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Access to traumatic spinal cord injury care in Saskatchewan, Canada:

A qualitative study on community healthcare provider perspectives

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Abstract

Healthcare provider experiences with access to care for disabled patient populations may inform healthcare system change and improve health outcomes. Persons with spinal cord injury often require access to life-long care. The objective of this study was to explore healthcare provider perspectives on client access to care in traumatic spinal cord injury. We used an interpretive qualitative study with semi-structured interviews and focus groups to explore provider perspectives on five access dimensions: availability, accessibility, affordability, accommodation, and acceptability. Volunteer (n=23) healthcare providers (therapists, physicians, nurses, home care workers and managers) working with traumatic spinal cord injury clients in Saskatchewan participated. Nine healthcare providers serviced rural areas. Healthcare providers felt restricted in their ability to ensure availabilit*y* of services. In rural areas, therapy and counselling services were often not available. Parking and transportation barriers severely impacted the accessibility of services. Inconsistencies related to the affordability of equipment and accessible housing were expressed. Efforts to accommodate clients to remain in their home communities were apparent. Night time or early morning care seemed impossible to accommodate. Healthcare providers accepted that attitudes and efforts concerning health advocacy among clients, families, and other care providers impacted access. Barriers related to availability, accessibility, and affordability were perceived to affect traumatic spinal cord injury care. Healthcare providers identified the need to accommodate clients' needs by assuming different healthcare and advocacy roles, especially in the face of service shortages. However, restrictions imposed by administrative guidelines, policies or cost were perceived to limit the ability to fully accommodate client's needs.

Key words

Qualitative research; spinal cord injury; rural; healthcare access

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Persons with traumatic spinal cord injury (SCI) require long-term, interdisciplinary care to meet their health needs. Lack of accessible healthcare services may delay and prevent care from occurring, resulting in secondary complications (McColl et al., 2012). Dryden et al. (2004) reported that persons with SCI were 2.7 times more likely to have physician contact and required rehospitalization 2.6 times more often than the general population. Consequently, a focus on effective access to care within the community is needed to minimize the impact of complications and improve the quality of life of persons with SCI.

A significant gap exists between hospital-based rehabilitation care settings and community-based services for persons with SCI (Kendell et al., 2003). Continuity of care may be interrupted and services may become fragmented with transition to community-based care (Kendell et al., 2003). A lack of available expertise has been identified as a potential barrier to appropriate care in both hospital (Kroll & Neri, 2003) and in community settings (Middleton et al., 2008). Guilcher et al. (2010) reported that persons with SCI in rural areas are less likely to access an emergency department. However, the factors that present the greatest barriers to access for SCI clients in community settings have not been previously described. Exploring these barriers from the perspective of healthcare provider experiences may inform healthcare system change and improve the health of persons with SCI.

Penchansky and Thomas (1981) defined access as the degree of “fit” between the clients and the healthcare system. Their comprehensive framework (Table 1) includes five related, yet distinct dimensions impacting client access: availability; affordability; acceptability; accommodation; and accessibility. Since access pertains to the interaction between clients and the system, an appreciation of healthcare system structures is needed. In 2013, the Saskatchewan healthcare system consisted of thirteen publicly-funded health regions. The province spans 588,239 square kilometers with a high proportion (39.1%) of the population located in rural areas (Statistics Canada, 2011). The Ministry of Health determines funding eligibility criteria and processes for access to the publicly-funded equipment and services for persons with disabilities (Government of Saskatchewan, 2012). Additional funding sources for clients may include private disability insurance, the Workers’ Compensation Board (WCB for workplace injuries), and/or Saskatchewan Government Insurance (SGI for persons injured as a result of a motor vehicle accident). A separate federal funding program (Non-Insured Health Benefits; NIHB) is also in place for those with First Nations status (Health Canada, 2014). Additional healthcare funds may be administered through Band Councils (governing bodies on the First Nation reserves) for services delivered on reserves (Aboriginal Affairs and Northern Development Canada, 2010).

While each healthcare system has its unique features and funding models, the factors impacting access to SCI care in Saskatchewan may be applicable to other jurisdictions with similar challenges. These challenges include the delivery of services for specialized populations across a large geographical area, involving often a complex system of possible funding sources. The perspectives of frontline care providers working within existing systems may provide valuable insight on issues related to access. The main objective of this qualitative study was to examine the perspectives of SCI healthcare providers on access to healthcare and support services in rural and urban Saskatchewan, utilizing the Penchansky and Thomas (1981) framework.

