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Rural Independent Living and Physical Therapy: Exploring Collaborations

Traditional rehabilitation services are often assumed to be incompatible with independent living (IL) philosophy, but perhaps rural individuals with disabilities might benefit from a collaboration between Centers for independent living (CILs) and rehabilitation services providers.

IL philosophy emphasizes improving opportunities for community participation by people with disabilities.^{1,2} Ecological models of disability emphasize that community participation results when the environment interacts with a person's capacity to access that environment.³ Participation may increase if environmental accessibility improves, and/or if the individual's capacity increases. For people with mobility impairments, technology (e.g. wheelchairs) frequently improves individual capacity. Less frequently, changes in a person's health behavior, such as increased physical activity, can reduce limitation due to secondary conditions and increase personal capacity.⁴⁻⁸ Unfortunately in rural environments people with disabilities rarely have access to opportunities for physical activity, and often lack basic sidewalks and curb cuts to encourage daily physical activity.

Centers for independent living provide IL skills training to teach individuals to change their behavior and increase their participation. However, most centers do not have the staff or facilities to help individuals increase their physical capacity. In rural areas, collaboration between physical therapists (PTs) and CILs promises to increase the availability of physical activity for people with disabilities. RTC: Rural researchers interviewed rural physical therapists to explore that possible solution.

Method

Participants: The University of Montana Institutional Review Board approved all procedures for this study. Researchers randomly selected ten U.S. CILs from a list of 89 centers in non-metropolitan counties, and then identified a total of forty physical therapists listed in online yellow pages as providing services within a 30-mile radius of these CILs. Four listings had disconnected telephones. Researchers contacted the remaining 36 PTs and offered each a \$50 stipend for participating in a 30 minute telephone interview. Sixteen declined to participate, primarily citing lack of time. After repeated attempts, four who had agreed to participate could not be scheduled for an interview.

Researchers ultimately interviewed and compensated sixteen participants in nine states in the northwestern, northeastern, southeastern and central plains regions. Most (62.5%) were women and 43.8% reported being self-employed. Participants worked an average of 4.9 days per week.

Measures: Four research staff, including two academic physical therapists, constructed and reviewed an interview protocol. Questions on practice parameters provided the context for other responses. Researchers designed questions to elicit participants' knowledge and beliefs regarding service delivery and then examined their responses for compatibility with IL philosophy. Introductory definitions of terms such as *participation* and *consumer control* helped control for semantic differences between CIL and PT practice.

Data analysis: Researchers recorded and coded survey responses to each question dichotomously. For example, if respondents indicated some knowledge of the *International Classification of Function* (ICF) by describing any of its aspects, the response was coded 1. Conversely, responses were scored 0 if the respondent had no knowledge or awareness of the ICF. Based on the coded data, researchers computed descriptive statistics for each question.

Results and Discussion

Overall, PT responses displayed mixed compatibility with IL philosophy, with both areas of convergence and divergence. Surprisingly, over half the sample reported receiving some (generally infrequent) referrals from disability service organizations. Many respondents noted that such referrals are limited by insurance regulations requiring physician referrals for physical therapy. This appeared to affect not only whom a therapist would treat, but also the PT practice itself. As one respondent said, "The doctor lays out how the patient will get the best outcome from treatment...some doctors want certain treatments for their patients and that's what they send them for." Because PTs depend on physician referrals, respondents clearly felt challenged to provide the prescribed treatment while meeting the client's needs. If control and oversight were changed from a "gate keeper" model to a "direct access with utilization review" model, perhaps the PT service delivery climate would become more compatible with CIL service delivery.

Therapists' responses on housing, transportation and the use of participation goals to plan and conduct therapy services were compatible with CIL philosophy. The majority of respondents said they consider participation goals in developing treatment plans. Most indicated that, when appropriate, treatment plans consider the home environment and transportation options. Respondents often stated that improved participation is physical therapy's primary goal, and some linked participation goals to quality of life and motivation for treatment.

While PT and IL services converged on considering participation goals and environments when developing treatment plans, they diverged on the roles of consumer choice and control in planning. Most respondents interpreted consumer choice as the individual's choice to use a physical therapy clinic's services. Based on this interpretation, these respondents respected consumer choice regarding whether or not the consumer chose to use their services. Only a small minority of respondents considered the consumer's choices regarding implementation of the treatment plan. A few respondents noted that consumers with newly-acquired impairments are unsure of their prognosis for improvement and unaware of treatment options for maximizing their abilities.

Many respondents said that most clients expect and respect the physical therapist's expertise in developing and implementing the treatment plan. This perspective justifies the therapists' control over treatment options. Consistent with this treatment philosophy, the majority of respondents cited

functional limitation as the primary determinant of disability and only one-fifth cited participation limitations. Viewing disability in these terms may limit a PT's understanding of how therapy might improve a consumer's life beyond just increasing functional ability. Many respondents seemed to assume that improved function is linked to increased participation, but were unaware of other mediating factors (e.g. lack of accessible transportation). By adopting a social model of disability, the therapist might work with consumers to increase their functional ability to a level that helps them meet their participation goals.

Although a majority of respondents appeared to use a medical model of disability, they also saw the benefit of coordinating PT and IL services. One respondent noted, "People don't have the skills to live with disability many times. We do the rehab and they need additional skills to fight the insurance battles, etc." Four out of five respondents would like to serve more people with disabilities, and a majority were interested in participating in a pilot program to coordinate PT and CIL services.

There is a gap between these service delivery networks— only 37.5% of respondents were aware that a local CIL existed. Some respondents asked the interviewer for the name of their local CILs so they could learn about IL services and inform their clients. Unfortunately, a couple of respondents described negative experiences in working with local CILs. One reported, "I've made recommendations for my clients to follow-up with the independent living center... the individual who runs the facility said they don't like medical referrals because they want people to be motivated." This anecdote may reflect the passive role assumed by many recipients of medical services. While passive patients may benefit from intervention to become active CIL consumers, more groundwork may be necessary to help CILs and PTs collaborate for the welfare of their clients.

Groundwork for physical therapists could involve more training and education in the *International Classification of Functioning, Disability and Health*. The ICF uses a social model of disability that describes participation as an outcome of individual functional level and environmental factors. This model is compatible with independent living philosophy. Unfortunately, fewer than half of respondents were aware of the ICF and only one-fifth could describe its purpose or any of its content. Broader awareness of this state-of-art classification system by physical therapists could facilitate integration of PT and IL services.

Conclusions and Next Steps

Physical therapy practice has changed since the independent living movement began nearly 30 years ago. While some PTs have traditional views of disability and physical therapy practice, many now have attitudes and practices consistent with independent living philosophy and values. Although this study's respondents' had low rates of understanding and incorporating consumer control, many were open to discussing ways to increase consumer choice and control in developing and implementing a treatment plan.

These interviews are a first step in understanding the perspective and values PTs would bring to a collaboration with CILs. The next step is to understand CILs' perspectives on such collaborations. Eventually, researchers could develop training materials to facilitate communication, understanding and coordination between these two fine services delivery networks working to increase the personal capacity and community participation of people with disabilities.

Resources and References

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