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## An Inventory of Evidence-Based Health and Wellness Assessments for Community-Dwelling Older Adults

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An Inventory of Evidence-Based Health and Wellness Assessments for Community-  
Dwelling Older Adults

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree

Master of Science in Occupational Therapy

School of Health and Natural Sciences

Dominican University of California

San Rafael, California

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This thesis, written under the direction of the candidates' thesis advisor and approved by the Chair of the Master's program, has been presented to and accepted by the Faculty of the Occupational Therapy department in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy.

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## **Abstract**

It is estimated that by 2020 older adults will make up one fifth of California's population. Many of these older adults are living in the community and are maintaining their independence. In order to help the older adults to maintain their independence, occupational therapists are turning to the newly emerged wellness promotion model to guide their practice. The wellness promotion model is a holistic model that addresses six domains of wellness (intellectual, spiritual, physical, social, emotional, and vocational). One of the concerns in using this model to guide the emerging practice area in occupational therapy is that there is little information on health and wellness assessments. The purpose of this project was to create an inventory of evidence-based Health and Wellness Assessments for use with the community-dwelling older adult population.



## **Introduction**

In 2010, 40 million people over the age of 65 lived in the United States (U.S.), which accounted for 13 percent of the total population (U.S. Department of Health and Human Services, 2012). By 2020 older adults aged 65 and older will make up one fifth of California's total population (State of California, Department of Finance, 2007). This increase in population among the older adults group is partly due to the Baby Boomers (those born between 1946 and 1964). Another possible contributing factor to the increase in this population is the increase in life expectancy from advancement in medical practices.

This project looks specifically at the community-dwelling older adults. One may think that the older adult population is more prone to become ill and restricting their participation in occupations. However, this is not the case. Older adults take pride in their independence and want to maintain it for as long as possible. Many of these community-dwelling older adults are still engaging in physical activity and maintaining a strong social support system (Yuen, Gibson, Yau, and Mitcham, 2007). A major concern expressed by the older adults is becoming dependent on others for care. To address this concern, occupational therapists have taken a different approach to working with these individuals.

In the past the medical model has been predominantly used to guide therapy. This model focuses on what individuals can no longer do as a result of an injury or disability. However, when working with community-dwelling older adults this model does not address barriers to independence. This is why health professionals, including occupational therapists, have turned to the wellness promotion model. This model does

not look at what a person cannot perform but rather at the strengths the person still possesses that can help him or her to increase participation in meaningful occupations.

Wellness promotion is an emerging practice area within the field of Occupational Therapy. There is limited availability and research on comprehensive Health and Wellness Assessments. Therefore, the purpose of this project is to create an inventory of evidence-based, comprehensive Health and Wellness Assessments.

## **Literature Review**

### **Current Views on Aging and Wellness**

The National Wellness Institute (n.d.) defines wellness as “an active process through which people become aware of, and make choices towards a more successful existence” (p. 14). According to Engel and Kieffer (2008), there are several different types of wellness based on contexts. These include physical, social, spiritual, emotional, vocational, and intellectual. Physical wellness includes participation in physical exercise, consuming wholesome foods, and practicing proper self-care. Social wellness is the formation and preservation of relationships with individuals through communicating and sharing interests and, initiating conversation with others. While spiritual wellness is the process of building on personal principles, discovering meaning and purpose in life, and finding a tranquil harmony with society; emotional wellness is properly interpreting, organizing, and expressing personal feelings. Intellectual wellness indicates broadening personal understanding through educational experiences, and inspiring pursuits. Achieving wellness in these contexts allows community-dwelling older adults to maintain their independence and participation in meaningful occupations (Engel & Kieffer, 2008).

According to Yuen et al. (2007), community-dwelling older adults view aging from three different perspectives which include resistance, adjustment/accommodation, and positive thinking. Resistance includes staying active and not relying on others for assistance. Adjustment/accommodation consists of being realistic about the effects of aging (e.g. requiring more time to complete activities and a reduction in overall performance) and simplifying one's preferred daily occupations in order to maximize participation. Finally, positive thinking consists of not seeing increased dependence as an outcome of aging, but rather community-dwelling older adults look at modifying their lives in order to continue participating in preferred occupations. This leads to feelings of happiness, enjoying life, and feeling younger (Yuen et al., 2007).

Kornadt and Rothermund (2011) found that community-dwelling older adults are viewed positively when it comes to strengths such as wisdom, honor, life experience, and gentleness. Kornadt and Rothermund (2011) also found that community-dwelling older adults can be viewed negatively when associated with stereotypes of being frail, dependent on others, and the misperception that most community-dwelling older adults develop conditions such as dementia.

**united states older adults.** As the baby boomers age, the population of community-dwelling older adults in the U.S. will increase. In addition, elevated knowledge of health and wellness results in an increased lifespan of senior citizens in the U.S. According to a national survey completed by Krantz-Kent and Stewart (2007) examining the occupations of 34,693 community-dwelling senior citizens, hours worked per day declined with age. Time directed towards sleeping and engaging in leisure and sports activities increased. For men, time spent completing domestic chores also

increased with age. Additionally, men were more likely to take up part-time jobs for a gradual transition into full retirement.

**california older adults.** By 2020 community-dwelling older adults aged 60 and older will have accounted for one fifth of California's total population (State of California, Department of Finance, 2007). The Los Angeles Basin and the San Francisco Bay Area contains approximately two thirds of California's community-dwelling older adult citizens. Over the next 40 years, this population will continue to increase in these metropolitan areas (State of California, Department of Finance, 2007). Increasingly diverse groups of community-dwelling older adults are living independently.

Educational achievement, income level, health and disability status are all factors which vary widely amongst the California community-dwelling older adult population. These factors require professionals to carefully examine their own service delivery models.

In the near future, the gap between community-dwelling older adults who have resources for wellness promotion and those who do not will continue to increase (California Department of Aging, 2008). Providing culturally sensitive outreach and assistance are integral to decreasing disparities in accessing health and social services (Lee & Villa, 2001). Blackman, Kamimoto, and Smith (1999) stated:

“Although risk factors for disease and disability increase with age, compromised health isn't necessarily a consequence of aging. Acquiring healthier behaviors (e.g. regular physical activity, a healthy diet, a smoke free lifestyle) and getting regular health screenings such as mammograms (e.g., colonoscopies, cholesterol checks, bone density tests, etc.) can dramatically reduce the risk for most chronic diseases” (p. 14)

Thus, the California Department of Aging (2008) and other agencies involved with aging collaborated to identify the crucial needs of community-dwelling older adults. These included community integration opportunities and access to wellness promotion programs (California Department of Aging, 2008).

The culmination of physical (e.g. physical activity, diet, access to medical services) and social (e.g. support from others, socioeconomic status) variables necessitates using approaches geared towards a dynamic senior citizen population in order to incentivize more community involvement from the older adults. It was found that many benefits could be resulted from community involvement including greater social supports and community participation, improved well-being, and higher socioeconomic status (Corporation for National and Community Service, 2007).