Table 1. Modified from Penchansky and Thomas' Dimensions of Access (Penchansky & Thomas, 1981).

Dimension	Definition
Availability	Relationship of the volume and type of resources to the clients' volumes and types of needs (includes supply of providers, facilities, and services)
Accessibility	Relationship between the location of supply and the location of clients, taking into account client transportation resources, travel time, distance and cost
Affordability	Relationship of the costs of services and the clients' ability to pay, income and existing health insurance, including clients' perceptions of worth relative to cost
Accommodation	Relationship between the manner in which resources are organized to accept clients (appointment systems, hours or operation, walk-in facilities, telephone services) and the clients' ability to accommodate to the facts as well as the clients' perception of their appropriateness

Acceptability	Provider attitudes about the personal characteristics of the clients (i.e., age, complexity, ethnicity, type of residence) and the clients’ attitudes about the personal and practice characteristics of providers.

Note: In the Penchansky and Thomas dimensions of access, the *client* refers to the patient. In considering healthcare provider perspectives on the dimensions of access, the client still refers to the patient and the perspectives expressed in the current study are those of the healthcare provider participants.

Data and Methods

Study Design

An interpretive descriptive approach was utilized with semi-structured interviews and focus groups to explore perspectives related to five dimensions of access: availability, affordability, acceptability, accommodation, and accessibility. Ethical approval was received from the University of Saskatchewan Research Ethics Board.

Participants

Inclusion criteria were healthcare providers or administrative managers working in Saskatchewan with people with SCI on their caseload. Invitations to participate were distributed widely to therapists, physicians, and home care workers and managers within eight Saskatchewan health regions via email and 35 individuals were invited directly by an author (MR) when contact information was provided by health region administrators.

Data Collection and Analysis

A preliminary interview guide was created addressing Penchansky and Thomas’ dimensions of access after review of the literature. Data collection occurred between January and May 2013 with in-person focus groups; or individual in-person or phone interviews. Focus groups were dependent on health region participant numbers and scheduling. All interviews were recorded, transcribed verbatim, and imported into Atlas.ti (version 7). Hard copies of transcripts were provided to each participant to confirm accuracy. Three participants made minor revisions to their transcripts; however, substantive content was not altered. After data saturation had been reached, three authors (KK, NR, MR) individually categorized the data according to barriers and facilitators related to the five dimensions of access, followed by team discussion until consensus was reached. Participants’ responses are presented here to support the analyses and interpretations.

Sample Description

Twenty-three healthcare providers participated, representative of six different Saskatchewan health regions. Participants included therapists, nurses, social workers, home care aides, physicians, and administrators (therapy and home care managers). Participants serving urban health regions included ten healthcare providers and four administrators, and participants serving rural health regions included six healthcare providers and three administrators.

Findings

Availability

With respect to availability, the main areas of concern expressed by healthcare providers were related to shortage of staff, treatment space, specialized equipment, and appropriate housing. Lack of staff to serve clients was the most prominent issue expressed by healthcare providers, especially in rural settings.

> “…we can’t get an OT to work in this community, we have enough work for an OT, but you can’t get an OT to work here.” (Rural provider).

It was not clear whether the main barrier related to availability of personnel was insufficient funding for rural positions, or recruitment challenges with providers preferring to work in more urban, supported centres. Therapists felt the need to see clients more frequently or for a longer period of follow-up than they were currently available to do so. In both urban and rural settings, care providers felt that their availability was restricted by waiting lists and program service guidelines set by administrative policy.

> “We’re restricted in the quantity of the care we can give to them.” (Urban provider).

> “…the more often we see a [person with a] spinal cord injury, the wait list in another chart is increased. There are just not enough resources for rehab. So we’re moving along but…most of my staff would say we need more.” (Urban provider).

When local rural services were not available, care providers referred clients to urban centres, but they also adopted transdisciplinary models of care in order to help clients remain in their home communities.

> “We’re not educated to areas of social work and addictions management. We’re not necessarily the best people to be doing all those other roles, but in the absence of support you wear multiple hats and do what you can.” (Rural provider).

Facilities suitable for rehabilitation or physical conditioning needs in rural communities were frequently unavailable. Therapists identified the need for community engagement and partnerships in order to build and share local facilities. Rural participants identified the need for more standard facilities or equipment while urban centres perceived the need for more specialized equipment within existing facilities.

> “What I would really like to see in our community is a bit more [of a] community based effort to building physical therapies and access to physical activity facilities in our community.” (Rural provider).

