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Readiness for Health Promotion

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Readiness for Health Promotion

There is growing interest in health promotion, wellness, and the prevention of secondary conditions among people with disabilities. In rural areas where there is limited access to health care providers knowledgeable about disability, managing one's own health and wellness and using strategies to prevent secondary conditions may be particularly important (Offner, Seekins & Clark, 1992; Seekins, 1992; Center for Disability Policy and Research, 1995; Seekins, Clay & Ravesloot, 1994; Seekins, et al., 1999).

For the general population, participation in health promotion and wellness programs improves quality of life and overall health, reduces medical care costs, and lowers mortality rates (US Dept of Health, Education, and Welfare, 1979; Stuijbergen, Becker, & Sands, 1990). Unfortunately, despite the potential benefits, most people do not participate in health programs and many do not practice healthy lifestyles. Our experience in developing and evaluating health promotion and wellness programs suggests that this may also be true for people with disabilities. At any one time, some individuals may be "ready" to participate in health promotion and wellness programs while others are not "ready." Readiness might be seen as a function of medical, cognitive and environmental factors (e.g., Ford, 1992). These factors may combine in different ways to create barriers to participation. If a "readiness factor" exists, targeting health promotion and wellness programs to those who are "ready," while helping to prepare others to participate in and

benefit from such programs, might enhance cost-effectiveness.

Research Goals

Our research goals are to develop an instrument that assesses "readiness" by identifying barriers to participation in health promotion programs and to develop interventions to address these barriers.

We anticipate that barriers will include many issues identified and addressed by Centers for Independent Living (CILs), such as transportation, accessible housing, etc. However, this study also addresses other barriers, such as psycho-social issues that may limit participation in community-based services.

Goals & Objectives of Our Research

1. Identify the community and individual barriers that preclude rural residents with disabilities from participating in health promotion programming.
2. Develop and evaluate an intervention that addresses the "readiness for health promotion" issues and that can help individuals prepare to participate in community-based health promotion.
3. Assess the costs and cost-effectiveness of providing health promotion services and readiness interventions.

Key Concepts and Terms

Readiness is a developmental concept suggesting that a critical set of environmental and behavioral variables may influence the degree to which an individual will engage in, and benefit from, a new experience. Factors influencing the degree of readiness can be negative (barriers or hindrances) or positive (facilitators).

Barriers influence participation in community life, including health promotion and wellness programs. Barriers can be external (i.e. environmental factors) or internal (i.e. personal factors). Barriers can be the presence of negative obstacles and hindrances, or the absence of positive supports or facilitators.

Research Process

Living Well with a Disability is RTC: Rural’s workshop for adults with disabilities related to physical impairments. Six months after completing the workshop, participants continued to experience reduced disability due to secondary conditions (Seekins, et al., 1999). Our next generation of research on effective health promotion programs will determine what factors influence attendance of, and benefits from, such programs.

Pilot Data

Using focus groups and interviews with program recruiters, we developed a list of 27 barriers that people with disabilities encounter in attending programs such as *Living Well with a Disability*. In a pilot study we surveyed 64 *Living Well* workshop enrollees at ten locations in nine states. On a 4-point scale, each participant rated the impact each barrier would have on his or her attendance.

Table 1 lists the items assessed in the pilot study (n = 64) and the mean ratings (0 = not a problem, to 3 = a very big problem) for each item as rated by the respondents two months before the workshop began. Respondents rated

		Mean Rating (0 - 3)
Fatigue:	I tire easily.	1.30
Pain:	I have pain when I do too much.	1.22
Disability:	My disability limits me too much these days.	.92
Need for Assistance:	I will need someone to help me.	.89
Body Functions:	I could lose control over my bowel/bladder.	.81
Transportation:	I don't have accessible transportation.	.75
Weather:	The weather is often too bad to get out.	.66
Concentration:	I have a hard time thinking and concentrating.	.64
Facility Access:	Buildings are not accessible to me.	.61
Physical Energy:	My daily self-care needs take too much energy.	.56
Exterior Access:	My neighborhood has too few curb cuts.	.55
Overweight:	My weight makes it hard to get around.	.42
Home Access:	It's difficult to get in and out of my house.	.41
Equipment:	I don't have the assistive equipment that I need.	.39
Time:	It would take too long to get to the program.	.34
Literacy:	I have trouble reading printed materials.	.33
Chemical Sensitivity:	Environmental chemicals bother me.	.27
Hearing Impairment:	I have trouble hearing what people say.	.23
Neighborhood Safety:	It is dangerous for me to leave my house.	.19
Job:	I can't take time off from my job.	.16
Activities:	I'm too busy with other important activities.	.14
Visual Impairment:	I can't see well enough to get around.	.14
Caregiver Responsibilities:	I take care of a family member.	<.10
Family Opposition:	My family will not support my coming.	<.10
Child Care:	I will have to arrange day care for my children.	<.10
Others' Disapproval:	Some important people will object.	<.10
Medical Disapproval:	My doctor will disapprove.	<.10

