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# One-on-One Delivery of Living Well with a Disability

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# Research Report

# One-on-One Delivery of Living Well with a Disability

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**Brief Summary**

The RTC: Rural conducted a research project on health management support for rural Americans. The approach used individually-focused programs, one of which included selected content from the Living Well with a Disability (LWD) health promotion program.

The project noted that transportation and limited access to group-based programs in rural areas may act as barriers for participation in health promotion programs. Findings suggest the traditional 10-week LWD group-based program is the recommended practice, but a shorter LWD program delivered one-on-one with a consumer may be an option in rural areas.

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People with disabilities may experience common secondary conditions such as pain, fatigue, and depression, which limit community participation. While secondary conditions can be managed through health promotion resources, people with disabilities living in rural areas may also face environmental barriers such as limited transportation and fewer health resources in the community. These additional barriers may make it more difficult for individuals living in rural areas to access health promotion opportunities that support healthy lifestyles and the management of secondary conditions.

The Living Well with a Disability (LWD) health promotion intervention teaches skills for developing healthy lifestyle behaviors (Ravesloot, Seekins, & White, 2005). It is a 10-week group workshop grounded in peer support, which guides consumers to set individual quality of life goals. LWD uses healthy behavior as a vehicle to reach goals by strengthening problem-solving skills for managing health and developing healthy lifestyle (www.livingandworkingwell.org). Research indicates that participants in the LWD program report 20% to 25% fewer limitations from preventable secondary conditions and a 10% reduction in their use of health care services. LWD participants report improvements in outlook, lifestyle, and health.

In a recent study, Independent Living (IL) Specialists delivered an education program based on an abbreviated version of LWD to consumers on a one-on-one basis, rather than through a traditional group-based workshop.

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## Hypothesis

We hypothesized the individually focused program would increase healthy lifestyle behaviors, decrease limitation from secondary conditions, decrease problems with community barriers and increase community participation. This report describes the process, outcomes, and recommendations for the one-on-one delivery of an abbreviated LWD program in rural areas.

## Methods

**Participants.** Participants included 30 people with disabilities who were recruited from three Centers for Independent Living (CIL). Twenty-four people (80%) completed the intervention and provided usable pre- and post-tests. For the recruited sample, the average age was 49 years; 80% were female, and 60% were Caucasian. They reported a variety of health conditions and impairments including arthritis (56.7%), back or neck pain (63.3%), hypertension (40%), eye/vision problems (46.7%), and emotional problems (60%). No differences were detected between those who completed versus those who did not complete the intervention and post-test.

**Measures.** Consumers completed surveys pre-, post-, and 3-months post-intervention. The measures included (1) the Health-Promoting Lifestyle Profile II (HPLP-II; Pender, Walker, Sechrist, & Frank-Stromborg, 1990; Walker, Sechrist, & Pender, 1987), which measured lifestyle dimensions like health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management; (2) an abbreviated version of the Secondary Conditions Surveillance Instrument (SCSI; Seekins, Smith, McCleary, & Walsh, 1990), which measured limitations people experience due to secondary conditions; (3) a brief measure of participation adapted from the Participation Survey/Mobility (PARTS/M; Gray, Hollingsworth, Stark, & Morgan, 2006); and (4) a measure of health promotion barriers adapted from Becker, Stuifbergen, & Sands (1991).

**Procedures.** The individually-focused LWD program was condensed to four health promotion sessions and was delivered individually to consumers. IL Specialists used guidebooks and/or PowerPoint slides to implement the intervention over the course of four weeks. The LWD sessions, designed to assist consumers with making health behavior change goals, focused on (1) physical activity, (2) nutrition, (3) arranging a healthy environment, and (4) self-monitoring and rewards. Consumers used a workbook to guide and track their health-related goals as they completed the sessions.

The physical activity session included a checklist to help consumers assess their basic knowledge of physical activity as well as how physically active they were. This assessment served as a starting place to help consumers determine their physical activity goals. The nutrition session assisted consumers with tracking food intake to evaluate what and how much they ate. They also recorded their food habits to take a closer look at what influenced what they ate and why. This led consumers to decide on a nutrition goal. In the arranging a healthy environment session, consumers completed workbook activities that helped them identify ways to create an environment to support their physical activity and nutrition goals. Consumers identified negative environmental cues to remove, as well as positive cues to add to support the creation of a healthy lifestyle. The final session on self-monitoring and rewards helped consumers develop a plan to maintain healthy behaviors. It consisted of tracking, recording, and monitoring health behaviors and providing appropriate self-rewards for goal success and progress.