> “…there’s really no exercise equipment and even room for them to be able to transfer onto a high low bed and to work with them.”(Rural administrator).

“We’re doing a very poor job of wheelchair skills because we don’t have the best set

> up to do it. Yes we have a ramp, we have a curb but, it takes so much time to set that up, and to do it. We don’t have hooks on the ceiling we could hook their wheelchair to.”(Urban provider).

Respite facilities capable of meeting the needs of clients with high level SCI and transitional housing were described as a major challenge, even in urban settings.

> “There is no access to facility respite. The only other place that can manage a ventilator is the hospitals.” (Urban administrator).
>
> “There really isn’t transition housing. You see a lot of people in unsafe situations.” (Urban provider).

Healthcare providers noted the impact these shortages had on caregiver burden and patient safety. Healthcare providers appeared to accept that clients might choose to live at risk rather than relocating if and when support services were not available.

> “The family caregivers are quite involved. They’re not just in the house, they have a full-time job…If they didn’t have a caregiver with them, we just couldn’t provide enough care.” (Rural provider).
>
> “…if he didn’t have family, if they just stopped and said, ‘we’re not doing this anymore,’ he would choose to live at high risk as well.” (Rural administrator).
>
> “The family…they are getting older and they take amazing care of him now but…they have health concerns and as they are less able to manage his care, there’s really nowhere for him to go…” (Urban provider).

Accessibility

The main themes pertaining to limited accessibility were those surrounding transportation, parking, meeting specialized seating needs, and housing. Transportation to services both within and outside the community was of greatest concern for those clients in rural communities. Long distances and other environmental factors were cited as barriers impacting accessibility.

> “Our closest larger urban centre is 244 kilometers from here so, it’s not really reasonable to be sending patients on a regular basis.” (Rural provider).

> "All of the major institutions you'd kind of need to get into are wheelchair accessible but it's just, just the way that the town's maintained, even just getting around most of the sidewalks and stuff, you can't get around on the sidewalk. So to do anything outside of the community is very difficult." (Rural provider).

Healthcare providers expressed strongly that accessible parking was a universal issue.

> "I had a woman who was driving herself from rural Saskatchewan, she can't park two blocks away. She can't park across the street to come in. There's two hour parking…" (Urban provider).

Housing, when available was clearly lacking in accessibility.

> "People are waiting - it seems like years - to get into some of the Sask housing wheelchair accessible units...they're just stuck in their house…or they get a family member to build them a ramp...Might be fine, and might be not." (Urban provider).

Affordability

Providers reflected on significant disparities and inequalities in the affordability of services, equipment and appropriate housing for clients. For First Nations peoples living on reserves, there appeared to be even further confusion related to what was or was not funded.

> "Some of the bands (governing council for indigenous people) are refusing, will refuse to pay for a trip in for physio… some bands will pay and some bands won't. And it seems to be, fairly haphazard, sometimes the band will pay for the same person (and) not someone else. And it always seems to be a fight to get that coverage." (Rural provider).

> "We had a lot of trouble around getting a vacuum dressing in place for a particular patient with his pressure sores that he has. It [vacuum dressing] was suggested, but we don't actually have that vacuum dressing, it's not part of our capital in the health region…it's not something that First Nations wanted to provide funding for, so that was a big mess as to who pays for it if he needs this and if it's in hospital, he's covered, but if he's at home, it's not; it's a jurisdictional thing that we struggle with." (Rural provider).

Inequalities related to affordability were also dependent on whether a client had additional private insurance.

> "I've had people, at the exact time, both of my patients at the same level of injury: one has insurance and one doesn't and it's really heart-breaking. One has a Cadillac

> wheelchair, has funding for being able to stay in a wheelchair-accessible apartment, taxis to come back and forth to their apartment; and the other gets the regular wheelchair provided by Sask Health, no transportation covered.” (Urban provider).

Inequalities related to specialized equipment were perceived by providers to directly impact some health outcomes, especially related to wound care management.

> “Unless there is a third party payer, funding is not available for some of the needed specialized equipment, and wounds often worsen.” (Urban provider).

Healthcare providers frequently expressed being frustrated by spending a great deal of time advocating on behalf of their clients to access funding sources; even though established funding programs may be in place to support clients.

> “I get letters of rejection so you can go on to the next funding resource. A huge, huge thing, because there really isn’t anyone else in the community that’s going to do that for clients who don’t have social work or anything like that. There’s social work but they don’t do that role in the community.” (Urban provider).