**marin county older adults.** Marin County presents its own challenges in transportation for community-dwelling older adults (Marin Community Foundation, 2011). These challenges translate into difficulty in obtaining medical appointments and services related to self-care, participation in physical exercise, and engaging in social events and activities. The high cost of living in Marin County affects the ability of community-dwelling older adults to live independently. Many find it difficult to afford basic needs including medical care. Nevertheless, community-dwelling older adults of Marin County are motivated to be involved in community-related activities (Marin Community Foundation, 2011). Tutoring, running programs, providing administrative support, and promoting significant issues are ways in which community-dwelling older adults of Marin County participate in community activities (Marin Community Foundation, 2011). Organizations that allow community-dwelling older adults to

participate in these endeavors are able to strengthen the workforce and increase production. According to the Marin Community Foundation (2011), community-dwelling older adults engage in these activities report an increased perception of purpose, health, and social support in Marin County.

### **Importance of Independence**

The concept of wellness includes many aspects, but perhaps the most important is independence. Yuen et al. (2007) stated that community-dwelling older adults take pride in and value their independence. A major concern for the elderly is dependence on others for self-care. Yuen et al. (2007) conducted a qualitative study to investigate what the community-dwelling older adults were doing in order to maintain their independence. Results of the study indicated that the community-dwelling older adults were engaging in physical activity as well as maintaining a strong social support system in order to maintain their independence. A paper published by Gignac and Cott (1998) further demonstrated the importance of independence in adults by arguing that independence is associated with autonomy, self-reliance, and a productive lifestyle and a loss of this independence often signals a compromise in identity, self-esteem, and meaning of life. Baker (2005) stated that for individuals who lived alone, independence was crucial in maintaining self-worth and engagement in activities of daily living. All of these studies addressed independence as a crucial part of an individual's overall wellness. In summary, successful wellness programs address an individual's independence and look at ways to maximize it.

**strategies to maintain independence.** Community-dwelling older adults implement strategies to maintain their independence. A study by Yuen et al. (2007)

looked at determining what strategies were used the most. This qualitative study recruited 163 community-dwelling seniors to answer open-ended questions such as “what does independence mean to you” and “how important is it for you to be independent in the future”. The results showed that engaging in health promotion strategies was a way to maintain their independence. Proper nutrition was the first strategy being addressed in health promotion. The study showed that community-dwelling older adults are maintaining good dietary practices and monitoring how much they eat. A similar study completed by Barnes et al. (2008) also focused on nutrition as a way to maintain independence. This pilot study examined the effectiveness of an adaptive living program. The program included a health education speaker who came in and educated the participants on the importance of a good diet. After attending the presentation, the participants reported greater knowledge in nutrition as well as successful weight losses.

Along with nutrition, community-dwelling older adults engage in physical activity as another strategy to maintain independence (Barnes et al., 2008). Kalapotharakos, Smilios, Parlavatzas, and Tokmakidis (2007) argued that physical activity programs are beneficial in promoting health and independence in the elderly. Yuen et al. (2007) further demonstrated the importance of physical activity when the participants identified physical activities such as walking, swimming, biking, and other household activities as an important way to maintain their independence.

The final strategy discussed in the study by Yuen et al. (2007) was maintaining a good social support system. Individuals who were actively engaged in their community and spent time with friends felt better about themselves and had greater overall health. Participants in the study identified social outings as a crucial strategy for maintaining

independence. Badger and Collins-Joyce (2000) completed a similar study in which the researchers divided 78 participants into two groups, depressed and non-depressed groups, based on their analysis on physical health impairment, psychosocial resources, and functional abilities. Results of the study indicated that social support is a significant predictor of functional level in community-dwelling older adults. These results support the study by Yuen et al. (2007) by demonstrating the importance of social support. Lastly Hays, Saunders, Flint, Kaplan, and Blazer (1997) analyzed the amount of social support and depression as risk factors for loss of physical functioning in life. This study utilized a prospective design in which the researchers tried to determine if depressive symptoms and low social support would predict deficits in three different physical domains. Results suggested that if depressive symptoms and social factors related to the physical domains could be improved, the risk of severe functional impairment among community-dwelling older adults could be reduced. Yuen et al. (2007) stated that “the degree of social support and health status among older adults are intricately linked; social (emotional and instrumental) support protects community-dwelling older adults against health declines and, thus, promotes healthy physical functioning” (p. 37). All of these studies demonstrate the crucial effects that a strong social support system has on supporting independence and wellness of an individual.

### **Medical Model vs. Wellness Promotion Programs**

For many years the medical model is the primary model used in Occupational Therapy practice. However, when applied to healthy seniors, this model has its limitations. Beitman (2009) stated that those practicing according to the medical model have been slow to recognize ways to minimize health-related challenges and understand



barriers for community dwelling older adults. The author continued to state that those who practice according to the medical model seemingly ignore the benefits of wellness and preventive activities. Therefore, when working with community-dwelling older adults, the medical model is inappropriate since it focuses only on the disability and symptomology of medical conditions.

While practitioners traditionally utilize the medical model when working with community-dwelling older adults, it has another limitation. Although the medical model addresses the medical conditions of community-dwelling older adults, it does not focus on the whole person. As such, the medical model cannot effectively address other ways to improve health such as decreasing barriers (e.g. motivation, time constraints, social support) and encouraging ways to live productively despite the presence of disease.

Another limitation of the medical model involves the administration of therapy. An article by AOTA (2002) stated that traditional medical model-based occupational therapy requires one-on-one intervention to address client factors and performance skills. This is a concern because some clients may work better in a group setting than in a one-on-one environment.

The same article also further pointed out the benefit of the wellness promotion model. Wellness programs use “create/promote, maintain, and prevent” approaches as intervention (AOTA, 2002). The create/promote stage focuses on promoting healthy behavior and good choices to stay healthy. The maintain stage focuses on maintaining the skills that the individual still possesses such as their strength, range of motion, eating habits, or anything that is important to the client. Finally, the prevent stage focuses on

preventing any further injury or loss of function. Occupational therapists embrace this approach to promote a healthy lifestyle for community-dwelling older adults.

Wellness promotion is an emerging practice area in occupational therapy. Wallace et al. (1998) examined the effectiveness of a wellness program. This randomized control trial had 100 participants who were divided into two groups, control and experimental. The participants were asked to fill out the Short Form-36 (SF-36) health survey as well as a depression scale. Participants in the intervention group received a six-month wellness program including exercise intervention, nutritional counseling, and a home safety assessment. Results of the study indicated that the intervention group had increased scores on the SF-36 survey and had fewer depressive symptoms than the control group. This study demonstrates that wellness programs are beneficial in increasing physical and psychosocial functioning.

### **Wellness Assessments**

Testing for reliability in wellness assessments indicates whether or not the instrument will measure consistently across similar populations (ICAA, 2006). A high reliability score indicates consistency and lack of error in the assessments. Validity helps determine whether an instrument is measuring what it is intended to measure (Portney & Watkins, 2009). Having the information on the reliability and validity of an assessment provides the reader with information regarding the consistency and amount of error in the wellness assessment.

