is not optimally integrated into primary care. Improved communication between primary and secondary care and financing of eHealth implementation can contribute to better integrating eHealth like Compas-Y. eHealth is used in a variety of ways. Facilitators are low cost and ease of use, while lack of time and limited digital proficiency are barriers. Professionals prefer blended care over self-help apps. Future research should focus on optimising roles and communication for joint implementation.

Introduction

Cancer is a significant public health concern in the Netherlands, with half of the population expected to be diagnosed with it during their lifetime (Puts et al., 2023). In 2023, the incidence of cancer in the Netherlands was 128,927 cases, with 68,736 males (53.3%) and 60,191 females (46.7%) (Integraal Kankercentrum Nederland, 2024). The 5-year survival rates have increased from 43.0% in 1990 to 66.0% in 2022 (IKNL, 2022), whereby more individuals now survive cancer but live with its consequences (Seely, 2023)—over 925,000 in 2022, rising to nearly 1.4 million by 2032 (IKNL, 2022). Besides many physical consequences of the illness, cancer can also have significant psychological and social impacts (Papadopoulou et al., 2022). For example, one in three cancer survivors faces mental health challenges like anxiety and depression, requiring psychological support, and perceived challenges can lead to difficulties in daily functioning, such as work limitations, financial challenges, and lack of social support (Lewandowska et al., 2020; Zimmerman-Schlegel et al., 2017). The psychosocial needs of cancer patients vary widely and reflect individuals' responses to the hardships of the illness.

To promote patients' psychological well-being and decrease psychological distress, psycho-oncological (PO) care, also known as psychosocial-oncological care, is offered to provide personalised psychological support and interventions for cancer patients[1] and their surroundings (Coppini et al., 2023; Schuit et al., 2021). PO care entails emotional (e.g., grief counselling), social (e.g., financial counselling), and spiritual support (e.g., meditation programs), mental health services (e.g., stress management), behavioural interventions (e.g., cognitive-behavioural therapy), and educational resources (e.g., nutritional counselling). PO care can be provided face-to-face, individually, remotely (e.g., via online therapy), with a partner, in a group, or through blended forms (i.e., combining different care methods). In the Netherlands, secondary care ('tweedelijnszorg') psychologists and mental health workers predominantly provide PO care in hospitals and specialised centres like the Helen Dowling Institute. Despite the need for psychological support, usage of PO care remains limited due to accessibility and availability issues, as well as significant burdens like resource shortages and time constraints (Schuit et al., 2021; Adam et al., 2023).

A promising aspect of PO care is integrating electronic health (eHealth) solutions. Research shows that replacing face-to-face consultations with eHealth does not adversely affect the psychological health of cancer patients and that patients prefer a combination of eHealth and in-person care (Buse et al., 2022; Caminiti et al., 2023). Benefits of eHealth include improving access and exchange of information and data and quality of care, reducing costs, and enhancing patient

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[1] For continuity in this study, 'patients' is used, although 'clients' may be appropriate in some professions.

empowerment and safety. Conversely, challenges include developing and implementing digital interventions to suit the majority of patients while ensuring patient compliance and adaptability for use in various healthcare systems and living environments (Aapro et al., 2020; Heinen et al., 2022; Scheibner et al., 2021). Specific examples of digital interventions that may be used in PO care are (1) Untire, which has been shown to reduce fatigue severity (Spahrkäs et al., 2022), (2) Oncokompas, which did not appear to significantly improve patient activation, self-efficacy or health-related quality of life (Schuit et al., 2022), and (3) Compas-Y, which revealed high patient satisfaction, increased relaxation, improved self-acceptance, and reduced anxiety (Austin et al., 2023). Compas-Y, a noteworthy eHealth solution, will be a focus of this study.

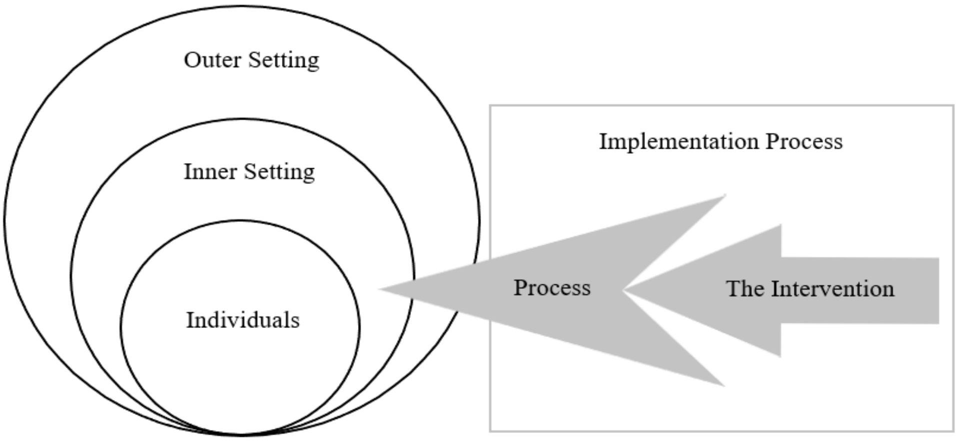
While eHealth interventions like Compas-Y offer promising opportunities to enhance PO care, the shift towards primary care has significant implications for implementing these tools. Over the years, PO care gradually shifted towards more (generalistic) primary care (‘eerstelijnszorg’) to meet easy access to PO services, rising demand, reduce healthcare costs, and alleviate the workload of secondary healthcare professionals (Jefford et al., 2022; Schuit et al., 2021). Primary care is directly accessible, making it more available closer to the patients. For instance, general practitioners (GPs) and practice assistants (POHs) provide PO care. Liemburg et al. (2022) examined Dutch GPs’ views on PO care in primary care, revealing that GPs opposed complete care substitution but supported greater involvement of primary care in oncological follow-up. However, it is unclear precisely what these PO care practices in primary care involve and what roles other primary healthcare professionals play in PO care. This study aims to clarify this.

Despite the benefits of digital interventions, healthcare professionals' adoption presents several challenges (Addotey-Delove et al., 2023). Erku et al. (2023) revealed that primary healthcare professionals experience challenges in various aspects, including digital literacy, funding, motivation and training, ICT infrastructure, health system requirements, and resistance to change. Additionally, Erku et al. (2023) emphasised the importance of developing additional conceptual frameworks to better comprehend eHealth and its related outcomes in primary care and identify the factors that impact the effectiveness of eHealth solutions. Understanding how eHealth integrates into the primary care landscape is crucial for successful implementation in PO care, to which this study will contribute.

Addressing challenges in adopting digital interventions like Compas-Y emphasises the need for a structured approach to implementation. This study uses the Consolidated Framework for Implementation Research (CFIR) 2.0 (Damschroder et al., 2022) to guide the development of implementation strategies within complex healthcare settings like primary care. CFIR 2.0 identifies specific enabling and hindering factors in our study that can influence primary healthcare professionals' implementation of interventions like Compas-Y, which helps develop strategies to improve implementation success. CFIR 2.0 incorporates 67 constructs (see Appendix A) organised into five domains (see Figure 1): (1) Innovation: the characteristics of the implemented intervention (2) Outer setting: the external factors surrounding the organisation, (3) Inner setting: the internal environment where the intervention is implemented, (4) Individuals: the roles and characteristics of individuals involved, and (5) Implementation process: the activities and strategies used to implement the intervention.

Figure 1

The Five Domains of the CFIR 2.0 Framework



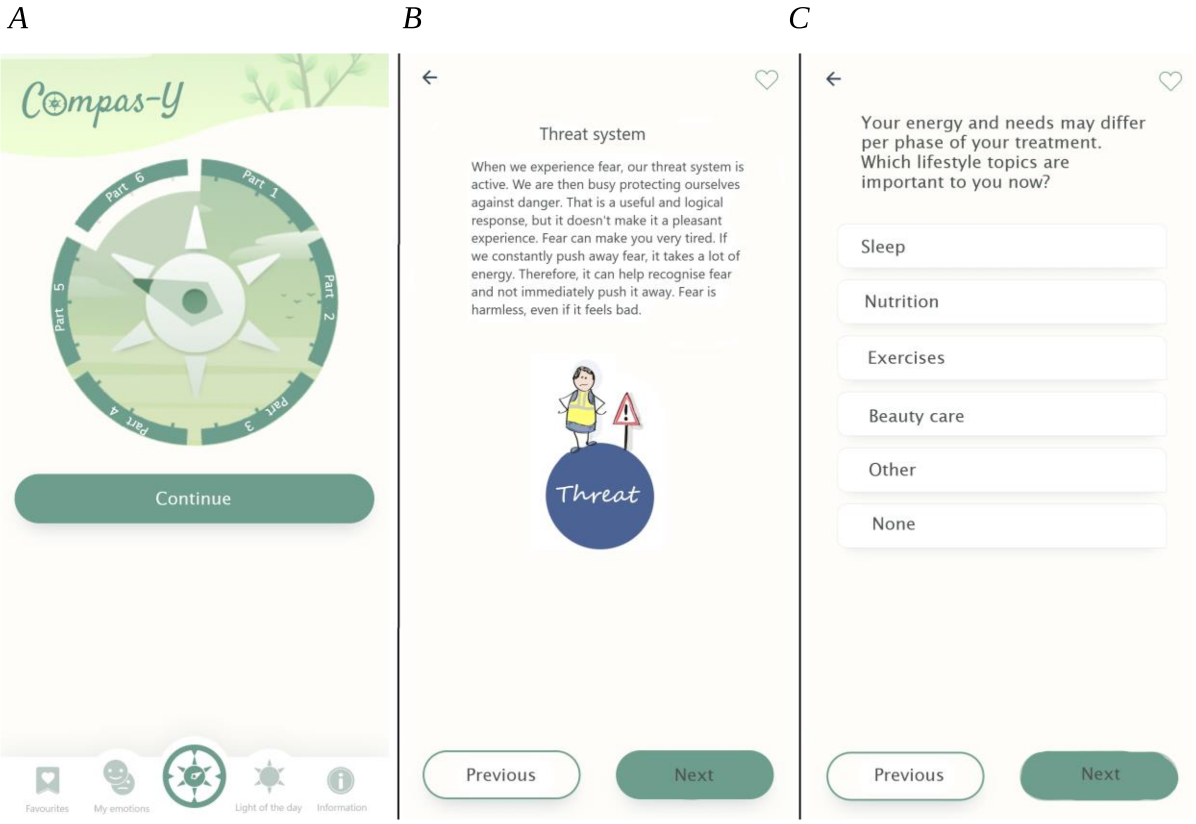
Note. Referring to the updated CFIR framework of prior research by Damschroder et al. (2009).