> “…we’re getting three or four funders together to get one piece of equipment…” (Urban provider).

Accessible, available housing was tightly linked with issues related to affordability.

> “…the housing in [urban center]…even if you wanted to renovate a different house, you had to wait for forever and a day to get those renovations and funding in place, if there was somewhere you could go in the meantime.” (Urban provider).

Accommodation

Despite acknowledging limits in resources and knowledge, care providers described accommodation aimed to keep people with SCI living in their own home. Home care workers needed to be especially resourceful in adapting to client needs on an individual basis to provide service in the home. However, healthcare providers expressed that accommodation was limited by policy which appeared to be guided by affordability. For example, criteria related to institutionalization seemed to be driven by service cost with less regard for the needs or wishes of the client and family.

> “So I can understand their desire to stay at home, it’s more comfortable and it’s their home! So we’ve had to change our thinking here at home care and I think that’s what home care really is about, is trying to think outside the box. We have to respect their choices and their decisions, even though they may not be what we would make ourselves…and so they are our customer and so we have to adapt ourselves as best as we can within the guidelines and policies that we have, to accommodate these people the best way we can.”(Rural administrator).

> “And once the cost of providing [publicly funded] home care service reaches the same amount that it would cost to keep you in long term care, we can’t provide you any more service, so if you want to stay in your home, we can only provide you thirty hours a week of service” (Rural administrator).

Care provider perspectives on service restrictions included limits on the number of hours of care that could be provided, as well as on the timing of the services.

> “The other challenge for them is sometimes if they have wounds, they need to be turned at night, and that is a service we don’t provide.” (Rural provider).

Despite SCI being a relatively rare diagnosis within the caseload of healthcare providers, these clients were recognized for their high needs and often accommodations were made to prioritize their needs.

> “Our wait list, I’ll prioritize for people that have pressure sores so that you’ll get seen usually within about two weeks on our end. But I mean, our wait list this past year has been up to fourteen weeks.”(Urban provider).

Care providers made reference to a shortage of specialized expertise related to caring for needs of SCI clients. Accommodating efforts or proposed solutions to help gain this expertise themselves or find the expertise elsewhere were expressed. They valued the opportunity to rely on more experienced team members and in the absence of such a team, they resorted to trying to solve problems more independently.

> “If there was an ideal circumstance, we’d have more of a team-based approach where you have all of the essential people that can the help the patient, and if I’m over my head on something or need a second opinion, I can ask questions to the other team members.” (Rural provider).

> "Sometimes a patient is expecting a therapist to be a specialist and we're not. We're generalists in terms of who we see…so sometimes we try to get information on what's needed." (Rural provider).

Care providers welcomed the opportunity to deliver care in settings that allowed an easy means of communication between healthcare providers. One reference was made to a rural setting where electronic medical records and a common work space accommodated better communication around patient care.

> "...so we have shared records, so no matter where you see the patient, the record is the same. We have an electronic system in place as well so there [aren't] gaps in information that often times could be there if you have other people seeing them. We don't have separate offices that people work out of...it actually works fairly smoothly" (Rural provider).

Acceptability

There were a number of care providers who mentioned that those clients who were able to advocate for themselves were more likely to be successful at accessing services or care. Healthcare providers largely accepted that health advocacy attitudes and efforts were variable across clients and they also recognized these health advocacy efforts impacted outcomes.

> "I think there'd probably be a difference of what services they receive depending on their voice. That's why if the client isn't able to advocate for themselves and if they don't end up with a healthcare team that does a lot of that on their behalf, they might miss out on things that otherwise they would get."(Urban provider).

Even though advocacy on behalf of clients was described as very time consuming, it was viewed as unacceptable when another healthcare provider appeared to dismiss the needs of a person with SCI.

> "Nursing definitely has to be an advocate for him. I just find that sometimes he's had a different couple of physicians in the area and at times you get the impression that, 'oh you know what, he's just a quad. Really how much better quality of life are we going to have?' It's like no! I mean his quality of life could be better! It doesn't matter if he's a quad." (Urban provider).

Care providers did not reference challenges with accepting the personal characteristics of their clients (i.e. age, sex, ethnicity etc…). They also appeared accepting of the challenges associated with their clients' specialized needs and equipment, even when these challenges might be experienced as anxiety-provoking or frustrating for care providers.

> "I think that's the most anxiety-producing element of the care…what kind of equipment am I going to find when I get there and am I going to know how to use it?"(Rural provider).