these 27 barriers again just before the workshop and immediately after the workshop. Then we calculated each respondent's sum of the ratings of the 27 barriers.

Figure 1 shows the mean sum of barriers that participants reported two months before the workshop, immediately before the workshop and immediately after completing the workshop. The average sum of the ratings of barriers was significantly lower after the *Living Well* workshop than at two months before the workshop, $t(63) = 3.69$; $p < .001$; or immediately before the workshop, $t(63) = 3.12$; $p < .01$. This suggests that factors perceived as barriers before the workshop were seen as less significant after participation.

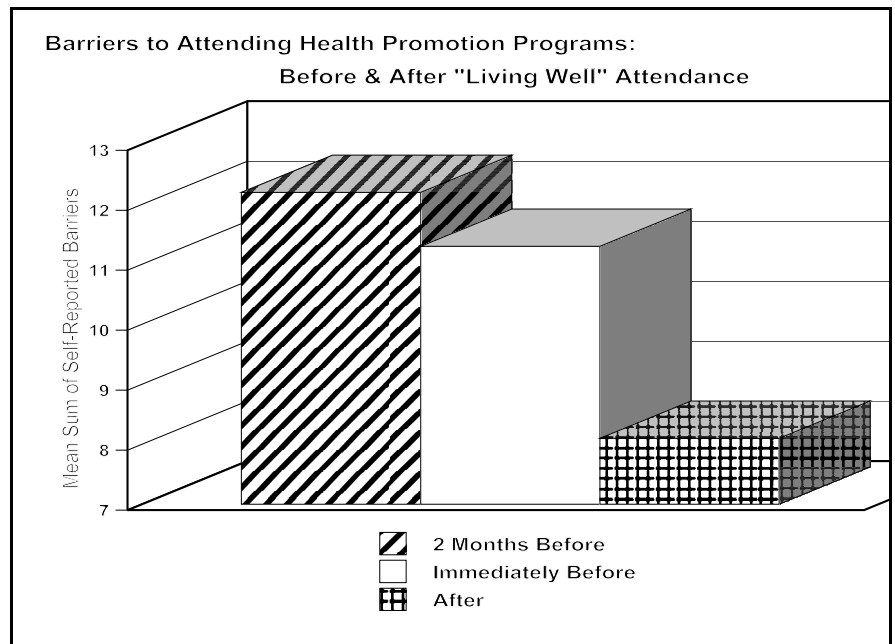


Figure 1.

Limitations of Pilot Study

This data must be considered with caution as the number of participants was small, there is a strong selection bias, and we have no control group of non-participants with which to compare these findings. The types of barriers overcome by those who attended our workshop might be very different from the types of barriers experienced by those who did not attend.

Next Steps

Did the *Living Well* intervention somehow remove the barriers, did the barriers fail to materialize, or did participants change the way they handle barriers? In order to develop readiness interventions, we need a more accurate description of these barriers, as well as measures of factors which influence the way people think about these barriers.

We are refining our instrument to survey environmental, medical, and cognitive barriers. To make our data more representative, we are testing this instrument in two demographically similar counties, with Medicaid enrollees who have never attended a *Living Well* workshop.

The Montana Medicaid office sent letters to all 2,752 Medicaid enrollees in Ravalli County, Montana, and the Maine Medicaid office sent letters to all 4,100 enrollees in Washington County, Maine. Postcards were returned by 793 respondents who were 18-65 years old, experienced a physical disability, and were interested in participating in our project. We sent surveys to 418 requesting respondents who had supplied a mailing address. We are analyzing this data and hope to be able to determine what types of barriers limit participation in health programs. Then we can begin developing intervention protocols that address these barriers.

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