Each domain provides a lens to explore implementation aspects, which contributes to understanding the interactions between the domains. For instance, financial costs are commonly mentioned as affecting eHealth implementation. With high innovation costs and limited funding, financial costs are a barrier; conversely, low costs and available funding can be a facilitator. Versluis et al. (2020) identified privacy and security concerns, along with the lack of recognised standards for eHealth applications, as hindering factors while engaging key stakeholders, planning the implementation, and providing training and support as crucial facilitators for implementing eHealth in primary care. This framework will help us identify crucial facilitators and barriers to implementing Compas-Y, which we expect to align with the findings of Erku et al. (2023) and Versluis et al. (2020).

Specifically, Compas-Y is a mobile health (mHealth) app developed by researchers, oncology nurses, and cancer patients. It was co-created to address the impacts of cancer through a six-week training program based on Compassionate Mind Training by Gilbert and Procter (2006) (see Figure 2A).

Figure 2

Oversight of Compas-Y's Features



Threat system

When we experience fear, our threat system is active. We are then busy protecting ourselves against danger. That is a useful and logical response, but it doesn't make it a pleasant experience. Fear can make you very tired. If we constantly push away fear, it takes a lot of energy. Therefore, it can help recognise fear and not immediately push it away. Fear is harmless, even if it feels bad.

Your energy and needs may differ per phase of your treatment. Which lifestyle topics are important to you now?

- Sleep
- Nutrition
- Exercises
- Beauty care
- Other
- None

Note. (A) Homepage with oversight of six modules and buttons to favourites, my emotions, the light of the day, and information. (B) Threat system exercise with psycho-education. (C) Multiple-choice reflection questions focusing on the drive system.

As described by Austin et al. (2023), Compas-Y covers six modules: (1) introduction of Compas-Y and self-compassion, (2) emotions in the context of cancer, (3) self-compassion and self-criticism, (4) taking care of your body, (5) the people around you, and (6) continuing with resilience. The core training components within these modules are psycho-education on self-compassion and related resistance and motivation to that. It introduces the three emotion systems model (i.e., threat, drive, and soothing (see Figure 2B)) with exercises including rhythm breathing and compassionate imagery. All six modules include psycho-education, audio-guided exercises, experiential and reflective practices (see Figure 2C), and optional peer experiences. There are 43 to 53 screens per module, taking about 60 to 90 minutes to complete. A new module unlocks each week regardless of completion status and can be revisited anytime. Supportive functionalities of Compas-Y are direct access to favourite exercises, a mood tracker based on three emotion systems, a ‘light of the day’ reflection exercise, and an information page on the homepage (see Figure 2A). Daily brief exercises and inspirational quotes are sent via push notifications, and automatic feedback, progress tracking, and visual rewards are used to encourage continued use and engagement (Austin et al., 2023).

This study explores primary healthcare professionals’ perceptions regarding integrating eHealth into their PO care practices, particularly Compas-Y. The following sub-questions have been formulated: (1) *What are the current practices in psycho-oncological care in primary care settings?* (2) *What are the practices and experiences of primary healthcare professionals with eHealth?* and (3) *What facilitators and barriers related to the CFIR 2.0 framework do primary healthcare professionals experience for integrating Compas-Y into their psycho-oncological care practices?* The findings aim to contribute to the eHealth implementation research in primary healthcare settings and specifically to the field of PO care.

Methods

Study Design

A qualitative research design was used to explore the perceptions of primary healthcare professionals. Twelve primary healthcare professionals participated in a digital semi-structured interview guided by the CFIR 2.0 framework. This study was approved by the Ethical Board of the Faculty of Behavioural, Management, and Social Sciences of the University of Twente (reference number 240484).

Participants and Procedures

The study population consisted of primary healthcare professionals with at least some experience providing PO care to cancer patients. Other inclusion criteria included professionals willing to participate in a digitally recorded interview and look into the preparatory information regarding Compas-Y. For this study, conducted between March and September, we aimed to include twelve participants due to the diversity of professions to achieve data saturation, as Hennink and Kaiser’s (2022) systematic review showed that 9 to 17 interviews reached saturation. Between April and May 2024, participants were recruited through purposive and snowball sampling via the researchers’ personal and social media networks and the supervisor's network. Participants were contacted digitally, by chat or e-mail, to provide them with information about the study (e.g., the goal, some example interview questions, and the privacy regulations), to ask questions regarding the research, and to sign up for participation. Participants who were willing to participate received an official information letter, general information, a link to an introduction video of Compas-Y on YouTube, a documentation file with Compas-Y figures, and a digital consent form. The interviews with the participants took place in May 2024 via video calls on a computer or mobile phone. Before the interview, participants were asked to provide digitally written consent (see Appendix B). All interviews were audio- and video-recorded and transcribed verbatim using the transcription function of the video call system. After manual checking and editing of the transcripts, the recordings were destroyed. To ensure anonymity, the participants were numbered (i.e., the ‘I’ of the interviewee was accompanied by the number based on the order of the interviews per profession), and all identifiable information was removed. All data were stored on a secured University of Twente page.

Materials

The mandatory introduction video of Compas-Y incorporated a screen recording through Compas-Y with a Dutch voice-over. It was about 12 minutes and provided a look inside the app, including information (i.e., by showing through a part and looking into the exercises) about three out of six themes, the functions, and general information provided to patients within the app. The comprehensive documentation file of Compas-Y consisted of a 364-page document showing screenshots of all the app’s pages and was used in previous research on Compas-Y. This document served as additional information for interested participants, as the video did not detail all parts of Compas-Y. Therefore, this document was additional and not mandatory.

Interview Scheme

An interview scheme guided the semi-structured interviews. The topics were derived from a literature study, meetings with the supervisors, and the CFIR 2.0 framework. The interview scheme included directed and more open-ended questions about the topics (see Appendix C). The introduction focused on this study's aim, practical information, and background information of the participants (e.g., age, work experience with cancer patients, and current profession). The main topics of the interview: (1) the current PO care in primary care (e.g., consultation characteristics, psychological issues and support for cancer patients, and perceived difficulties in providing PO care), (2) the practices and experiences with eHealth (e.g., the current application of eHealth and positive and negative experiences), and (3) the facilitators and barriers regarding integrating Compas-Y into their PO care practices were related to the three research questions (RQs). Examples of interview questions regarding these topics are provided in Table 1. Specifically, for topics regarding RQ1 and RQ2, some more directed questions were asked to provide insight into more descriptive and detailed data, for example, *"How much time do you have per consult?"* and *"What are your positive experiences with eHealth?"*. For the topic regarding RQ3, the questions were primarily based on the five domains of the CFIR 2.0 framework and mainly derived from the official CFIR interview guide tool (CFIR Guide, n.d.). The concluding part focused on the participants' closing remarks, and information was provided regarding the interview summary (i.e., member check).

Table 1

Overview Example Questions of Topics

Topic	Example questions
(1) The current practices in PO care in primary care settings	• How do you currently provide PO care in your practice? - How many cancer patients do you see a week? - What issues do you encounter in cancer patients? • What do you think of the current PO care for cancer patients? - What do you think is going well/not so well? - What difficulties do you encounter?
(2) The practices and experiences with eHealth	• What does your eHealth use currently look like? - What specific eHealth interventions do you use? • What experiences do you have with eHealth?
(3) The facilitators and barriers regarding integrating Compas-Y into their PO care practices	• (IV): What was your first impression of Compas-Y? • (OS): What external incentives influence the decision to integrate Compas-Y into your organisation? • (IS): Would Compas-Y work in your healthcare organisation? - If so, why yes? If not, why not? • (I): Would you be motivated to integrate Compas-Y in your PO care practices? - If so, why? • (IP): What could a blended form (Compas-Y and face-to-face appointments) look like in your PO care practices?

Note. PO = psycho-oncological; IV = individuals; OS = outer setting; IS = inner setting; I = individuals; IP = implementation process.

Data Analysis

The data were analysed using ATLAS.ti version 23. One coder coded and analysed the transcripts via both inductive and deductive approaches. For instance, inductive approaches were used for topics relating to RQ1 and RQ2. For example, detailed specific data for broader generalisations were examined. Both approaches were used for RQ3 by deductively categorising statements into the CFIR 2.0 domains, inductively exploring other subcategories within the data, and finally, determining whether the conclusions of this study are consistent with the existing theory. Specifically, the six-step thematic analysis outlined by Clarke and Braun (2013) was used. First, the researcher familiarised with the data (i.e., reading and re-reading the interview transcripts). Second, initial codes were generated (i.e., open coding is generated to describe the data and identify first-order codes). Third, the data was searched for themes and patterns in codes (i.e., patterns and categories emerged, leading to second-order themes). Fourth, themes were reviewed by the researcher based on the supervisors' input. Fifth, the themes were defined and named (i.e., indicating specific healthcare professionals' responses). Finally, the findings were reported.

Quality Criteria

The trustworthiness of this study was maintained by considering credibility, transferability, dependability, and confirmability (Frambach et al., 2013). Credibility was considered by doing a member check on the participants by asking for additions or adjustments to the interview summary sent after the interview. Transferability was considered by explaining the sampling strategy and discussing the findings' resonance with existing literature from different settings. Dependability was considered by reaching data saturation by collecting data until no new themes emerged. Both data collection and data analyses were iterative. Confirmability was considered by discussing the research process and findings with peers, supervisors, and other researchers.

Results

Participants

In Table 2, the characteristics of the participants (*N* = 12) are presented in order of profession group: POHs (*n = 5)*, physiotherapists (*n = 5)*, psychosocial (*n = 1)* and occupational therapists (*n = 1)*. Most participants were POH-GGZ (*n* = 4) and oncological/oedema physiotherapist (*n* = 3). Additionally, there were participants with the profession POH-Oncology (*n* = 1), oedema physiotherapist (*n* = 2), psychosocial therapist (*n* = 1), and occupational therapist (*n* = 1). All participants were female and had experience with cancer patients ranging from 0.3 to 25,0 years, averaging 8.2 years with cancer patients and 5.1 years in their current profession.

Table 2

Characteristics of the Participants

Interviewee	Profession	Age (yrs)	Work experience (yrs)	
			With cancer patients	In the current profession
I-1	POH-GGZ	34	0.3	3.5
I-2	POH-GGZ	58	3	3
I-3	POH-GGZ	66	5	5
I-4	POH-GGZ	53	14	8
I-5	POH-Oncology	57	25	5
I-6	Oncological and oedema physiotherapist	26	4	3
I-7	Oncological and oedema physiotherapist	34	12	12
I-8	Oncological and oedema physiotherapist	27	3	1
I-9	Oedema physiotherapist	24	1	1
I-10	Oedema physiotherapist	31	10	3
I-11	Psychosocial therapist	66	12	12
I-12	Occupational therapist	30	9.5	5

Note. I = interviewee; yrs = years; POH = practice assistant; GGZ = mental health care.

RQ1: Current Psycho-Oncological Care Practices in Primary Care

The professionals were asked about the following topics: *the consultation characteristics in primary care*, *the psychological issues of and support for cancer patients*, and *the perceived difficulties in providing PO care*. Figure 3 provides a comprehensive overview of the professionals' answers to topics two and three, and all topics will be discussed in more detail below.