The following portions of the literature review describe several wellness assessments and their evidence. These wellness assessments include the Health Promoting Lifestyle Profile-II assessment (HPLP-II), the Barriers to Health Promoting

Activities for Disabled Persons Scale (BHPADPS), the Health and Wellness Assessment (HAWA), Health Enhancement Lifestyle Profile (HELP), Short Form-36 (SF-36), Pizzi Holistic Wellness Assessment (PHWA), Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS), Occupational Performance History Interview –II (OPHI-II), and Assessment of Occupational Functioning (AOF).

**hplp-ii and bhpads.** These two assessments are holistic and address a variety of contextual factors. They address and measure different aspects of wellness such as health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management (Pascucci, 2012). The BHPADPS determines interpersonal, intrapersonal, and environmental barriers to health promoting activities (Pascucci, 2012).

In a community-based setting, Pascucci (2012) administered the HPLP-II and the BHPADPS to 52 elderly participants. Researchers divided participants into two age groups, 80-90 and 91-101 years of age. Twenty-seven individuals were between the ages of 80-90, 25 participants were between the ages of 91 and 100. Twenty-four individuals in the younger group were living independently. Fourteen participants in the older age group lived independently. Pascucci (2012) reported that the sample was predominately composed of Caucasian-widowed women. Specifically, there were 40 women and 12 men who participated in the study.

Interviews were used to administer the HPLP-II and the BHPADPS. As part of the assessment procedure, researchers read questions to participants and used visual aids for answer choices to facilitate responses (Pascucci, 2012). In-person interviews were more effective in obtaining straightforward responses to personal questions. Results indicated that there were differences between the different age groups with regards to

home responsibility, physical activity and nutrition. The study concluded that health, function, age, and motivation were to be considered to foster optimal living (Pascucci, 2012). Pascucci (2012) reported high reliability measurements (.82-.94) in the HPLP-II and BHPADPS.

**hawa.** The HAWA obtains a person's perceptions on satisfaction in life, wellness activities, rating of self-efficacy, and readiness for behavior change in six different dimensions of wellness. These dimensions of wellness include physical, emotional, social, intellectual, spiritual and vocational contexts.

Engel and Kieffer (2008) created the HAWA after analyzing 259 surveys from community-dwelling older adults in Tucson, Arizona and Chicago, Illinois metropolitan areas. Researchers asked participants to provide answers to Likert scales and open-ended questions regarding wellness promotion. Upon completion, each participant received feedback by mail. The feedback report contained a summary of the participant's strengths and weaknesses with recommendations on personal growth. In addition, the report also reviewed participants' views on ratings of satisfaction, self-efficacy, help and support, and the use of wellness resources (Engel & Kieffer, 2008).

A limitation of the study was self-selection sampling being utilized. With self-selection sampling, it was not possible to know what characteristics the participants possessed. As a result, it was difficult to generalize results of the studies using self-selection procedures (Portney & Watkins, 2009). Engel and Kieffer (2008) reported HAWA as being a reliable and valid assessment, but the specific statistical values were not reported.

**help.** There are two versions of the HELP, the screener which has 19 questions and the full version with 69 questions. This assessment measures perceived performance in exercise, diet, productive activities, social participation, leisure, activities of daily living, stress management, and spiritual participation (Hwang, 2010). In one study, the researchers recruited 158 community-dwelling seniors in southern California through advertisements. The participants came from a variety of community-based sites such as senior citizen centers, senior residential communities, independent living facilities, adult day health care centers, local senior social/activity groups, and religious groups/organizations (Hwang, 2010). Researchers administered the HELP assessment using two different methods. The first method included a direct interview with either a graduate student or a faculty member. The second method utilized a written format in which participants answered questions independently (Hwang, 2010). The purpose of the study was to determine the reliability and validity of the HELP assessment. Hwang (2010) reported HELP as a reliable assessment for community-dwelling older adults. Reliability coefficients ranged from .75 to .92 (Hwang 2010). In another study conducted by Hwang (2013), reliability for the HELP screener was reported to be .93.

**sf-36.** This assessment contains 36 questions on functional health and well-being, and measures physical functioning, bodily pain, general health, vitality, and mental health (ICAA, 2006). Friedman, Heisel, and Delavan (2005) examined the criterion and construct validity of the SF-36 as it relates to the manifestation of major depression in 1,444 functionally impaired, community-dwelling older adult patients aged 65 and older residing in nineteen counties in western New York, West Virginia, and Ohio. Data to determine the criterion and construct validity of the SF-36 were obtained by observing

and interviewing the community-dwelling older adults. Analysis of the data suggested good criterion and construct validity

**phwa.** The PHWA is a self-assessment that aims to increase awareness in community-dwelling older adults of the most important health issues affecting daily occupational performance. The assessment also addresses self-responsibility for health by exploring self-determined strategies to optimize health. Therapists' roles are facilitators of health only. The dimensions of wellness addressed are physical, psychosocial, spiritual, environmental, social, occupational, and intellectual (Pizzi, 2001).

Pizzi (2001), the author of PHWA, completed a pilot study to identify eight specific areas of health through collaboration with an interdisciplinary team. From the pilot study both quantitative and qualitative measures were developed. The quantitative portion consists of a rating scale from one to ten in each health area, where clients rate their perceived levels of health. Clients then work in collaboration with the occupational therapists on the qualitative section to strategize ways to improve specific health areas based on their quantitative results.

Pizzi (2001) utilized a small convenience sample in the study. As a result, the results may not be able to generalize to the general population (Portney & Watkins, 2009). Pizzi (2001) reported that the PHWA had good beginning face and content validity and found it to be useful in a clinical setting. However, additional research on its psychometric properties and reliability were recommended.

**ocairs.** The OCAIRS is a semi-structured interview that obtains information on 12 areas. These areas include roles, habits, personal causation, values, interests, skills,

short term goals, long term goals, interpretation of past experiences, physical environment, social environment, and readiness for change (Scaffa, Reitz, & Pizzi, 2010).

In a study by Scaffa et al. (2010), clients were interviewed by occupational therapists. Following the interview, the occupational therapists gave a rating to each item using specific criteria to assign a score using F.A.I.R. scale (F: the item “facilitates participation in occupation”; A: the item “allows participation in occupation”; I: the item “inhibits participation in occupation”; R: the item “restricts participation in occupation”). The criteria for scoring are based on how well the measured items influenced the clients participation (Scaffa et al., 2010). Scaffa et al. (2010) reported excellent inter-rater reliability and satisfactory concurrent validity for the OCAIRS.

**ophi-ii.** This is a historical interview that intends to give a broad and detailed view of a person's life, the impact of disability, and the direction in which the person wants to take his or her life. Researchers explore occupational identity, occupational competence, and occupational settings to get a full picture of the client. It also provides clients the opportunity to reflect on their life stories. The dimensions addressed are physical, psychological, social, and occupational (Kielhofner, Mallinson, Forsyth, & Lai, 2001).