## Results

Overall, results were in the predicted direction for each hypothesis with a mix of statistically significant and nearly significant within subject changes. Table 1 displays the average values and percent change for health promoting lifestyle, secondary conditions, barriers, and participation. In addition to the hypothesized results, post-hoc analysis indicated substantial change in social support (increase = 18%, $p < .01$) and days subjects experience pain (decrease = 33%, $p = .06$). These effects were not maintained at the 3-month follow-up.

## Discussion

These results suggested that a health promotion intervention delivered individually by an IL Specialist had positive effects on the health and participation of people with disabilities. Compared to the traditional group-based LWD workshop, consumers in the abbreviated one-on-one version had similar lifestyle and secondary conditions improvements (Ravesloot, Seekins, & White, 2005). While reductions in their experience of barriers were not statistically significant, consumers in the one-on-one version reported an average of two more trips into the community for the week following the intervention compared with the week before the intervention. However, maintenance of this affect was not observed at the 3-month follow up.

The one-on-one LWD program used a condensed four session approach, focused only on health-related goals. The traditional LWD program, in comparison, has used 10 sessions to focus on quality of life goals and use of healthy lifestyle as a way to reach those goals. The traditional LWD program has included additional skill-building exercises such as problem-solving, avoiding frustration and discouragement, seeking information, and communicating one's needs through advocacy, whereas the one-on-one program focused primarily on goal setting and monitoring. These content differences may explain why the effects in this study were not maintained during the follow-up period.

Another important difference between the one-on-one program and the traditional LWD intervention was peer support. The peer support component of the traditional group-based LWD program has provided a safe environment for people with disabilities to share similar experiences, provide support, and assist others in coping and addressing environmental barriers that can make healthy lifestyle changes and community participation opportunities challenging. Peer support has created an empowering group dynamic, which has often built consumer confidence to make self-directed choices (Ravesloot & Liston, 2011). The peer support provided in the traditional LWD program during and after intervention may account for the maintenance observed in the LWD national trial that was not observed in this study.

## Recommendations

The one-on-one LWD program could provide an effective way to address the management of secondary conditions for rural settings if significant barriers exist to participating in a group-based program. The program offered opportunity for consumers to participate in a health promotion program that might not have been available due to unique barriers often experienced by people living in small rural communities, such as transportation and limited capacity of provider services. For example, the one-on-one delivery method allowed more flexibility for service providers to bring the health intervention to the individual in his or her home or to deliver the intervention via telephone or e-mail. It was also useful for service providers who had difficulty recruiting enough participants in a rural community to form a group. In addition, the one-on-one approach might benefit consumers who feel less comfortable and are not quite ready to participate in a group environment.

**Table 1. Within Subject Change from Pre- to Post-test**

| Variable | Mean pre-test | Mean post-test | % change | p |
|---|---|---|---|---|
| Health Promoting Lifestyle ratings | 2.5 | 2.7 | 8% increase | .07 |
| Secondary conditions ratings | 41.7 | 29.3 | 29% decrease | .00 |
| Barriers ratings | 31.1 | 28.9 | 7% decrease | .13 |
| Participation | 11.0 (Trips) | 13.2 (Trips) | 20% increase | .09 |

**Note: Conventional interpretation of the p statistic interprets values less than .05 as statistically significant.**

Nonetheless, maintenance of the benefits over time will probably require follow-up with consumers beyond delivery of the intervention itself. The traditional group-based LWD program is recommended as the standard to achieve positive consumer outcomes for long-term maintenance of secondary conditions; however, in rural and resource-limited areas, the one-on-one delivery of LWD may be more suitable.

## Next Steps

The one-on-one delivery method of the LWD program has potential promise as an individually-focused health promotion program for people with disabilities living in rural communities. Future research should examine more closely the factors affecting long-term maintenance of program effects. For example, a rural provider could deliver the program materials one-on-one and then introduce people to a peer mentor or peer group to support change over time.

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