Figure 3

Oversight Topics 2 and 3 Showing Frequencies of Professionals Involved

2

The Problems of and Support for Cancer Patients

Problems of Cancer Patients

- Physical and emotional challenges (*n = 10*)
- Existential and psychological issues (*n = 9)*
- Social and practical issues (*n = 9*)

Support by Primary Healthcare Professionals

- General support (*n = 12*)
- Specific support (*n = 7*)

3

Perceived Barriers in Providing Psycho-Oncological Care

Information Coordination and Provision

- Lack of organisational structures (*n = 7*)
- Missing information on referral indications (*n = 7*)

Declaration Issues

- Difficulty in declaration of inter-professional meetings (*n = 1*)

Complexity of Healthcare Questions

- Specialist referrals required (*n = 2*)

Imbalance in Availability of Resources for Patients

- Patients feeling overwhelmed by resources (*n = 5*)
- Lack of post-treatment support (*n = 7)*

The Consultation Characteristics in Primary Care

The answers to questions about consultation characteristics in primary care were divided into two categories. Patient- and professional-related characteristics (see Table 3) will be discussed below.

Table 3

Consultation Characteristics of Psycho-Oncological Care in Primary Care

Profession	Consultation Characteristics					
	Patient-Related			Professional-Related		
	Number of patients (a week)	Patient population	Interval	Referral resources	Duration (min)	Format
POH-GGZ	1-3	YA-E	2-4 weeks or above	GPs	30-60	1-on-1
POH-Oncology	40-50	YA-E	2-4 weeks or above	GPs	30-60	1-on-1
Oncological/ oedema physiotherapist	30-40	A-E	Days - weeks	Specialists, Secondary care physiotherapists	25-60	1-on-1/G
Oedema therapist	2-4	A-E	Days - weeks	GPs, physiotherapists, specialists	30-45	1-on-1/G
Psychosocial therapist	0-5	C-E	2-4 weeks or above	POHs and colleague specialists	60	1-on-1
Occupational therapist	3	A	1-4 weeks or above	Occupational physician	45-60	1-on-1

Note. POH = practice assistant; GGZ = mental health care; min = minutes; A = adults; YA-E = young adults – elderly; Y-E = adults-elderly; C-E = children – elderly; GPs = general practitioners; G = group. Consultation characteristics are based on information from the interview and may vary. Cancer patients may frequently include ex-patients and/or relatives.

Patient-Related Consultation Characteristics. First, there appeared to be variation across professions in the numbers and types of cancer patients they encountered in their practice; the oncological specialised professions have encountered higher *numbers* of cancer patients seen in a week compared to the other professions, even though the profession POH-Oncology is still emerging. Second, the *patient populations*, which relate to the patient's age group, differ between professions, whereas the profession groups correspond. Physiotherapists see cancer patients across all adult age groups, *"Very variable from 30 to 80 plus and everything in between but a large group in their forties" (I-6)*. Psychosocial therapists also work with children (I-11), and occupational therapists focus on younger adults reintegrating into their social and working lives (I-12). Last, there were several scheduling practices where the *consultation interval* generally ranged from 2 to 4 weeks for POHs, psychosocial, and occupational therapists. Physiotherapists can have more frequent consultations scheduled from 1 to 3 times a week, depending on the treatment phase, as Interviewee 6 highlighted:

> *Prehabilitation [revalidation before surgery] is indicated three times a week. In practice, this is often difficult in terms of planning, and for the clients with hospital visits and everything and other healthcare professionals, they still have to visit. Often twice a week, we also focus on self-management so that they pick up that other part themselves. (I-6)*

However, it is essential to remember that these consultations do not entirely focus on PO care but incorporate psychosocial support in their consultations besides physical rehabilitation.

Professional-Related Consultation Characteristics. First, the *referral resources* relate to the resources professionals receive patients from, which differ per profession. POHs mainly receive patients through the GPs within their organisations; the psychosocial therapist specifically receives patients from specialised colleagues elsewhere, and the occupational therapist receives referrals from company doctors. Second, the *consultation duration*, which relates to the duration of the consultation in minutes, varies slightly and ranges from 25 to 60 minutes, and only oedema therapists have a maximum of 45 minutes. Lastly, the *consultation formats*, related to the setting and organisation of the consultation, were almost always one-on-one. However, physiotherapists offered consultations in group formats, focusing on exercises. These group formats can also differ, as Interviewee 6 mentioned:

> *That [size of the group] differs a lot. I have groups of two, but I also have groups of four to five. Those groups are really all at the end of the process, and before that, it is no longer that they have chemo, but they are still in that part back to work. So, if they are a bit more in the initial phase or during chemo, groups are limited to two to three. (I-6)*

Psychological Problems of Patients and Types of Support Offered by Primary Care Professionals

Two categories emerged in response to the questions of what issues of and support for cancer patients looked like. The first related to the problems that professionals encountered in cancer patients, and the second related to the type of support they usually provided. Due to the similarities between professions, the data has been merged.

Problems of Cancer Patients. The psychological problems that professionals encounter in cancer patients can be divided into three types. First, all professionals reported their patients to have *physical and emotional challenges*, such as adjustments to changing bodies, fatigue, dealing with emotions, feelings of guilt, and self-criticism of the illness or treatment. Interviewee I4 mentioned: *"What makes them sad or what makes them feel like, 'hey, I really just can't do certain things in my life like I used to'." (I-4).* Second, several professionals reported that patients with *existential and psychological challenges* as cancer patients face questions of meaning and acceptance arising from the illness. Finally, *social and practical challenges* were mentioned as cancer patients deal with post-treatment reintegration difficulties, such as returning to everyday life, including work and social interactions, as Interviewee 4 mentioned:

> *I see cancer patients with different requests for help, for example, having to pick up normal life again after being out of treatment but not yet ready for it, so full commitment is already being asked in the labour process whether they can rebuild. They [the cancer patients] notice that the pace of their head is not yet sufficiently concentrated or that they experience pressure from the employer or suffer financial consequences. (I-4)*

The professionals emphasised that the patients deal with various problems; therefore, they need PO care, which can also vary per consultation.

Support Provided by Primary Healthcare Professionals. The psychosocial support that the professionals provide can be divided into three types. First, *general support* refers to the primary forms of support provided by the professionals, such as a listening ear, asking questions, making space for emotions, and normalising patients' feelings, as Interviewee 4 stated: *"The first instance, listening, making room for the emotions and experiences and especially normalising that these things are normal and part of it but also tough, isn't it? This is also tough for human life." (I-4)*. Second, *specific support* refers to a specific form of support or psychological (treatment) approach that professionals can use to support their patients optimally, such as providing information, giving emotional validation, enhancing coping strategies, or providing tailored advice. Interviewee 11 mentioned discussing sensitive information with parents and how they can discuss it with their children. Education and resources, such as websites, books, and digital tools, also were used to support patients. Most professionals specifically mentioned providing mindfulness and relaxation exercises to their patients. Last, a *multidisciplinary approach* is used to provide the best support to their patients when needed. This approach includes referring to specialists, working with other professionals, and integrated care planning. Interviewee 8 mentioned the following about referrals to other professionals: *"We could do quite a lot ourselves if you are just a little trained in that [...] However, you always have very intense things to consider: Shouldn't that go to a professional who knows more about that?" (I-8)*. Several professionals mentioned working with GPs, psychologists, (other) physiotherapists, and occupational therapists. Interviewee 7 mentioned: *"We have a coach for cancer in our building."* Showing the diversity of professionals' multidisciplinary approaches to provide support.

Perceived Barriers to Providing Psycho-Oncological Care

Four categories emerged in response to what could be improved about current PO care, revealing several barriers to providing PO care (see Figure 3) in the categories of information coordination and provision, declaration issues, complexity of psychological support, and imbalance in availability of resources for patients.

Information Coordination and Provision. Many professionals mentioned the barrier to providing PO care: *the lack of organisational structures*, which relates to the absence or inadequacy of systems and frameworks that facilitate coordinated, multidisciplinary approaches between primary and/or secondary healthcare professionals, as mentioned by Interviewee 4: *"The organisational structure for multidisciplinary approaches in primary care is often inadequate" (I-4*). Another significant barrier was *the missing information on referrals* related to digital or paper-based referrals to primary healthcare professionals from transferring patients from secondary to primary care. This missing information makes it harder for professionals to understand what PO care was already provided in secondary care. As a result, professionals must request this information by telephone or e-mail if applicable, which costs extra time: *"Very bad [the information on the reference]. The only thing that is often on a referral is only condition build-up to lung carcinoma or very brief. So I have to call quite often for more information." (I-8).*

Declaration Issues. A barrier mentioned by a few professionals was *difficulties in the declaration of inter-professional meetings,* which relates to the financial aspects of multidisciplinary approaches. Interviewee 4 underlined the following about declaration issues:

> *I can't declare those meetings, can I? So it's quite a problem that everyone easily takes the lead in their own way but doesn't take it with each other. That's the bit of the awkwardness of not working in a multidisciplinary way. You can't claim those meetings; they are only client-centred care. (I-4)*

The professionals mentioned that these infrastructures demotivate multidisciplinary work. Although they could help patients, they hinder the professionals and the organisation, as investing time without being able to declare it costs money.

Complexity of Psychological Support. A barrier to providing PO care was that a few professionals did not see themselves as capable of providing the adequate care that *specialist referrals required.* Interviewee 8 underlined that sometimes healthcare questions are too complex, and physiotherapists refer to GPs and POHs. In contrast, POHs refer to psychologists or psychosocial therapists, showing a gradient between the complexity of the healthcare questions and the experienced capability of providing adequate care.

Imbalance in Availability of Resources for Patients. The barrier was that, according to the professionals, *patients felt overwhelmed* by resources during the treatment phase in secondary care. At the same time, they underlined that there is a *lack of post-treatment support*, which many professionals have mentioned. Interviewee 2 stated: *"There was much information during patients' diagnosis and treatment, and then their treatment was finished... They are standing on the hospital's doorstep, and there is nothing" (I-2)*. Professionals in primary care do not want to overload their patients while receiving PO care in secondary care; however, it is unclear what patients received sufficient and insufficient amounts of PO care. Also, many professionals highlighted that for some patients, psychological problems arise after the treatment phase.

RQ2: Professionals' Practices and Experiences with eHealth

The professionals were asked about the topics: their *application of eHealth* and their *positive and negative eHealth experiences*. Figure 4 provides a comprehensive overview of the professionals' responses, which are discussed in more detail below.