In 1988, researchers originally studied the OPHI-II with a sample of 154 occupational therapy clients from gerontology practice in the United States and Canada. This investigation found that the raw total score obtained from the rating scale was only marginally stable across raters and time (Kielhofner et al., 2001). To improve the validity of the scale, researchers used a heterogeneous group of raters and subjects. This allowed the researchers to determine whether these rater and subject variables have an

effect on the psychometric properties of the rating scale. Researchers collected data from 151 raters of occupational therapists, occupational therapy students, and 249 subjects. Each rater rated a minimum of one of the four videotaped interviews in order to determine their bias (i.e., relative severity or leniency) (Kielhofner et al., 2001). Kielhofner et al. (2001) concluded that the OPHI-II contained three valid scales applicable to community-dwelling elderly. However, reliability was not established.

**aof.** The AOF is a screening tool to collect a broad range of information that can influence a person's occupational performance and to identify areas that may need more in-depth evaluation. The dimensions addressed are psychological, social, and occupational (Ikiugu & Anderson, 2009). Clients are asked to provide answers to open-ended questions that address values, personal causation, interests, roles, habits, and skills. Therapists review and rate the answers on a scale of one to five. After completing the rating, the therapist can then generate follow up questions to go more in-depth in areas that need to be addressed. In a study completed by Ikiugu and Anderson (2009), researchers performed a meta-analysis of 19 studies using the validity generalization method. The study determined an estimate of the mean validity and generalizability from research to clinical settings. Ikiugu and Anderson (2009) concluded that the validity of the AOF was .36. However, the reliability had not been determined.

To conclude, while the previously mentioned Health and Wellness Assessments measure multiple contexts, there are several limitations to the various studies. The limitations may include a lack of variation in the study samples in regards to gender and sample selection methods. Nevertheless, there is evidence that some of these assessments have either good reliability or validity such as the HPLP-II, BHPADPS, HELP Full



Assessment, HELP Screener, SF-36, PHWA, and the OPHI-II. While others have both good reliability and validity.

### **Statement of Purpose**

Maintaining independence and engagement in meaningful occupations are two important aspects of wellness for community-dwelling older adults in Marin County. On one hand, research suggests that wellness programs can be effective in helping community-dwelling older adults maintain independence. On the other hand, literature also demonstrates a lack of evidence on wellness assessments. Many of the current wellness assessments measure isolated aspects of wellness or symptomology related to medical conditions. Without a comprehensive wellness assessment, there may be a lack of effective wellness programs to address the different dimensions. In addition, there is also a lack of comprehensive inventories of Health and Wellness Assessments in the literature.

Therefore, the specific purpose of our project is to create a comprehensive inventory of evidence-based Health and Wellness Assessments for community-dwelling older adults.

### **Theoretical Framework**

For this project, we created an inventory of evidence-based Health and Wellness Assessments that covered multiple dimensions. The inventory serves to offer a resource to clinicians to help determine the best assessment(s) to use with their clients.

Assessments were chosen with the intention of addressing a variety of factors related to a client's occupational performance. The Person-Environment-Occupation-Performance (PEOP) model served as a guide for the creation of this inventory.

Community-dwelling older adults want to maintain health, wellness, and independence in daily activities. The main concepts of the PEOP model provide a way to understand this phenomenon. The first is Human Agency, which is the instinctive will of a person to explore different aspects of life and demonstrate mastery within these contexts (Cole, 2008). A person attains competence when he or she is able to execute tasks that meet their needs. A healthy person performs various activities that can create a balance between intrinsic and extrinsic demands. This person is someone who can look after oneself and perhaps even others, balancing work, play and active participation in both home and community. This is also a person who has a good balance of roles that meet personal and societal beliefs.

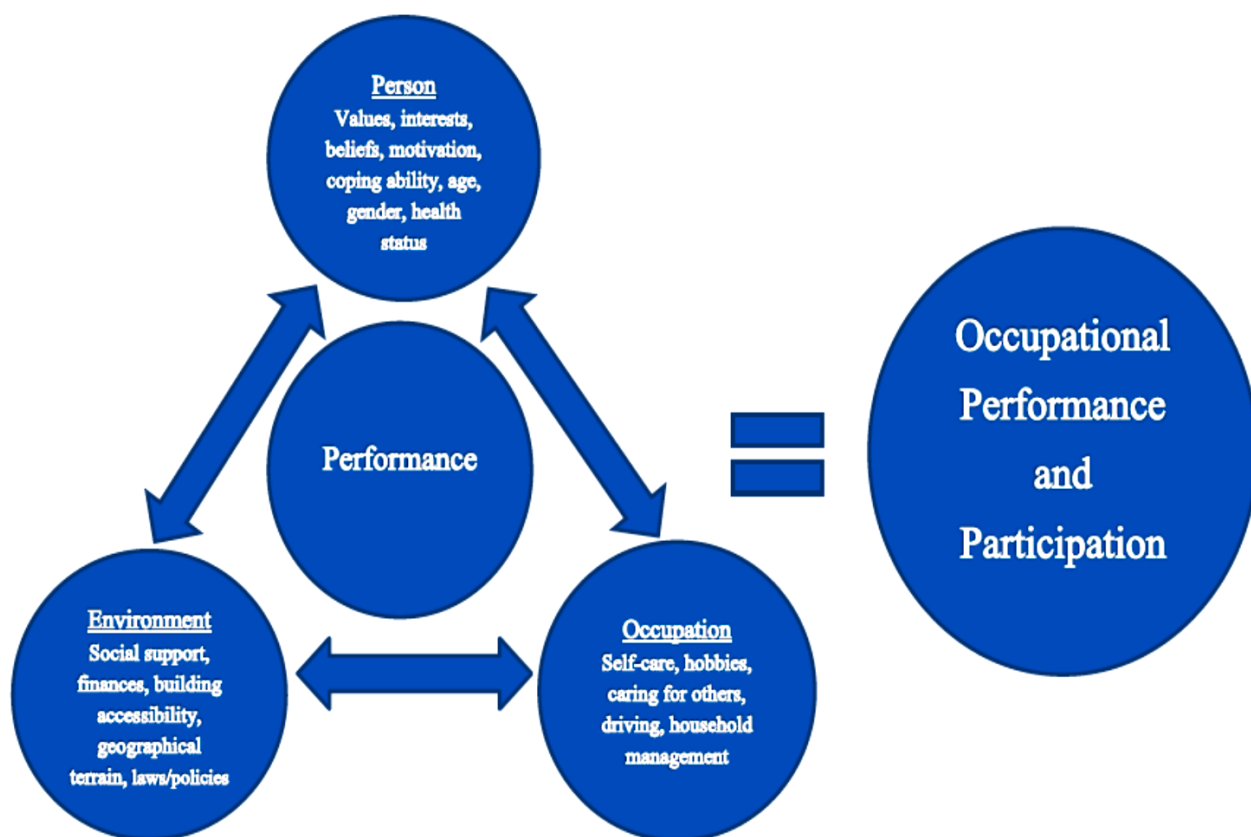
According to PEOP, health serves as an enabler not as an outcome (Cole, 2008). This means that persons need to be proactive in maintaining and improving their health in order to be successful in participation of daily activities. The PEOP model views individuals as having the ability to exercise more control over their health in various areas such as personal, social, and environmental. Third, the process of adaptation (Cole, 2008) is where persons meet the demands of daily living by successfully using their resources. Fourth, persons gain a sense of satisfaction and a better understanding of themselves by successfully completing tasks (Cole, 2008). Therefore, community-dwelling older adults must effectively utilize supports within their personal, social, and material contexts and balance personal and environmental demands (Scaffa, Reitz, & Pizzi, 2010) in order to exhibit increased occupational performance in meaningful activities (Cole, 2008).