Care providers frequently assumed roles beyond their usual scope of professional practice when services were not available. These roles often included counselling roles and co-ordinating or advocating for funding for equipment. As exemplified in previous sections above, some healthcare providers accepted these roles, despite the additional time commitments and challenges involved.

Discussion

Receiving timely and preventive care for those with SCI is important, but significant barriers to accessing healthcare services exist for persons with physical disabilities residing in the community. The National Council on Disability (2009) cited that the following may prevent persons with disabilities from accessing care: affordability of services, transportation problems, limited availability of appropriate services, environmental barriers, inaccessible medical equipment, and limited disability-related knowledge amongst care providers. The results from our study suggest that barriers for clients with SCI, from the perspective of healthcare providers, are similar to those of disabled populations in general.

The viewpoints and experiences of healthcare providers in dealing with these barriers may be informative of practice patterns and guide change. Among the five Penchansky and Thomas dimensions related to access, availability featured most prominently. Limited availability of human resources was voiced as a challenge, especially for occupational therapy, counselling, and social services. Providers expressed frustration related to insufficient staffing. These insufficiencies in many cases may reflect real personnel shortages. For example, in the province of Saskatchewan, it is estimated that service availability for occupational therapists is 29 per 100,000 residents, considerably lower than the national average of 40 per 100,000 (Canadian Institute for Health Information, 2013a). While physiotherapy numbers in Saskatchewan may be slightly higher than the national average of 51/100,000 (Canadian Institute for Health Information, 2013b), only 10% of Saskatchewan physiotherapists work in rural settings (Canadian Institute for Health Information. 2013b). Since more than a third of the population reside (Statistics Canada, 2011) in rural settings, service distribution strategies for rural areas are needed, especially with ongoing shortages of allied healthcare providers projected into the future (Statistics Canada, 2011). Enhanced training, recruitment, retention and co-ordination efforts among allied healthcare providers will be critical if the gap identified for continued, complex community SCI care is to be improved.

Therapists felt restricted in the amount or type of service they could provide, with the maximum amount of services perceived to be set by policy. However, care providers also expressed some autonomy to bend the rules in order to meet client needs. They frequently appeared to adopt patient-centred, transdisciplinary models of care in order to accommodate clients. Transdisciplinary models of care incorporate continual, cross-disciplinary education and overlapping, flexible healthcare provider roles (Ruddy & Rhee, 2005). Trans-disciplinary care is patient-centred care in that the values and perspectives of the client are central to clinical decision making at all stages (Burkman, 2012). It has been suggested that flexibility in role functioning among healthcare team members may be instrumental to improving outcomes in medically complex environments (Institute of Medicine, 2001). Healthcare providers identified that when a service was not available in their Saskatchewan communities, they sometimes took on roles outside of their usual scope of practice. They reported not having formal training in these roles, but the alternatives (i.e., no services to address a perceived patient need) were voiced as unacceptable. Family physicians, physical and occupational therapists in rural areas reported doing this role shifting in particular in order to meet psycho-social and addictions service related needs.

Similar role sharing among care professionals in rural areas was previously described as common when there was a shortage of care providers (Williams & Cutchin, 2002). Having well-trained professionals in rural areas was a key factor to higher quality care (Williams & Cutchin, 2002). Inter-professional education may be one way to prepare a workforce for shifting roles to address gaps in care. A Cochrane review concerning the effectiveness of inter-professional educational interventions provided preliminary support for improved mental health treatment competencies among healthcare providers (Reeves et al., 2008). However, it is not clear if inter-professional educational interventions improve healthcare processes or patient outcomes. In our study, a need for collaborative partnerships and more regular communication centred on client needs were mentioned by a number of care providers in Saskatchewan rural areas. To achieve this, some healthcare providers described success with sharing a common physical work space where all healthcare providers were based. This shared space, together with one accessible clinic electronic medical record allowed more regular communication related to client needs in real time. Healthcare providers also identified a desire for more case-based specific learning opportunities from professionals based out of larger centers.

The accessibility of services was challenged by long travel distances, lack of transportation and a shortage of local treatment spaces. These challenges are not new and are supported by the literature (National Council on Disability, 2009). Healthcare providers acknowledged certain services could not be feasibly met in rural communities, yet they felt that basic, safe and accessible facilities and housing should be available in all communities. There were implications from care providers that if these basic facilities were in place, enhanced care could be provided. Care providers mentioned that living at risk where services were not available was preferred by clients over residing in long-term care facilities or relocating.