Figure 4

Oversight Topics 1 and 2 Showing Frequencies of Professionals Involved

①

Application of eHealth

Specific Platforms and Apps Used
- Therapieland (*n* = *2*)
- Minddistrict (Evie) (*n* = *2*)
- Physitrack (*n* = *5*)
- VGZ Mindfulness Coach App (*n* = *4*)
- Meditation Moments (*n* = *1*)
- Non-Users (*n* = *2*)

Purpose and Focus
- Informing patients
- Monitoring progress
- Evaluating progress
- Psychological focus (*n* = *10*)
- Physical focus (*n* = *7*)

Blended Care Preferences
- Supportive role of eHealth (*n* = 6)
- Human-centered care (*n* = 12)

②

Positive and Negative eHealth Experiences

Patient-Related Experiences
Positive experiences
- Enhanced self-management (*n* = *8*)
- User-friendly applications (*n* = *7*)
- Comfortable and logistically feasible (*n* = *6*)

Negative experiences
- Non-completion of modules (*n* = *5*)
- Resistance of patients (*n* = *8*)
- Cognitive constraints (*n* = *2*)
- Distractions and misuse (*n* = *4)*

Professional-Related Experiences
Positive experiences
- Managing workload and waitlists (*n* = *5*)
- Ease of use (*n* = *9)*

Negative experiences
- Insufficient digital proficiency and engagement (*n* = *5*)
- Preference for face-to-face interactions
- (*n* = *4)*
- Maintenance intensity of eHealth interventions (*n* = *5*)

Application of eHealth

Three categories emerged in response to the questions of the purpose and focus of eHealth within their consultation, what eHealth applications professionals use, and how they prefer to see eHealth use in their daily practices. Almost all professionals had at least some experience with eHealth in their healthcare practices. Table 4 provides a comprehensive overview of the eHealth practices per profession to show variety.

Table 4

General eHealth Use Healthcare Professionals

eHealth application	Profession					
	POH-GGZ	POH-Oncology	Oncological/ oedema physio-therapist	Oedema physio-therapist	Psycho-social therapist	Occupational therapist
Purpose	Informing Monitoring Evaluating	[a]	Informing Monitoring Evaluating	Informing Monitoring Evaluating	[a]	Informing Monitoring Evaluating
Focus	Psychological	[a]	Psychological Physical	Physical	[a]	Psychological
Platform/ App	Therapieland Minddistrict (Evie) VGZ app	[a]	Physitrack VGZ app	Physitrack	[a]	VGZ app Meditation Moments

Note. Using platforms such as YouTube is not considered eHealth and, therefore, not included.
[a] Non-user of eHealth.

Purpose and Focus. eHealth was used for various purposes. First, eHealth was used to *inform patients*, which relates to psycho-education components or information provided regarding exercises. Second, professionals *monitor progress* by tracking patients' outcomes via digital tools (I-4) to track progress and make decisions within the treatment plan. Interviewee 8 mentioned: *"Giving eHealth as exercises to do at home to continue with that, but then monitor it face-to-face" (I-10).* Last, most professionals *evaluate progress*, referring to gaining insight into outcomes related to achieving the set goal by assessing psychological outcomes and interventions' effectiveness, *"Usually as evaluation moments and to see if they are a bit adherence to therapy" (I-9).* They use these insights to track improvements and decide if new goals or approaches should be formulated. The focus, referring to the central aspect targeted by eHealth, was on *psychological aspects*, addressing patients' mental health issues or on the *physical* aspects relating to health issues only done by physiotherapists.

Specific eHealthPlatforms and Apps Used. The eHealth platforms or applications that professionals use vary depending on the profession. Two POHs used *Minddistrict* and two used *Therapieland*. The professionals who used Minddistrict also use *Evie*, a personalised interactive intervention tool Minddistrict and PRO praktijksteun developed. Five physiotherapists used *Physitrack* to prescribe exercises. Four professionals adopted the *VGZ Mindfulness Coach App* for mindfulness and relaxation exercises. The occupational therapist mentioned using *Meditation Moments* to provide patients with relaxation exercises. Two professionals (I-5 and I-11) did not use platforms or apps, making them *non-users*.

Blended Care Preferences. Most professionals preferred blended care over self-help only. First, integrating eHealth with face-to-face consultations highlighted the *supportive role of eHealth* by multiple professionals, *"I think maybe hybrid, so one part is digital and face-to-face" (I-1).* Additionally, all professionals emphasised the importance of *human-centred care* and maintaining human interaction besides eHealth interventions, as Interviewee 6 underlined: *"Our society is already very much online, and it is precisely that bit of humanity that is sometimes still missing. I think it's nicer to keep it human as a general and an oncology physiotherapist" (I-6).* Using eHealth in blended care, including eHealth and face-to-face consultations, remains human interaction. This enhances patient bonding and provides them the space to have something for themselves.

Positive and Negative eHealth Experiences

Two categories emerged in response to the experiences professionals encounter with patients and themselves while working with eHealth. One related to experiences (positive and negative) for their patients, and the other to experiences from their perspective as professionals (see Figure 4).

Patient-Related Experiences.

Positive Experiences. First, most professionals underlined that eHealth *enhances self-management* as patients can manage complaints independently. Interviewee 3 mentioned:

> *The advantage of online programs is… and that is what I always tell my patients: You can't look back at what kind of conversation we had…what did she [the professional] say again? Yes, you don't remember exactly. And, of course, you forget half of it, and you can watch online programs endlessly. (I-3)*

Additionally, some professionals highlighted platforms and apps like Physitrack and VGZ as user-friendly: *"It is easy and easier to give exercises" (I-9),* relating to patients' ease of using the apps and navigating through exercises. Finally, according to some professionals, eHealth is deemed *comfortable and logistically feasible*, which relates to the comfort patients can experience while using apps at home rather than travelling to organisations for consultations during treatment or daily life. Interviewee 11 stated: *"In general, people are busy enough with hospital appointments that they don't immediately have another appointment everywhere and nowhere. And then it's nice that they can do something at home when possible." (I-11).*

Negative Experiences. First, *modules' non-completion*, relating to patients not completing modules provided by the professionals, was mentioned many times*: "I also noticed that adherence isn't that great with these kinds of things. Most people don't finish them, so something like 90% stop at some point, and very few finish them to the end" (I-1).* The professionals mentioned that providing eHealth modules makes it less appealing, as patients do not complete them, and they want patients to take control of their recovery. Additionally, most professionals mentioned the *resistance of patients,* which relates to patients not wanting to start eHealth modules or not seeing the point. These are especially patients with low energy and the elderly who resist or struggle with eHealth applications on phones, making them not want to use them anymore (I-2). Further, *cognitive constraints,* which relate to the cognitive abilities that hinder eHealth use of specific patient populations, may hinder engaging or recalling information from eHealth platforms, as Interviewee 6 underlined: *"People often suffer a bit from that brainfoq, so then they read it and then they think, what have I actually read?" (I-6).* Last, altough a home environment can offer peace and comfort. However, some professionals also underlined that home environments could be *distracting and misuse* can occur, relating to other things than eHealth interventions or insufficiently using eHealth platforms can lead to treatment inconsistencies, *"They get distracted at home and are not here" (I-11).*

Professional-Related Experiences.

Positive Experiences. First, multiple professionals, especially POHs, mentioned that eHealth helps *manage workload and waitlists*, referring to the number of patients that can be placed on professionals' agendas. Providing patients with eHealth helps provide continuous care to patients who need support, as Interviewee 1 described: *"I say, 'Hey, you know, you can either wait a very long time for 12 months or 9 months for a face-to-face treatment, or you can start online right away.'" (I-1).* Also, the *ease of use and accessibility,* referring to the advantages of eHealth of apps like Physitrack to cater to diverse populations, including languages that professionals might not speak, enhances treatment options (I-9).

Negative Experiences. First, among a few professionals, there was *insufficient digital proficiency and engagement*, referring to the ability of the professional to engage with eHealth for treatment options due to limited digital skills. Clients not completing modules can demotivate professionals' use of eHealth, *"If I'm not too active [with eHealth], people quickly leave it behind." (I-2)*. Interviewee 1 highlighted that some older colleagues also struggle with other digital tools. Additionally, half of the professionals highlighted their *preference for face-to-face interaction,* referring to consultations that include both face-to-face and eHealth interventions due to the importance of nonverbal communication (I-6). According to I-6, nonverbal communication tells professionals much about whether a patient wants to talk about something. Last, the *maintenance intensity of eHealth interventions*, referring to staying up-to-date with eHealth, was perceived as time-consuming, including reviewing new eHealth options, *"I don't have time to look at that eHealth in addition to [the appointments in a day]. That is the problem with the full agenda." (I-3)* Interviewee 12 also stated that some training sessions on eHealth are more marketing than providing the key points, making it more commercial than informing (I-12).

RQ3: Facilitators and Barriers Related to CFIR 2.0 for Integrating Compas-Y

The professionals' answers related to the promoting and hindering factors of integrating Compas-Y into their current PO care practices could be divided into the CFIR 2.0 domains: the *Innovation*, *Outer Setting*, *Inner Setting*, *Individuals*, and *Implementation Process*. Table 5 provides a comprehensive overview of the facilitators and barriers primary healthcare professionals perceive.

Table 5

Oversight of Facilitators and Barriers per theme based on the CFIR 2.0 domains

CFIR Domain	Theme	Facilitator	Barrier
Innovation	Application Characteristics	- User-friendliness and accessibility - Content and functionality - Flexibility	- The limited interactive support
	Cost-Effectiveness	- Affordability for the patients - Low costs for the organisation	- Cost concerns for added value for PHTs
	Comparison with other Apps or Platforms	- Extensive information provision - Specific content and approach	- Lack of monitoring features
Outer setting	External Policies	- Involved regional networks	- Lack of external funding
	Incentive Strategies	- Supportive incentives for adoption - Accreditation requirements	
Inner setting	Structural Characteristics	- Variety in forms and meetings	
	Networks and Communication	- Several means of communication	
	Implementation Climate	- Space for initiatives	- Closed organisation cultures - Time and agenda constraints - Approval constraints
	Use of and Access to Technology	- High status of eHealth use	- Differences in current systems (platforms) used
Individuals	Digital Literacy	- General digital awareness (PA/PR) - Skills with mobile devices (PA/PR)	- Low digital awareness (PA/PR)
	Target Group and Suitability	- Younger populations for implementation (PA/PR)	- Appropriately implementing Compas-Y (PR)
	Personal Attitudes	- Motivation and interests (PA/PR)	- Acceptance of the effectiveness of Compas-Y (PA/PR)
Implementation Process	Needs of Professionals	- Firsthand experience with Compas-Y - Access to comprehensive information - Specific practical tools - Cooperation with others	- Lack of time-efficient resources
	Responsible Parties	- Broad deployment in the care lines - Training and education	- Specific professionals as implementers (PHTs)
	Implementation Strategies	- Information material for patients - Concrete implementation actions - Patients-centered care	- Mixed preferences for patients' information material
	Adapting Compas-Y	- Monitoring functions - Interactive features with patients - Specific adaptations for patients in further phases of cancer	

Note. PHTs = physiotherapists; PA = patients; PR = professionals.