The Person-Environment-Occupation-Performance model is an approach that considers the person's wants and needs, and examines the interaction of the person, environment, and occupation and the inter-related effects each has on performance (Scaffa, Reitz, & Pizzi, 2010). The first part, the person factors, are made up of any intrinsic factors that make up one's skill sets such as cognitive, physiological, and spiritual (Cole, 2008). The personal context consisted of age, gender, and socioeconomic and educational status.

The second part of the PEOP model is the environment, which consists of extrinsic characteristics such as built, natural, cultural, and social factors that can affect participation in meaningful occupations (Cole, 2008). How persons interact within their environments is also a crucial step in understanding their occupational performance. Built and natural factors include geographic terrain, a client's home, office buildings, and transportation systems. Social context includes a client's relationship with friends or colleagues, organizations, and the local government. Material context includes anything consumed for personal use such as scissors, dishes, or shoes (AOTA, 2008). Cultural factors include customs, beliefs, activity patterns, and morals while social factors consist of relationships and expected roles with different people and groups (AOTA, 2008). All contexts and factors, from the location where the occupation takes place to the people the occupation is being completed with, could have an effect on the interaction of these contexts. For example, if citizens in a community do not believe that the community-dwelling older adults need to stay active or if there is any stigma related to aging, communities may not find it necessary to provide support for participation to these individuals. Conversely, if citizens in the community recognize the important roles of the

older adults in the community, then the community may provide resources that support the older adults in active occupational engagement. The third part of the PEOP model is occupations. These are the meaningful activities that individuals perform on a daily basis. These range from self-care activities such as bathing, grooming, and feeding to more complex tasks such as household chores, shopping, volunteering, and driving. The fourth part of the PEOP model, performance, is the interaction of the person, environment, and occupations and how they affect occupational performance (Cole, 2008). According to the PEOP model, a healthy individual is someone who has the perfect balance of person, environment, occupation, and performance. In working with healthy seniors and promoting wellness, the PEOP model can be used to guide intervention to facilitate maintenance of independence in community-dwelling older adults.

The PEOP model demonstrates how person, environment, occupation, and performance factors combine to determine a community-dwelling older adult's occupational performance and participation (figure 1). The PEOP model was selected as it views community-dwelling older adults from a holistic perspective, much like the wellness model. Each considers a combination of factors such as physiological, cognitive, spiritual, psychological, cultural, social, and physical that can affect the amount, type, and quality of occupational performance and participation.



**Figure 1:** *PEOP model*

## Methodology

### Design

During the process of literature review, we came across a manual of wellness assessments (ICAA, 2006). This manual was then used as a guide in our project to develop the wellness inventory. The theoretical framework of PEOP was used to determine the criteria for our inventory. Hence, our goal was to analyze the wellness assessments based on all areas of the model (person, environment, occupation, and

performance). Thus, it was determined that a successful wellness assessment would fulfill our criteria measuring all of these areas and be reliable or valid, or both.

### **Agency Description**

Dominican University of California is a private liberal arts university in San Rafael, CA. This university has a variety of professional majors including occupational therapy. This program offers a course entitled Occupations of Adults and Seniors II. This course focuses on developing the knowledge and skills necessary for working with the adult population. As part of the course content, students are required to complete a community practice lab, the Healthy Seniors program, which provides students with the opportunity to practice the skills they have learned in the classroom by working with real participants from the community. In this lab students are required to assess their participants, community-dwelling older adults, and formulate interventions based on the assessment results.

### **Target Population**

The target population for this project is two-folded: the community-dwelling older adults and the students in the Occupational Therapy program. We created the inventory in order to promote wellness in the participants who come to the Healthy Seniors Program at Dominican University of California. The participants are older adults who live in the community and neighborhood of the campus. The inventory will provide a quick and easy reference in evidence-based Health and Wellness Assessments available as of March, 2013. With the use of the inventory, faculty and students can make appropriate decisions in choosing the best “fit” assessment for their participants.

## **Project Development**

The project was developed in three phases: 1) needs assessment 2) establishing key components for the inventory 3) literature searches.

**needs assessment.** In order to create an inventory of wellness assessments, needs assessments were conducted with faculty and students in the Occupational Therapy department. These assessments allowed the project administrator the opportunity to ask questions regarding past assessments and what the faculty and students felt would be important areas to focus on, in order to improve the intervention planning process in the Healthy Seniors program. We created a standard questionnaire (see appendix A) for the needs assessment. The responses we obtained from the interviews helped with identifying key areas for the creation of the assessment inventory. Faculty members interviewed included professors Dr. Kitsum Li, Ms. Sue LeBlanc, and Ms. Alison Virzi. We chose these faculty members because they have had experience with conducting the Healthy Seniors program at Dominican University of California. The focus group consisted of occupational therapy students in the undergraduate program that had already completed their Healthy Seniors community practice lab in fall 2012. A total of three students volunteered for the needs assessment. We conducted the focus group in the library of Dominican University of California and the faculty interviews were conducted individually in the professors' offices.

The faculty members have previously used the Functional Independence Measure (FIM) and the Health Enhancement Lifestyle Profile (HELP) in the Healthy Senior program. The goal of the appropriate assessments is to provide adequate information for students to develop their intervention plan for the Healthy Seniors program. The faculty

members determined that FIM was an inappropriate tool for the Healthy Seniors program since the community practice lab only lasted for eight weeks each semester and FIM was not sensitive enough to measure change in that short period of time with a group of community-dwelling older adults. HELP was determined to be a more holistic assessment than the FIM as it covers more contexts such as physical, social, spiritual, emotional, and occupational. However, this assessment was primarily quantitative and did not address health and wellness from the community-dwelling older adults' perspective. Therefore, there was a need for more comprehensive and qualitative assessments to further explain the results obtained from HELP in order to guide treatment planning.

After completing the interviews with the faculty members and the students, we then analyzed the responses for common themes. Our analysis aided in determining the criteria for the Health and Wellness assessment inventory. One of the common themes that came up was an appropriate assessment for the Healthy Seniors program does not need to focus on all contexts (physical, spiritual, social, intellectual, emotional, occupational, and environmental), but should primarily focus on the physical and psychosocial aspects. The assessments need to be both qualitative and quantitative and include both open and closed-ended questions. Another common theme revealed that two assessments could be considered in order to cover the different domain areas comprehensively.