The lack of gym or other recreational facilities in rural communities and parking issues in both rural and urban communities were felt to be unacceptably restricting access. Previous qualitative studies have found serious negative physical, psychological, social and economic consequences for adults with physical disabilities who are unable to access timely care, including deterioration in health and activity limitations (Neri & Kroll, 2003). Accessing suitable places to perform physical activity is especially important for those with SCI (Fernhall et al., 2008) and having access to facilities is a significant facilitator (Kehn & Kroll, 2009). The perspectives from the healthcare providers in our study highlight further that transportation barriers may be at least partially overcome by improving the availability of local physical treatment spaces.

Those working in urban ambulatory rehabilitation settings reported on the benefits of having access to more specialized and accessible treatment spaces and equipment, but felt they were oversubscribed, sometimes beyond capacity. Healthcare providers identified the need for increased community partnerships to tackle restricted access to recreational facilities in rural centres and accessible parking and housing everywhere. Care providers reflected on how these issues severely impacted care and the quality of life of patients with SCI in the community.

Affordability was also a factor clearly contributing to accessing appropriate housing and highly specialized equipment. Inequalities related to affordability were remarkably apparent despite the fact that this research took place within a country with a universal publicly-funded healthcare system. Care providers described frustration with inconsistencies related to policy, levels of advocacy and funding opportunities. All of these factors may impact the availability and affordability of housing, equipment, transportation, and services. Insurance coverage has previously been described to play an important role in outcomes for those with SCI in Canada. A study from British Columbia found that having motor vehicle insurance or worker's compensation significantly reduced the risk of being discharged to an extended care unit after acute care for a spinal cord injury (Anzai et al., 2006).

Assisting patients in navigating a complex system often required a high investment of time, and significant advocacy efforts on the part of healthcare providers. Much of this advocacy work related to assisting clients with administrative work such as applying for funding for equipment, housing or transportation. Advocating for clients has been recognized as an intrinsic part of providing care for some providers, such as nurses (Wheeler, 2000), but without specific guidelines, care providers may not know what is within their expected scope of practice (Wheeler, 2000; Segesten, 1993). Care providers found that patients benefited in terms of improved access to services when family members or patients themselves assumed strong health advocate roles.

Care providers appeared accepting of the personal characteristics of their patients and their attitudes. Apart from a lack of an apparent health advocate voice in some cases, the personal characteristics of clients were not perceived by healthcare providers to pose large barriers related to access. Healthcare providers described making accommodations in scheduling and roles in order to meet the needs of people with SCI, although they expressed that existing policies did not always allow sufficient accommodation to meet needs.

Strengths and weaknesses

A strength of this study is the inclusion of perspectives from a range of healthcare professionals, including allied health care professionals, nurses, physicians, and managers working in rural and urban settings. A potential weakness relates to response bias. The perspectives of volunteer participants may differ from those of healthcare providers who did not participate. Provider perspectives may also be impacted by the duration and location of past work experiences which were not analyzed in this study. The Penchansky and Thomas framework applied to this research may have restricted analysis of other pertinent themes related to the experiences of SCI healthcare providers. However, adopting this framework to evaluate the perspectives of healthcare providers allowed a comprehensive assessment of healthcare access. The perspectives of healthcare providers from this study may be less applicable to healthcare systems with different models of governance or with different funding structures.

Conclusion

Healthcare providers involved in the care of persons with SCI in the community provided insight on coping with the challenges specific to healthcare access. A summary of the key findings are listed in Table 2. Providers reflected on a lack of available services, access to treatment facilities in rural communities, accessible parking and affordable housing, equipment and services. In order to improve access to care, healthcare providers often adapted by taking on other roles sometimes beyond the scope of their practice. Accommodation was felt to be restricted in part by affordability and policy. Health advocacy efforts by care providers or patients were expressed as having a large impact on access to services. Further attention to accommodation and health advocacy strategies may lead to improved healthcare access for persons with SCI.

Summary of key findings from perspectives of healthcare providers on access to spinal cord injury care:

1. Healthcare providers engaged in health advocacy on behalf of their SCI clients, and they believed these efforts impact access to services.

2. Healthcare providers described assuming new roles beyond their scope of practice to provide SCI clients with access to services otherwise not available.

3. Transdisciplinary models of care and community partnerships aimed at improving accessible housing and treatment spaces were identified as possible solutions for improving access to care and services in rural communities.

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