Innovation Domain

We identified three critical themes within the innovation domain: Application Characteristics, Cost-Effectiveness, and Comparison with other Apps and Platforms. The first relates to Compas-Y's specific features. The second relates to its economic aspects, Specifically the value of its cost. The last relates to how Compas-Y compares with alternative options available.

Application Characteristics. Compas-Y was rated very positively for ***user-friendliness, accessibility, content and functionality***. Professionals emphasised its easy navigation, well-organized structure, and calming layout. Various exercises and modules in video and text format were also appreciated, *"I'm very visual, but someone who prefers to read can read it." (I-5).* The option to safe favourite exercises enhance functionality, and the diverse cancer-related information was deemed relevant when one professional raised concerns about the potentially overwhelming amount of content for this audience, which could lead to higher drop-out rates (I-3). There was slight variety in answers relating to ***flexibility***, as most professionals indicated the ability to skip parts and proceed at patients' own pace as an added value; some underlined that opening a module each week could rush patients. Interviewee 12 also asked why users skip certain parts, questioning whether it reflects avoidance or irrelevance. Some professionals emphasised Compas-Y as a self-help app, ensuring patients' privacy for the ability to communicate confidentially about their emotions (I-10 and I-9). However, few professionals underlined that ***Compas-Y's limited interactive support*** could hinder successful implementation as the content could trigger intense emotions, and only text or video explanations are available where there is no possibility for questions of the patients.

Cost-Effectiveness. All professionals found ***affordability for patients*** and ***low costs for the organisation*** essential to successfully implementing Compas-Y, as it improves accessibility. Interviewee 11 noted that some patients have financial constraints:

> *There is a category that doesn't have that much money and it's a shame that those costs are also added again. It may cost something [in an app store]... But if it becomes very expensive [for patients]. (I-11)*

Physiotherapists, in particular, express ***cost concerns*** about the added value to their practice, as psychosocial support is not their main focus. Some mentioned offering it for free in an App Store could be beneficial.

Comparison with other apps or Platforms. The professionals were generally positive about the added value of Compas-Y compared to other apps and modules on platforms due to the ***extensive information provision*** and the ***specific content and approach*** within Compas-Y (e.g., self-compassion training). One professional even praised information integration more than Therapieland modules, *"Therapieland is much more text and psychoeducation. Where it gets a bit more of a top-*

down feeling, the doctor tells, and you listen, and then we come and ask some questions: "How is that for you?" (I-9). Interviewee 12 also mentioned, *"It [modules of Therapieland] lack focus on individuals who study or volunteer, such as the AYA group"* However, there were mixed opinions on this extensive information, as Interviewee 3 underlined that Therapieland offers separate modules related to the cancer journey facilitating manageability. The lack of monitoring features in Compas-Y, as available in other platforms such as Therapieland and Minddistrict (Evie), is seen as hindering, especially for POHs. However, some professionals emphasise that dig is a problem if it is only used as a self-aid, *"For closed people, it is also very good to do that for themselves at home because then other people can not hear or see it." (I-9).* The option to use or not to use it could offer a solution.

Outer Setting Domain

We identified two critical themes within the outer setting domain: External Policies and Incentive Strategies. The first relates to policies outside the organisation. The second relates to adaptive methods to promote adoption.

External Policies. Several professionals externally mentioned organisations and policy measures that influence the implementation of eHealth within organisations (e.g., ONCOnet and HCDO). ***Involved (regional) networks***, such as overarching organisations, play a crucial role. However, a lack of external funding and financial constraints may hinder the implementation of Compas-Y. Facilitators are regional networks as they play an essential role in regional decision-making. Overarching organisations such as THOON set digitisation targets to ensure the availability of new modules. Interviewee 1 mentioned: *"There is a message [from THOON], for example, about something that has been added. (I-1)"*. The ***lack of external funding*** to promote digitisation within organisations is a barrier. Interviewee 1 commented: *"More and more organisations do everything online because they want to stay financially healthy. So I think there's going to be a lot more money going around soon" (I-1).* These organisations create a robust system for implementing eHealth by supporting technologies like Compas-Y.

Incentive Strategies. Several professionals emphasise the impact of supportive incentives for eHealth adoption. Accreditation requirements can promote participation in sessions on Compas-Y. Facilitators are **supportive incentives for adoption** that GP practices receive from overarching organisations. Additionally, most professionals highlighted that healthcare professionals must earn points to meet **accreditation requirements**, which can be acquired through training, webinars, and other organisational activities: *"People love points because they have to have them for their association" (I-4).*

Inner Setting Domain

We identified four critical themes: Structural Characteristics, Networks and Communication, Implementation Climate, and Use of and Access to Technology. The first refers to the organisational and social structure within the organisation. The second refers to the quality and nature of communication and professional relationships. The third refers to the readiness for implementation, willingness to change, and organisational cultural aspects. The last refers to the availability, accessibility, and usage of eHealth within the organisation.

Structural Characteristics. There is room to introduce Compas-Y in their organisation. Several professionals stated they have a ***variety in forms and meetings*** within the organisation, including peer consultations and intervision moments, *"We have regular work consultations with all colleagues" (I-7)*

Networks and Communication. Professionals can communicate both internally and externally. A facilitator were the ***several means of communication*** within the organisation. Professionals mentioned, for example, newsletters via email and the Silo app, which announce new developments and promote interprofessional communication, *"So if there's new stuff, then it's often communicated in a newsletter" (I-6).*

Implementation Climtate. Even though there is space, there are some crucial barriers. Most professionals experience ***space for initiatives*** within the organisations, especially POHs and oncology physiotherapists. Organisations are open to value-added innovations, especially young teams, *"If it has an added value... If it turns out to be from a trial period, for example, then I think they can be open to that." (I-9)*. Conversely, a ***closed organisational culture*** and ***time and agenda constraints*** form barriers, especially POHs: *"As far as my schedule allows... because that's a thing... full agendas" (I-3)*, hindering the opportunity for exploring digital interventions and ***approval constraints*** for new initiatives often require approval from managers. Interviewee 4 underlined, *"It depends on whether there are costs attached to it yes or no"*

Use of and Access to Technology. A facilitator is a ***high status of eHealth use***. Some organisations, especially those of POHs, use daily eHealth platforms such as Minddistrict (Evie) and Therapieland. Physiotherapists use Physitrack for exercise programs. However, not all professionals use eHealth daily (I-5, I-6, and I-11), and ***differences in current systems and platforms*** can make broad integration of Compas-Y difficult. Interviewee 12 commented: *"As soon as you start doing it through Therapieland, you only stick to the healthcare professionals who work with Therapieland, which means that the occupational and physiotherapists can't do anything with that " (I-12).* Organisations of POHs choose one of the platforms to get access of POHs choose one of the platforms to get access to modules offered in daily practices, as this comes with costs. The Play Store or App Store can make it more accessible for professionals using these platforms.

Individuals Domain

We identified three critical themes: Digital Literacy, Target Group and Suitability, and Personal Attitudes. The first relates to aspects including general digital awareness and skills with mobile devices. The second relates to Compas-Y's suitability for specific populations. The last relates to personal motivations, interests, acceptance, and perceptions regarding Compas-Y.

Digital Literacy. Most professionals emphasised the importance of ***general digital awareness*** and ***skills with mobile devices*** for adopting Compas-Y among patients and professionals. While younger generations tend to be more skilled, opinions were divided on older generations. Some professionals noted that many older people are getting better at using digital tools, although this varies significantly from individual to individual. *"Young people are a suitable target group. At least not the elderly of 70 plus, who are not used to doing so much behind the screen... Although my mother is 93, she could still do that, so it's also a bit type-oriented, right?" (I-11)* and Interviewee 12 emphasised, *"Nowadays, I think most of them [elderly] can handle a mobile phone" (I-12).*

Barriers include ***low digital awareness***, unfamiliarity with eHealth, and challenges for patients with lower IQ, EQ or dyslexia. Additionally, professionals highlighted that colleagues who have insufficient skills with digital devices may hinder the implementation of Compas-Y, *"Those [some colleagues of 60] find it difficult to log in to the computer sometimes, and they can't send attachments via e-mail." (I-1).*

Target Group and Suitability. Most professionals deemed Compas-Y primarily suitable for ***younger populations***. However, some thought it could be extended to older adults, *"I think, especially young people, and yes, at least up to the age of 60 to 70"*, and those with other psychological difficulties if the information was adapted:

> *I think this can also be much broader, such as just not feeling good about yourself or having a burnout. Although this [Compas-Y] is really focused on cancer, I also think this app can exist for other target groups. However, with references to other sites, just one part is different because a lot of information is cancer-specific. (I-11)*

There was agreement that younger patients and professionals are more likely to adopt Compas-Y, most likely due to the aforementioned digital skills and their general use of eHealth. Multiple professionals specifically mentioned the adolescents and young adults (AYAs) group.

Personal Attitudes. The ***motivation and interests*** have a significant influence on the adoption of Compas-Y. While most professionals and patients were motivated to use the app, *"I'm a* *cancer patient myself, and I think, well, I'm curious, so I would like to do it [Compas-Y]." (I-5),* some preferred a more personalised approach in consultations (I-6). Barriers were the need for proper timing after professionals had bonded with their patients, relating to ***appropriately implementing*** Compas-Y and the ***acceptance*** based on beliefs about practical ***effectiveness*** by one professional: *"It [Compas-Y] could be additional, but I do have doubts... I think it's a very nice concept, but will it work in practice?" (I-6)*. However, in general, the professionals were open to considering Compas-Y.

Implementation Process Domain

We identified four critical themes: Needs of Primary Healthcare Professionals, Responsible Parties, Implementation Strategies, and Adapting Compas-Y. The first relates to the needs of healthcare professionals to successfully implement Compas-Y. The second refers to who is responsible for implementing Compas-Y. The third refers to the methods and strategies that could be used to implement Compas-Y. The last refers to modifying Compas-Y to fit the needs of professionals better.

Needs of Primary Healthcare Professionals. The professionals' first need was to ***experience Compas-Y firsthand*** before integrating it into their healthcare practices. This allows them to understand the functions and better understand possible obstacles. *"Ideally, I would like to know what that app looks like and what questions I can expect, and sometimes, I will prepare people for something like this, which will be discussed. (I-12)* Most professionals preferred ***access to comprehensive information*** such as features and practical applications. ***Specific practical tools***, such as step-by-step plans and sample questions to support deeper consultations, were mentioned several times. The ability to ***cooperate*** with others about Compas-Y, such as colleagues who also use it, was preferred by multiple professionals. On the other hand, ***a lack of time-efficient resources*** can be a barrier, as Interviewee 12 emphasised the importance of directed information about Compas-Y due to agenda constraints, *"There is often much more advertising than going into depth, so then you are there for a whole day while you get the core of the entire product in an hour" (I-12).* During working hours, extra time is required to read this relevant information about Compas-Y.