Both the faculty members and the students also agreed on three other important factors to consider in choosing the appropriate assessment for the Healthy Seniors program. Firstly, the time the students take to learn and become proficient with



administering the assessment was important. The Healthy Seniors program was short, lasting only a total of eight weeks in duration. A good assessment needed to be fairly easy to comprehend and administer. Secondly, the type of assessment given whether it is in a self-report or rating scale was another important factor. Thirdly, the appropriate assessment should not take too long to administer because it was important that students have as much time as possible to plan and provide client-centered intervention instead of spending too much time on assessment only.

**establishing key components for the inventory.** The next step in the process consisted of choosing a framework. For this project we chose to use the Person-Environment-Occupation-Performance model. This framework provided the guidelines for us to create the following categories for the inventory sheet: time required to administer/number of questions, domains assessed, qualitative/quantitative, open/closed-ended questions, type of assessment, ownership/access, and validity/reliability. Following the PEO framework, the categories of domains assessed, qualitative/quantitative, type of assessment, and open/closed-ended questions are person factors as they provide ways to analyze a community-dwelling older adults unique situation and experiences from multiple perspectives. Time required to administer/number of questions and ownership/access are considered as environment factors, which are unique to the occupational therapist. Additionally, occupational therapists are allowed a limited amount of treatment and evaluation time, so assessments cannot have too many questions or require a lot of time to complete. Assessments also need to be specific to the area(s) of occupation(s) (e.g. dressing, cooking) that are of concern to the community-dwelling older adult. Validity/Reliability is a performance

factor as assessments need to measure what they say they're measuring (e.g. how well a person can perform grooming and hygiene tasks), and they have to provide consistent results over time (e.g. Is this person improving?).

**literature searches.** We searched databases, websites, and other scholarly sources for Health and Wellness Assessments. Databases searched were primarily health professional based such as CINAHL, ProQuest, Science Direct, and OT seeker. Keywords for our search terms included community-dwelling, quality of life, independence, wellness promotion, occupations of adults, and occupational therapy.

### **Project Implementation/Plan**

Following the above processes, we located 10 assessments to be included in the inventory. We evaluated these assessments based on the criteria on the established inventory categories. Cost of assessment, administration time, copyright information, type of assessment (qualitative/quantitative, domains addressed, open/closed-ended, self-report, rating scale), and administration process were all part of the inventory. We then sent an email (see Appendix B) to each of the 10 authors, asking for their permission to use a sample of their assessment in our inventory. This process resulted in a finished inventory of wellness assessments along with a brief analysis of each one (see Appendix C).

### **Project Evaluation**

Once the inventory was created, the completed inventory was evaluated by our professors Dr. Kitsum Li, Ms. Sue LeBlanc, and Ms. Alison Virzi. A questionnaire (see Appendix D) was used to rate the appropriateness of the inventory to be used in the Healthy Seniors community practice lab. Using the questionnaire, these faculty members

rated the organization of the inventory as satisfactory to good, usefulness and thoroughness as satisfactory, and the readability as fair to satisfactory. On a scale of 1 to 3 asking how useful were the categories in the inventory in helping to determine an appropriate Health and Wellness Assessment. Time required to administer/number of questions was rated as 3, domain assessed as 2.5, qualitative/quantitative as 2.5, open/closed-ended questions as 2.5, type of assessment as 2.5, ownership/access as 3, and validity/reliability as 2.5 (see Appendix D). When asked if they would recommend this Health and Wellness Assessment Inventory to other healthcare professionals who work with community-dwelling older adults, all of the faculty members said they would recommend it (see Appendix D). An additional suggestion from these faculty members was to make the samples of the assessments in the inventory more legible.

### **Ethical and Legal Considerations**

The Occupational Therapy Code of Ethics and Standards (2010) is a public statement of principles that intends to promote conduct-related standards within practice, education, and research in occupational therapy. The set of principles that specify significant standards appropriate to this project include beneficence, social justice, and nonmaleficence.

The Occupational Therapy Code of Ethics and Standards (2010) described beneficence as “Occupational therapy personnel demonstrating a concern for the well-being and safety of the recipients of their services” (p. 3). As related to the project, “occupational therapists will administer an appropriate evaluation and intervention plan for all recipients of occupational therapy services” (AOTA, 2010). To uphold this principle, the researchers developed an inventory of evidence-based Health and Wellness

Assessments for community-dwelling older adults. This allows Occupational Therapists to have access to a variety of information on the assessments and choose the most appropriate one(s) for their clients, thereby guiding them in planning and implementing interventions that lead to the best possible outcome(s) for their client(s).

Social justice “refers to the fair, equitable, and appropriate distribution of resources” (Occupational Therapy Code of Ethics and Ethics Standards, 2010, p. 6). The evidence-based Health and Wellness assessment inventory enables practitioners to choose appropriate assessments for their clients, thereby ensuring appropriate utilization of resources and reducing unnecessary or potentially harmful interventions.

The Occupational Therapy Code of Ethics and Standards (2010) defined nonmaleficence as “occupational therapy personnel shall avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees” (p.4). The inventory will accomplish this by keeping students and practitioners from choosing inappropriate assessments for their client(s), which may lead to inappropriate planning and implementing of interventions to their participants.

### **Conclusion**

The community-dwelling older adult population in the U.S. is continually growing, especially in the Los Angeles and San Francisco (S.F.) Metropolitan areas. Within the S.F. Metropolitan area, Marin County has the most dense population of community-dwelling older adults in California.

There is a need for Health and Wellness Assessments for this population. Evidence-based assessments which help to promote health and wellness in various domains (cognitive, spiritual, emotional, physical, and intellectual) for the community-

dwelling older adults of Marin County are most appropriate. Attaining health and wellness in these domains allows the older adults to live independently and engage in meaningful occupations. Studies show that maintaining independence is an important aspect of health and well-being in the community-dwelling older adult.

The purpose of our project was to create an inventory of Health and Wellness Assessments directed towards achieving these goals. More specifically, this inventory was created to provide the Dominican University of California Occupational Therapy department with an inventory of appropriate assessment tools for the Healthy Seniors Community Practice Lab.

It is the hope of the project administrators that this comprehensive inventory displaying Health and Wellness Assessments can be used by occupational therapists working with community-dwelling older adults, to guide their decision in choosing the most appropriate Health and Wellness Assessment(s), and thus enabling them to make informed decisions regarding the best intervention approaches in wellness promotion.

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## Appendix A

### Needs Assessment

- 1) What key aspects should the assessments focus on?
  
- 2) How many assessments would be ideal?
  
- 3) How detailed should the assessments be? For example, should they include only close-ended questions where answer choices are limited? Only open-ended questions where the client is free to answer in their own words? Or should there be a combination of both types of questions?
  
- 4) What are the negatives and positives of current assessments? And what is being used? or were being used?
  
- 5) What contexts (physical, spiritual, social, intellectual, emotional, occupational, environmental) should the assessments focus on?
  
- 6) Is it appropriate to recommend using a combination of assessments to address multiple contexts?
  
- 7) Should we have a combination of qualitative and quantitative assessments?
  
- 8) What is the goal of the assessment? How do you envision it fitting into the CPL? Any limitations such as length of the assessment or equipment needed? What types of assessments? Self report? rating scale?
  
- 9) What kind of assessment or information is needed to formulate intervention in health seniors? i.e. how can it fit the prevention and health promotion model in CPL?