Responsible Parties. Many professionals expressed that ***broad deployment in the care lines*** of Compas-Y, both primary and secondary, would benefit most patients, *"I think that the hospital should be much more active in providing psychological and mental care for cancer patients because that happens far too little." (I-4).* For example, it was also emphasised that professionals in secondary care are more likely to see cancer patients but that cooperation between the lines is essential by clear communication. There were mixed opinions on ***specific professionals as implementers***, such as physiotherapists. Interviewee 6, a physiotherapist, questioned whether physiotherapists were the right implementers without further therapy. Conversely, Interviewee 4, a physiotherapist, stated: *"I don't think anyone specific. I think almost all medics or paramedics would be able to do that if they think they know enough about the app [Compas-Y]. " (I-4).* However, the POH also understands mixed feelings about this topic as they understand if physiotherapists will refer to other professionals (I-11). This might also depend on whether Compas-Y is implemented as a self-help app or therapy tool.

Implementation Strategies. Almost all professionals mentioned ***training and education*** with examples such as e-learning modules, refresher courses, and presentations, *"Well, I think it's an information and training moment, then everyone gets it right between the ears, right?" (I-4).* ***Information materials for patients*** were also discussed on several occasions. Several ***concrete implementation actions*** were deemed essential, such as integrating Compas-Y into existing (regional) network platforms (ONCOnet and NOFON). All professionals supported adapting the use of Compas-Y based on patients' needs and preferences through ***patient-centred care***. However, a small barrier was the ***mixed preferences for information material for patients***, as some professionals stated that leaflets would quickly end up on the bottom of a pile and that e-mails were not read.

Adapting Compas-Y. POHs and some other professionals especially found it essential that Compas-Y, if used as a therapy tool, is adapted to better support specific requests for help from patients. The ***monitoring functions and notifications*** are essential for identifying alarming patient scores, *"We may be talking about two different target groups, right? The people who come to me have complaints, so I want to support them in a targeted way with the complaints" (I-2).* However, some professionals also underlined the strength of Compas-Y as a self-help tool, *"I think it's a very nice, beautiful tool for people to get started with, to see for themselves what they need there at that moment. " (I-4).* ***Interacting functions with patients***, such as a chat function, facilitates patient involvement and support. In addition, ***specific adaptations*** were made several times for a broader target group, such as adding information about patients in later stages of cancer and/or recovery or for families who have to deal with cancer: how to talk to children, the Wish Ambulance, and taking ink fingerprints when still alive.

Discussion

This qualitative study explored primary healthcare professionals' perceptions regarding integrating eHealth, particularly Compas-Y, into their PO care practices.

Main Findings and Explanations

What are the current practices in psycho-oncological care in primary care settings?

The first main finding is significant differences between specialised cancer professions (e.g., POH-oncology and oncology physiotherapist) and non-specialised professions. These findings were in line with our expectations, altough we expected POH-GGZ to encounter more cancer patients in their practices as the POH-Oncology is relatively new and not all general practices have a POH-Oncology specialisation. This suggests they are favourably positioned to implement digital interventions for this target group. The second main finding is that PO care is provided in individual consultation formats, while we expected more diversity as we discussed the variety of options. However, Osma et al. (2019) revealed that 85.4% of patients with emotional disorders prefer treatment in an individual format, 14.2% in a group, and 0.4% online. These participants argued that group formats lacked privacy and expression difficulties, and the online format was considered impersonal and ineffective. We acknowledge that the study by Osma et al. (2019) focused on a different target group and was in a public mental health centre rather than primary care. Nevertheless, these results show a preference for patients receiving psychological support. By providing PO care in individual formats, you can focus on personalised support, confidentiality and privacy, intensity of emotions, complex psychological factors, and varied reactions to treatment. The third main finding was the lack of information and coordination between secondary and primary care, which was perceived as a barrier to providing PO care in primary care settings. This included a lack of organisational structures and insufficient referral information. In agreement, studies by Callaço et al. (2024) and Lisy et al. (2021) found that limited communication and information exchange are critical issues within primary care and between primary and secondary healthcare professionals and are crucial for successful integrated care. These authors emphasised the lack of clearly defined roles in cancer care, poor coordination, and insufficient communication between these care levels. Enhanced teamwork, increased collaboration between primary and secondary care, earlier involvement of primary care professionals, treatment summaries, care plans, and video call technology could offer solutions. The last main finding related to the imbalance in the availability of resources for patients, where professionals encountered patients who often felt overwhelmed by the options or lacked post-treatment support. This issue is interconnected with the previous barrier, as problems in information provision and coordination can aggravate the challenges related to resource availability. Determining clear professional roles in primary and secondary care ensures patients are not overwhelmed by resources or lack of support in treatment aftercare. However, altough professionals perceived problems with secondary care, Garpenhag et al. (2022) revealed that many cancer patients perceived primary care services as not essential to their treatment. Critical barriers to effective primary care included poor coordination and communication with specialist care, insufficient cancer expertise, limited availability, lack of personal continuity, and inadequate attention to cancer-specific needs. This shows that more research is needed on effective communication pathways and improving organisational cultures to support better care integration between primary and secondary care.

What are the practices and experiences of primary healthcare professionals with eHealth?

The first main finding is that most interviewed professionals incorporated eHealth into their current practices, altough two were identified as non-users due to digital skill barriers or a preference for human-centred approaches. Given our study's higher representation of POHs and physiotherapists, we now focus on these groups. POHs predominantly use eHealth platforms (Therapieland or Minddistrict (Evie)) by providing modules to monitor and evaluate patients' data and at times an app (VGZ Mindfulness Coach App). Da Fonseca et al. (2021) found that 13.0% of eHealth interventions addressed cancer, with mental illnesses being the second most common focus at 20.0%. POHs in our study were eager to use eHealth for treatments, although their focus differs from that of psychologists or psychiatrists. Our findings align with Lattie et al. (2022), who emphasised the effectiveness of self-guided interventions in managing large populations and controlling mental health condition waitlists. The growing use of blended approaches, as noted by Lattie et al. (2022), is also preferred by our participants. To date, no studies have explored POHs' use of digital interventions in PO care, indicating a need for further research into self-guided interventions in blended care formats to improve implementation strategies. The physiotherapists use a specific platform for exercise programs (Physitrack) with additional free relaxation or mindfulness apps. Merolli et al. (2022) reported that physical therapists infrequently use digital interventions but are open to using them for specific functions like photo-based image capture, tracking patient information, and using electronic systems. Tools like Physitrack, which can be tailored to patient languages, were especially valued. However, selective use by physiotherapists could hinder broader implementation, as they prioritize digital tools based on added value, often sidelining psychological aspects of care. Estel et al. (2022) highlighted the potential of digitalisation in physiotherapy, with 50.4% seeing value in it, though concerns about data security and financial remuneration persist, particularly among younger professionals. While digitalisation improves workflow and patient communication, 45.5% of physiotherapists expressed concern about the high effort required for successful implementation. The second main finding is that most professionals experienced increased self-management as positive and resistance to change as negative patient-related experiences with eHealth. Professionals experienced ease of use as positive, and insufficient digital proficiency and engagement and maintenance intensity of eHealth were negative professional-related experiences with eHealth. This aligns with the findings of Carlqvist et al. (2021), who reported enhanced self-management, user-friendly applications, and logistical convenience as positive eHealth experiences. However, there were also negative patient experiences. Addressing these challenges is crucial for improving outcomes and facilitating eHealth integration in psycho-oncological care practices, as they can negatively influence eHealth adoption.

What facilitators and barriers within the CFIR 2.0 framework do primary healthcare professionals experience when integrating Compas-Y into their psycho-oncological care practices?

Our study revealed that professionals could identify barriers and facilitators in all five CFIR 2.0 domains. First, the *innovation domain's* most critical facilitators were user-friendliness and acceptability, and low costs for the organisation. These were also identified as essential facilitators in previous studies investigating apps for PO care (Carlqvist et al., 2020; Luigjes-Huizer et al., 2023; Meurs et al., 2022). For example, it is emphasised that improving access to care is effective and affordable. Meurs et al. (2022) emphasised that user-friendliness is crucial for the successful implementation of eHealth and that the low costs to the organisation were significant because the added value of the application is based on its effectiveness, which encouraged organisations to invest in its implementation. Second, within the *outer setting domain* supportive incentives appeared necessary for adoption. These results align with Herrara et al. (2020) and Nascimento et al. (2023), who found that government and multisector incentives were facilitators and that the lack of financial support is a principal barrier to carrying out projects like healthcare technology. Third, within the *inner setting domain,* a high status of eHealth use appeared as a crucial facilitator. This finding aligns in general with the findings of Erku et al. (2023) as they revealed digital literacy. We acknowledge that this is not the same; however, digital literacy and the high status of eHealth use are related to the proficient digital literacy of professionals. We also found that time and agenda constraints were the most critical barriers to integrating digital interventions; these align with the findings of Lisy et al. (2021) and Schuit et al. (2021), who revealed that primary healthcare professionals' high workload and consistent lack of time as barriers to participation in integrated care. Fourth, within the *Individuals domain*, our study revealed that motivation and interest were the most critical facilitators The study by Parmet et al. (2023) showed that for a cancer patient in distress, their intention and willingness to follow through is facilitated by past positive experiences and accessibility. Patients and professionals who are internally motivated and already show interest in eHealth use are likelier to adopt eHealth applications like Compas-Y, with perceptions of usefulness relating to the added value of the app related to being willing to implement it (Borges do Nascimento et al., 2023). The most critical barrier was low digital awareness. Lepore et al. (2019) also found that low digital literacy, which was part of our study, was associated with anxiety about using a computer among breast cancer patients when integrating internet-based peer support groups. We are aware that this is not the same as eHealth or mHealth. However, it does emphasise that low digital literacy must be considered when delivering digital interventions for cancer patients. Finally, within the *implementation process domain* were firsthand experience, training and education, and patient-centered care. All professionals stated they wanted to have firsthand experience with Compas-Y.

Specifically, the findings regarding training and education align with previous studies (Erku et al., 2023; Versluis et al., 2020). The study of Borges do Nascimento et al. (2023) is adherence promotion campaigns to increase healthcare professionals' use of eHealth technologies. It was also revealed that to implement eHealth successfully, there should be a positive impact on the quality of care, and one aspect was patient-centred care, which Neves and Burgers (2022) also underlined. The professionals are willing to integrate Compas-Y into their PO care practices, prioritising patient-centred care by providing blended options. In order to implement Compas-Y, we recommend letting the professionals test Compas-Y, providing free access, offering training and education, and conducting a pilot study among primary healthcare professionals.

In addition to previous crucial facilitators and barriers, this study identified several facilitators potentially facilitating the successful implementation of Compas-Y in primary care. The professionals suggested that requiring accreditation in primary healthcare providers could boost Compas-Y’s adoption. They also noted that monitoring or interactive features in Compas-Y could enhance insight into patients’ psychological well-being and treatment progress. However, it is unclear if professionals will use this information to adjust their treatment strategies.