10) What should be considered when determining ease of use of the assessments? Time it takes to become proficient with administering it? Cost? **Below you will see that we have created a list of criteria for the faculty to rank based on ease of use of an assessment.**

**Please rank order the below items based on ease of use of an assessment. For example, if you think “time to administer” makes an assessment easiest to use then put a “1” next to “time to administer”.**

Cost

Time to administer

Time it takes to become proficient with administering

Equipment

Type of assessment (ex. Self report or rating scale)

Open/close-ended questions

## Appendix B

### Email Inquiry to Assessment Authors

Dear Mr./Mrs./Ms./Dr.

We are Occupational Therapy students at Dominican University of California and we are currently working on our Master's Thesis. Part of our thesis project includes creating an inventory of the most current and evidence-based Health and Wellness Assessments for the elderly population. This inventory could be used as a resource for occupational therapists practicing in the areas of geriatrics, wellness promotion, and productive aging.

We came across your \_\_\_\_\_assessment and would like to include it in our inventory. To provide the readers with a better illustration of the \_\_\_\_\_assessment, we would like to request access to a few pages of your assessment and include them as a sample in the inventory. Our Master's Thesis will be published electronically in the Dominican University of California library in 2014. In order to protect all the copyrighted material, we shall watermark the provided sample pages and reference everything appropriately in our thesis.

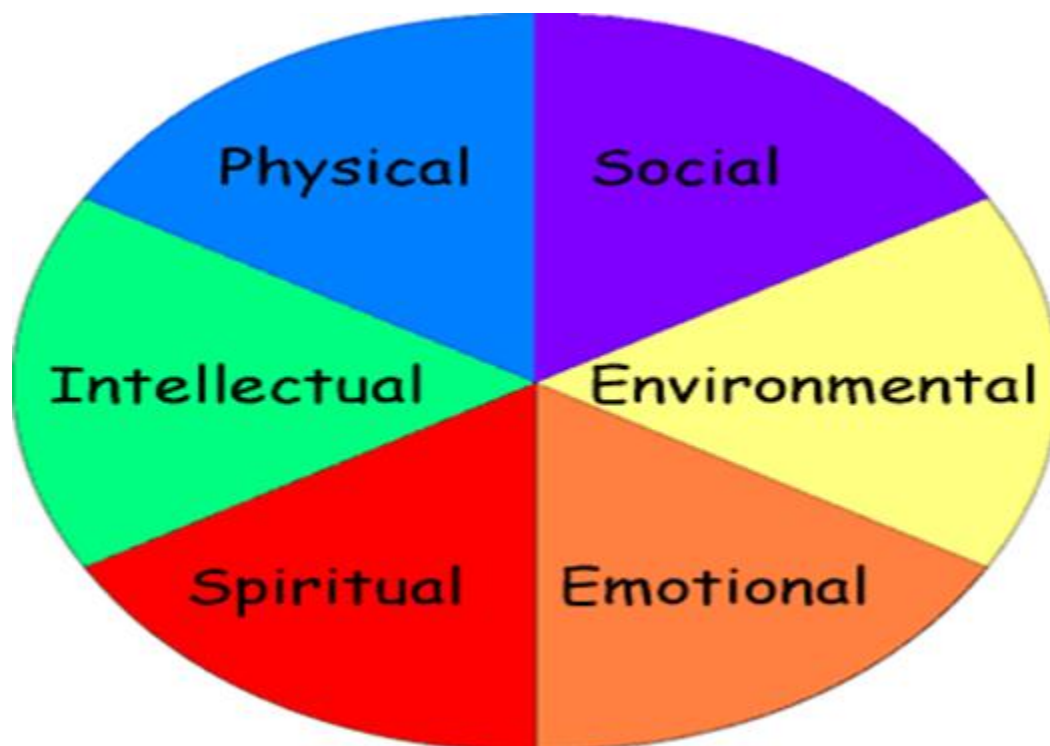
We would like to thank you for your consideration and please feel free to contact us or our thesis adviser should you have any questions. We look forward to your favorable reply.

Sincerely,

Matthew Carlson & Elliott Brent (Thesis Adviser: Kitsum, Li, OTD, OTR/L  
kitsum.li@dominican.edu)

## Appendix C

**Comprehensive Health and Wellness Assessments:  
An Evidence-Based Inventory for Occupational  
Therapists Working With Community-Dwelling  
Older Adults**



Elliott Brent, OTS

Matthew Carlson, OTS

Dominican University of California

Department of Occupational Therapy

March 2013

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## **Introduction**

By 2020 senior citizens aged 60 and older will account for one fifth of California's total population. Increasingly diverse groups of older adults are living independently. As a result, knowing and deciding which assessments are appropriate to use with community-dwelling older adults may be challenging for occupational therapists. To address this professional challenge, an comprehensive inventory of the most evidence-based Health and Wellness Assessments was created.

This evidence-based Health and Wellness Assessment Inventory contains the following assessments: Pizzi Holistic Wellness Assessment, Health and Wellness Assessment (HAWA), Health Enhancement Lifestyle Profile (HELP)-Screeners, Health Enhancement Lifestyle Profile (HELP)-Full Assessment, OCAIRS, Occupational Performance History Interview –II (OPHI-II), Health Promoting Lifestyle Profile-II (HPLP-II), Short Form-36 (SF-36), Barriers to Health Promoting Activities for Disabled Persons Scale (BHPADPS), and Assessment of Occupational Functioning (AOF). Criteria used to evaluate each assessment include the time required to administer/number of questions, the domain(s) assessed (i.e. physical, psychosocial, spiritual, environment, occupational, and intellectual), qualitative/quantitative, open/closed-ended questions, the type of assessment (i.e. rating scale, self-report), ownership/access, and validity/reliability. We were able to obtain sample pages of some of the assessments from the original author(s) and they are meant for reference only.

It is our hope that this comprehensive inventory displaying Health and Wellness Assessments can be used by occupational therapists working with community-dwelling older adults, to guide their decision in choosing the most appropriate Health and Wellness Assessment(s), and thus enabling them to make informed decisions regarding the best intervention approaches in wellness promotion.



This evidence-based inventory of Health and Wellness Assessments was developed as part of a master's thesis by graduate students from the occupational therapy department at Dominican University of California. Those who would like to use this inventory have permission to use without prior authorization.

**Pizzi Holistic Wellness Assessment**-Assesses clients' self-perceptions of health using a 1-10 self-rating scale, and identifies strategies to involve individuals in problem-solving solutions to enhance or restore their own health. It addresses physical, psychosocial, spiritual, environmental, occupational, and intellectual domains of health and wellness.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership/ Access</b>	<b>Validity/ Reliability</b>
30-45 minutes	Physical  Psychosocial  Spiritual  Environment  Occupational  Intellectual	<b>Quantitative:</b> 8 specific health areas are addressed	<b>Closed-Ended:</b> Self-rating	<b>Rating Scale:</b> 1-10 rating scale	Available at <a href="http://www.michaelpizzi.com">www.michaelpizzi.com</a> for \$100	More research is needed on its psychometric properties and to develop reliability. It has good beginning face and content validity and was found to be useful in a clinical setting however, the numbers were not reported in literature.