Strengths and Limitations

First, we used a widely accepted implementation framework to provide the foundation for organising and interpreting qualitative data, as a robust research framework is essential for good-quality reporting of qualitative healthcare research (George, 2024; Means et al., 2020). Second, using a multidimensional approach, the three RQs provided detailed data on the perceptions of primary healthcare professionals who provide PO care. Additionally, to our knowledge, no previous studies have integrated this variety of primary healthcare professionals, contributing to the PO research field. Last, conducting a member check with all participants by providing a summary of the interviews increased the study’s credibility by allowing participants to verify if the data and interpretations reflect their experiences and perspectives, which aligns with Frambach et al.’s (2013) emphasis on the importance of credibility in decision-making processes. However, as with other studies, our study has limitations in providing insight into complex settings such as primary care. First, selection bias could have occurred due to the purposive and snowball sampling strategies. This could lead to a sample that is not fully representative of the broader population of primary healthcare professionals who provide PO care. More comprehensive recruitment reaches outside the researcher's social and professional network and can offer a solution to a more diverse field of participants from various organisations. However, recruiting willing participants was complex, and therefore, we attempted to raise more attention on professional network pages, allowing everyone to respond and potentially participate. Second, the study population has an unbalanced distribution of different professions, which means insights gained from less represented groups remain underestimated, potentially limiting the generalisability of the results (Pallesen et al., 2020). Expanding the number of participants per profession can offer a solution. Nevertheless, the underrepresented professions had more extended experience with the target group, sometimes even more than other represented professions. Last, all participants were female, meaning the male perspective is missing, potentially resulting in bias and generalisability limitations as differences in how males and females experience and implement eHealth may occur (Denend et al., 2020). Recruiting men specifically could offer a solution. However, the fact that the healthcare sector is predominantly female increases the likelihood that the findings of this study do represent the population of primary healthcare professionals. The general social media call was open to males and females, indicating no deliberate exclusion.

Future Research Opportunities and Implications

In addition to our study, we recommend conducting additional qualitative research to uncover secondary healthcare professionals' perspectives on implementing eHealth like Compas-Y and find a clear division of roles and communication strategies that can contribute to the joint implementation of Compas-Y throughout the care lines. A clear view on whether Compas-Y will be used as a therapy tool or as a self-help app provides further direction as to which professionals are vital implementers and on what platforms or app stores Compas-Y can be offered. Additional features such as monitoring functions facilitate acceptance in primary healthcare professionals' PO care practices, ultimately improving PO care for cancer patients. This study provides valuable insights into the practices and experiences of various healthcare professionals providing PO care and the facilitators and barriers to integrating eHealth, like Compas-Y, into their current PO care practices. This study contributes to a broader understanding of how eHealth applications can be leveraged, offering insights that can be applied to implement eHealth applications in the field of PO care.

Conclusion

PO care is still sub-optimal embedded in primary healthcare, and the professionals mentioned various ways this could be improved, mainly by better communication and financing. Most primary professionals in PO care use eHealth, but the intensity and ways differ strongly. Professionals see facilitators as low costs, user-friendliness, supportive incentives, training and education, and patient-centred care, but also barriers such as time and agenda constraints and low digital awareness. Most professionals strongly preferred blended forms of care over self-help apps solely. This study provided many concrete recommendations for implementing Compas-Y in primary care, the most important being firsthand experience for professionals. Future research is recommended on how roles and communication strategies can be optimised for joint implementation across care lines.

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Appendices

Appendix A

Extensive Overview CFIR 2.0 Domains and Constructs

Domain	Construct name
1. INNOVATION DOMAIN = The "thing" being implemented, e.g., a new clinical treatment, educational program, or city service	A. Innovation Source = The group that developed and/or visibly sponsored use of the innovation is reputable, credible, and/or trustable.
	B. Innovation Evidence-Base = The innovation has robust evidence supporting its effectiveness.
	C. Innovation Relative Advantage = The innovation is better than other available innovations or current practice.
	D. Innovation Adaptability = The innovation can be modified, tailored, or refined to fit local context or needs.
	E. Innovation Trialability = The innovation can be tested or piloted on a small scale and undone.
	F. Innovation Complexity = The innovation is complicated, which may be reflected by its scope and/or the nature and number of connections and steps.
	G. Innovation Design = The innovation is well designed and packaged, including how it is assembled, bundled, and presented.
	H. Innovation Cost = The innovation purchase and operating costs are affordable.
2. OUTER SETTING DOMAIN = The setting in which the Inner Setting exists. There may be multiple Outer Settings and/or multiple levels within the Outer Setting.	A. Critical Incidents = Large-scale and/or unanticipated events disrupt implementation and/or delivery of the innovation.
	B. Local Attitudes = Sociocultural values (e.g., shared responsibility in helping recipients) and beliefs (e.g., convictions about the worthiness of recipients) encourage the Outer Setting to support implementation and/or delivery of the innovation.
	C. Local Conditions = Economic, environmental, political, and/or technological conditions enable the Outer Setting to support implementation and/or delivery of the innovation.

	D. Partnerships & Connections = The Inner Setting is networked with external entities, including referral networks, academic affiliations, and professional organization networks.
	E. Policies & Laws = Legislation, regulations, professional group guidelines and recommendations, or accreditation standards support implementation and/or delivery of the innovation.
	F. Financing = Funding from external entities (e.g., grants, reimbursement) is available to implement and/or deliver the innovation.
	G. External Pressure = External pressures drive implementation and/or delivery of the innovation. *Use this construct to capture themes related to External Pressures that are not included in the subconstructs below.* 1. Societal Pressure = Mass media campaigns, advocacy groups, or social movements or protests drive implementation and/or delivery of the innovation. 2. Market Pressure = Competing with and/or imitating peer entities drives implementation and/or delivery of the innovation. 3. Performance-Measurement Pressure = Quality or benchmarking metrics or established service goals drive implementation and/or delivery of the innovation.

3. INNER SETTING DOMAIN = The setting in which the innovation is implemented. There may be multiple Inner Settings and/or multiple levels within the Inner Setting.	A. Structural Characteristics = Infrastructure components support functional performance of the Inner Setting. *Use this construct to capture themes related to Structural Characteristics that are not included in the subconstructs below.* 1. Physical Infrastructure = Layout and configuration of space and other tangible material features support functional performance of the Inner Setting. 2. Information Technology Infrastructure = Technological systems for tele-communication, electronic documentation, and data storage, management, reporting, and analysis support functional performance of the Inner Setting. 3. Work Infrastructure = Organization of tasks and responsibilities within and between individuals and teams, and general staffing levels, support functional performance of the Inner Setting.
	B. Relational Connections = There are high quality formal and informal relationships, networks, and teams within and across Inner Setting boundaries (e.g., structural, professional).
	C. Communications = There are high quality formal and informal information sharing practices within and across Inner Setting boundaries (e.g., structural, professional).
	D. Culture = There are shared values, beliefs, and norms across the Inner Setting. *Use this construct to capture themes related to Culture that are not included in the subconstructs below.* 1. Human Equality-Centeredness = There are shared values, beliefs, and norms about the inherent equal worth and value of all human beings. 2. Recipient-Centeredness = There are shared values, beliefs, and norms around caring, supporting, and addressing the needs and welfare of recipients. 3. Deliverer-Centeredness = There are shared values, beliefs, and norms around caring, supporting, and addressing the needs and welfare of deliverers. 4. Learning-Centeredness = There are shared values, beliefs, and norms around psychological safety, continual improvement, and using data to inform practice.

	E. Tension for Change = The current situation is intolerable and needs to change.
	F. Compatibility = The innovation fits with workflows, systems, and processes.
	G. Relative Priority = Implementing and delivering the innovation is important compared to other initiatives.
	H. Incentive Systems = Tangible and/or intangible incentives and rewards and/or disincentives and punishments support implementation and delivery of the innovation.
	I. Mission Alignment = Implementing and delivering the innovation is in line with the overarching commitment, purpose, or goals in the Inner Setting.
	J. Available Resources = Resources are available to implement and deliver the innovation. *Use this construct to capture themes related to Available Resources that are not included in the subconstructs below.* 1. Funding = Funding is available to implement and deliver the innovation. 2. Space = Physical space is available to implement and deliver the innovation. 3. Materials & Equipment = Supplies are available to implement and deliver the innovation.
	K. Access to Knowledge & Information = Guidance and/or training is accessible to implement and deliver the innovation.
4. INDIVIDUALS DOMAIN = The roles and characteristics of individuals.	ROLES SUBDOMAIN Project Roles: [Document the roles applicable to the project and their location in the Inner or Outer Setting.]
	A. High-level Leaders = Individuals with a high level of authority, including key decision-makers, executive leaders, or directors.
	B. Mid-level Leaders = Individuals with a moderate level of authority, including leaders supervised by a high-level leader and who supervise others.

	C. Opinion Leaders = Individuals with informal influence on the attitudes and behaviors of others.
	D. Implementation Facilitators = Individuals with subject matter expertise who assist, coach, or support implementation.
	E. Implementation Leads = Individuals who lead efforts to implement the innovation.
	F. Implementation Team Members = Individuals who collaborate with and support the Implementation Leads to implement the innovation, ideally including Innovation Deliverers and Recipients.
	G. Other Implementation Support = Individuals who support the Implementation Leads and/or Implementation Team Members to implement the innovation.
	H. Innovation Deliverers = Individuals who are directly or indirectly delivering the innovation.
	I. Innovation Recipients = Individuals who are directly or indirectly receiving the innovation.
	CHARACTERISTICS SUBDOMAIN Project Characteristics: [Document the characteristics applicable to the roles in the project based on the COM-B system [11] or role-specific theories.]
	A. Need = The individual(s) has deficits related to survival, well-being, or personal fulfillment, which will be addressed by implementation and/or delivery of the innovation.
	B. Capability = The individual(s) has interpersonal competence, knowledge, and skills to fulfill Role.
	C. Opportunity = The individual(s) has availability, scope, and power to fulfill Role.
	D. Motivation = The individual(s) is committed to fulfilling Role.
5. IMPLEMENTATION PROCESS DOMAIN	A. Teaming = Join together, intentionally coordinating and collaborating on interdependent tasks, to implement the innovation.

= The activities and strategies used to implement the innovation.	B. Assessing Needs = Collect information about priorities, preferences, and needs of people. *Use this construct to capture themes related to Assessing Needs that are not included in the subconstructs below.* 1. Innovation Deliverers = Collect information about the priorities, preferences, and needs of deliverers to guide implementation and delivery of the innovation. 2. Innovation Recipients = Collect information about the priorities, preferences, and needs of recipients to guide implementation and delivery of the innovation.
	C. Assessing Context = Collect information to identify and appraise barriers and facilitators to implementation and delivery of the innovation.
	D. Planning = Identify roles and responsibilities, outline specific steps and milestones, and define goals and measures for implementation success in advance.
	E. Tailoring Strategies = Choose and operationalize implementation strategies to address barriers, leverage facilitators, and fit context.
	F. Engaging = Attract and encourage participation in implementation and/or the innovation. *Use this construct to capture themes related to Engaging that are not included in the subconstructs below.* 1. Innovation Deliverers = Attract and encourage deliverers to serve on the implementation team and/or to deliver the innovation. 2. Innovation Recipients = Attract and encourage recipients to serve on the implementation team and/or participate in the innovation.
	G. Doing = Implement in small steps, tests, or cycles of change to trial and cumulatively optimize delivery of the innovation.

	H. Reflecting & Evaluating = Collect and discuss quantitative and qualitative information about the success of implementation and/or the innovation. *Use this construct to capture themes related to Reflecting & Evaluating that are not included in the subconstructs below* 1. Implementation = Collect and discuss quantitative and qualitive information about the success of implementation. 2. Innovation = Collect and discuss quantitative and qualitative information about the success of the innovation.
	I. Adapting = Modify the innovation and/or the Inner Setting for optimal fit and integration into work processes.

Appendix B

Information and Consent Provided to and of Participants (Dutch)

Toestemmingsformulier voor: "Percepties van eerstelijnszorgprofessionals betreft het integreren van eHealth in de psycho-oncologische zorgpraktijk”

U KRIJGT EEN KOPIE VAN DIT FORMULIER VOOR GEÏNFORMEERDE TOESTEMMING

Gelieve de juiste vakjes aan te kruisen.	Ja	Nee
Meedoen aan het onderzoek		
*Ik heb de studie-informatie gedateerd [*28/04/2024*] gelezen en begrepen, of het is mij voorgelezen. Ik heb vragen kunnen stellen over het onderzoek, en die zijn naar tevredenheid beantwoord.*	☐	☐
Ik stem er vrijwillig mee in om deel te nemen aan dit onderzoek en begrijp dat ik kan weigeren vragen te beantwoorden en me zonder opgaaf van reden uit het onderzoek kan terugtrekken.	☐	☐
Ik begrijp dat deelname aan het onderzoek bestaat uit een interview (digitaal of op locatie), het bekijken van de introductievideo van Compas-Y en indien gewenst het lezen van aanvullende informatie (pdf-bestand). Ik begrijp ook dat wat ik zeg zal worden getranscribeerd als tekst (inclusief een samenvatting die na het interview wordt verzonden) en dat de opname na het succesvol afronden van het onderzoek zal worden vernietigd.	☐	☐
Gebruik van de informatie in het onderzoek		
Ik begrijp dat de informatie die ik verstrek alleen wordt gebruikt voor wetenschappelijk onderzoek of kan worden gebruikt als achtergrondinformatie voor onderzoek van Compas-Y.	☐	☐
Ik begrijp dat persoonlijke informatie die over mij is verzameld en die mij kan identificeren, zoals [bijv. mijn naam, beroep, werkorganisatie en aantal jaren werkzaam in dit beroep], niet zal worden gedeeld buiten het onderzoeksteam.	☐	☐
Ik ga ermee akkoord dat mijn informatie kan worden geciteerd in onderzoeksresultaten.	☐	☐
Ik ga ermee akkoord om audio/video (via Teams of Zoom) op te nemen zodat dit kan worden gebruikt voor de gegevensanalyse.	☐	☐

Toekomstig gebruik en hergebruik van de informatie door anderen	Ja	Nee
Ik sta toe dat de [geanonimiseerde transcripties, audio-opname] die ik verstrek, worden gearchiveerd in de [database Google Drive of M-/P-Drive] en alleen worden gebruikt voor toekomstig onderzoek en om van te leren.	☐	☐
Ik ga ermee akkoord dat mijn informatie kan worden gedeeld met andere onderzoekers voor toekomstige studies die vergelijkbaar zijn met deze studie. De informatie die met andere onderzoekers wordt gedeeld, bevat geen informatie die mij direct kan identificeren.	☐	☐

Handtekeningen

Naam van de deelnemer	Handtekening	Datum

Naam van de onderzoeker	Handtekening	Datum

Contactgegevens studie voor meer informatie:

Cheryl Barneveld, e-mail: c.barneveld@student.utwente.nl

Contactgegevens voor vragen over uw rechten als onderzoek deelnemer

Als u vragen heeft over uw rechten als deelnemer aan het onderzoek, of informatie wilt inwinnen, vragen wilt stellen of zorgen over dit onderzoek wilt bespreken met iemand anders dan de onderzoeker(s), neem dan contact op met de secretaris van de Ethische Commissie/domein Geesteswetenschappen en Sociale Wetenschappen van de Faculteit Gedrags-, Management- en Maatschappijwetenschappen van de Universiteit Twente via ethicscommittee-hss@utwente.nl

Appendix C

Interview Scheme (in Dutch)

Onderdeel	Vragen
Introductie	- Welkom en bedankt voor de tijd/moeite - Doel: Inzicht krijgen in de percepties van zorgprofessionals over de integratie van eHealth binnen psycho-oncologische zorg in de dagelijkse praktijk. - Geen verkeerde antwoorden mogelijk! - Data wordt geanonimiseerd - Alle vragen van dit interview zijn gerelateerd aan uw rol als zorgprofessional in psycho-oncologische zorg en ondersteuning met de kijk op eHealth zoals Compas-Y binnen deze domeinen. - Leeftijd - Beroep - Jaren ervaring (kanker patienten/in huidige beroep)
(1) De huidige praktijken van psycho-oncologische zorg in de eerstelijnspraktijken	- Hoeveel kankerpatiënten ziet u per week/maand/jaar? a. Aan hoeveel kankerpatiënten biedt u psycho-oncologische zorg? - Hoeveel tijd heeft u gemiddeld per consult? - Hoevaak ziet u gemiddeld een kankerpatiënt per week? - Wat voor soort ‘problematiek’ komt u vaak tegen bij deze kankerpatiënten tegen? a. Hoe ziet pscho-oncologische zorg en ondersteuning er uw dagelijkse praktijk eruit? b. Zijn er methodieken of programma’s beschikbaar voor deze ondersteuning - Ervaart u dat kankerpatiënten behoefte hebben aan aanvullende ondersteuning naast de reguliere zorg? a. Zo ja, op welke manier merkt u dat? - Met wie of welke organisaties werkt u samen binnen de psycho-oncologische zorg? a. Hoe hebben deze samenwerkingsverbanden invloed op elkaar? - Wat vind u van de huidige PO/PS ondersteuning van kankerpatiënten a. Wat vind u dat er goed gaat? b. Wat vind u dat er verbeterd kan worden? c. Ervaart u enige moeilijkheden in het bieden van PO ondersteuning?

(2) De praktijken en ervaringen met eHealth	- Maakt u in het algemeen gebruik van eHealth in de dagelijkse praktijk? a. Zo ja, hoe ziet dat eHealth gebruik eruit? b. Zo ja, wat zijn uw ervaring met het gebruik van deze eHealth? c. Zo nee, wat is hier uw redenen voor? d. Hoe vaak zet u eHealth in ? e. Via welk platform maakt u hiervan gebruik? ➢ Bent u bekend met nog andere platformen? f. Wat voor soort interventie zet u dan in? - Wat is het doel van eHealth binnen uw behandeling? a. Hoe heeft u interactie met uw patiënten via de eHealth? - Hoe zou een gecombineerde interventie (eHealth + face-to-face afspraken) eruit kunnen zien in uw praktijk? a. Denkt u dat er vraag is naar een gecombineerde constructie? - Wat zijn factoren die invloed hebben op het gebruik van eHealth in uw dagelijkse praktijk?
(3) De facilitators en barrieres voor de integratie van Compas-Y	INNOVATION - Wat wat uw eerste indruk van Compas-Y? a. Wat vond goed aan Compas-Y? b. Wat vond u minder goed aan Compas-Y? - Denkt u dat Compas-Y zelf-compassie verhoogd bij kankerpatienten? - Wat vindt u van de aanpassingsmogelijkheden van Compas-Y om te voldoen aan de patient zijn/haar behoeftes? - Wat zijn uw gedachtes over kosten gerelateerd aan Compas-Y gebruik? - Wat vindt u van Compas-Y in vergelijking met andere apps die u gebruikt? OUTER SETTING - Hoe zou Compas-Y ontvangen worden door kankerpatiënten in uw praktijk? a. Hoe goed zou deze interventie aansluiten bij de behoeften van uw patiënten? Op welke manieren? - Zijn er externe netwerken of strategieen die de implementatie van Compas-Y kunnen beïnvloeden? - Welke financiële of andere prikkels beïnvloeden de beslissing om Compas-Y te integreren in uw organisatie? INNER SETTING - Zou Compas-Y werken in uw zorgpraktijk? a. Zo ja, waarom? b. Zo nee, waarom niet? - Hoe verhoudt Compas-Y zich tot andere bestaande programma's in uw zorgpraktijk?

	- Zijn er factoren die het integreren van Compas-Y in uw zorgpraktijk beïnvloeden a. Wat zijn dan bevorderende factoren? b. Wat zijn dan belemmerende factoren? c. Welke veranderingen in de organisatie moeten er worden gedaan om het gebruik van Compas-Y mogelijk te maken? ➢ Worden er (personeels) vergaderingen gehouden ? INDIVIDUALS a. Welke vaardigheden beinvloeden uw gebruik van Compas-Y? - Hoe voel je je over Compas-Y als het gebruikt zou worden in uw setting? - Zou u gemotiveerd zijn om Compas-Y in te zetten naast face-to-face behandelingen? a. Zo ja, waarom wel? b. Zo nee, waarom niet? - Heeft u vertrouwen dat u Compas-Y kan inzetten in de dagelijkse praktijk? a. Zo nee, wat heeft u daarvoor nodig om hier wel vertrouwen in te krijgen? IMPLEMENTATION PROCESS - Hoe zou een ‘blended vorm’ van Compas-Y en face-to-face afspraken er in uw praktijk eruit zou kunnen zien? a. Hoe past Compas-Y op deze manier in uw ‘werkflow’? - Wat heeft u nodig om Compas-Y in uw zorgpraktijk te integreren? a. Welke aanpassingen zijn er volgens u nodig aan Compas-Y om deze goed te kunnen gebruiken in uw zorgpraktijk? - Hoe zou het implementeren van Compas-Y er in uw praktijk uitzien? a. Wie hebben de meeste invloed als het gaat om het integreren van Compas-Y binnen uw zorgpraktijk? b. Welke professionals zouden volgens u geschikt zijn om Compas-Y bij kankerpatienten aan te bieden?
Afsluiting	- Aanvullingen: Zijn er nog dingen die volgens u niet aan bod zijn gekomen maar die volgens u wel belangrijk zijn? - Bedankt voor uw tijd en moeite! - Interview samenvatting: U heeft de mogelijk om aanpassingen te doen als u denkt dat het onjuist is geïnterpreteerd of anders is dan u heeft aangegeven. - Fijne dag!