**Health and Wellness Assessment (HAWA)**- A 110 item (100 closed-ended and 10 open-ended) survey and customized report designed to enlighten, educate, and motivate older adults about opportunities to enhance health and well-being. It addresses physical, emotional, social, and intellectual domains of health and wellness.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership/ Access</b>	<b>Validity/ Reliability</b>
110 items/ Questions	Physical  Emotional  Social  Intellectual  Spiritual	<b>Qualitative:</b> 10 questions     <b>Quantitative:</b> 100 items	<b>Open- Ended:</b> 10 questions- self- reported   <b>Closed- Ended:</b> 100 items- self-rated	<b>Self-report:</b> 10 questions     <b>Rating scale:</b> Not reported	Contact Dr. Jeff Engel @ <a href="http://www.optimumhealthmissoula.com/contact-us/">http://www. optimumhea lthmissoula. com/contact -us/</a> and send email to ask permission to access and use the HAWA.	<b>Reliability:</b>  Physical (alpha = .27)  emotional (alpha = .79)  social (alpha = .77)  intellectual (alpha = .63)  spiritual (alpha = .84)  vocational (alpha = .66)  <b>Validity:</b> Not reported

**Health Enhancement Lifestyle Profile (HELP) Screener**-This screener measures perceived performance in exercise, diet, productive activities, and social participation, leisure, activities of daily living, stress management, and spiritual participation. If client answers “No” in nine or more items, then the full HELP assessment is indicated. It addresses the physical, psychological, social, occupational, and spiritual domains of health and wellness.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain(s) Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership /Access</b>	<b>Validity/ Reliability</b>
15 items	Physical  Psychological  Social  Occupational  Spiritual	<b>Quantitative:</b> 15 items	<b>Closed- ended:</b> 15 items- self rated	<b>Rating scale:</b> Yes/No	Contact Dr. Hwang at ehwang@ csudh.edu to get permissio n to use the HELP Screener	<b>Reliability:</b> .93  <b>Validity:</b> Reported as good construct validity

**HEALTH ENHANCEMENT LIFESTYLE PROFILE (HELP) – SCREENER**

Please check "Yes" or "No" for each of the following statements.

1. I spend sufficient time taking good care of myself (e.g., grooming, showering, cooking, house cleaning). YES/NO
2. I avoid health-risk behaviors (e.g., excessive drinking, smoking, consuming over-the-counter drugs). YES/NO
3. I consume a variety of healthy foods rich in protein, fiber, or calcium everyday (e.g., white meat, fish, fruits, vegetables, milk, soy products). YES/NO
4. I go out with my family or friends at least once a week. YES/NO
5. I pursue my hobbies at least once a week. YES/NO
6. I have skills for coping with stress. YES/NO
7. I frequently monitor my health (e.g., blood pressure, blood sugar, body weight). YES/NO
8. I frequently get quality sleep and rest. YES/NO
9. I engage in my religious/spiritual activities at least once a week. YES/NO
10. I frequently avoid those foods high in fat, cholesterol, sodium, or sugar (e.g., red meat, butter, eggs, canned soup, desserts). YES/NO
11. I frequently read the nutrition facts labels of food products before buying/eating them. YES/NO
12. I exercise more than twice a week. YES/NO
13. I engage in activities in my community (e.g., attending senior center, volunteering) at least once a week. YES/NO
14. I frequently look for resources or information on health promotion through the mass media, health practitioners, or classes/clubs. YES/NO
15. I frequently avoid sedentary activities/behaviors (e.g., watching TV, sitting and reading). YES/NO

**Health Enhancement Lifestyle Profile (HELP) Full Assessment-** This assessment measures perceived performance in exercise, diet, productive activities, and social participation, leisure, activities of daily living, stress management, and spiritual participation. The full HELP assessment has 69 items that address the physical, psychological, social, occupational, and spiritual domains of health and wellness.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain(s) Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed-Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership / Access</b>	<b>Validity/ Reliability</b>
69 items	Physical  Psychological  Social  Occupational  Spiritual	<b>Quantitative</b> 69 items	<b>Closed-ended:</b> 69 items-self-rated	<b>Rating scale:</b> Never 1-2 days 3-4 days 5-6 days 7 days 1-2 days a month	Contact Dr. Hwang at ehwang@c sudh.edu to get permission to use the HELP Full Assessment	<b>Reliability:</b> .75-.92  <b>Validity:</b> Reported as good construct validity

Health Enhancement Lifestyle Profile (HELP)-Full Assessment

How often during a week do you perform stretching or flexibility exercises (such as joint mobility/stretching exercise, calisthenics or Yoga)?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a week do you eat 3 or more servings of healthy foods rich in protein in one day (such as white meat, lean poultry, fish, beans, nuts, reduced-fat milk, cottage cheese, tofu, or soymilk)?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a week do you visit or go out with your friends or family members or relatives who do not live with you?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a week do you go out for watching sport games, movies, concerts, plays, live shows, museums, or exhibitions?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a week do you stay up late at night or sleep less than 5 hours a night?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a week do you spend at least 20 minutes in a day doing simple things that can bring about your good moods (such as caring for pets, or singing, reading, listening to music etc.)?

Never 1-2 days 3-4 days 5-6 days 7 days \* 1-2 days a month

How often during a month do you monitor your health at home (such as measuring blood pressure, heart beats, respiratory rate, blood sugar level, or body weight)?

Never 1 day 2 days 3 days 4 days 5 days or more

**OCAIRS**-A semi-structured interview that provides information about a person's life and occupational participation by taking into account their Roles, Habits, Personal Causation, Values, Interests, Skills, Short-Term Goals, Long-Term Goals, Interpretation of Past Experiences, Physical Environment, Social Environment, and Readiness for Change. The therapist then rates each of these areas using the following scale: F-Facilitates participation in occupation, A-Allows participation in occupation, I-Inhibits participation in occupation, R-Restricts participation in occupation.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership /Access</b>	<b>Validity/ Reliability</b>
20-30 minutes, with an additional 5-10 minutes for interpretation and recording of results	Physical Psychological Social Occupational	<b>Quantitative:</b> Roles, Habits, Personal Causation, Values, Interests, Skills, Short-Term Goals, Long-Term Goals, Interpretation of Past Experiences, Physical Environment, Social Environment, and Readiness for Change	<b>Closed- Ended:</b> Interview	<b>Rating scale (completed by therapist):</b> F-Facilitates participation in occupation  A-Allows participation in occupation  I-Inhibits participation in occupation  R-Restricts participation in occupation	Can be purchased @ <a href="http://www.cade.uic.edu/moho/productDetails.aspx?aid=35">http://www.cade.uic.edu/moho/productDetails.aspx?aid=35</a> for \$43.50	Reported as excellent inter-rater reliability and satisfactory concurrent validity



## OCAIRS Forensic Mental Health Interview (Form 3) Questions and Rating Scales

### ROLES

Do you have any family responsibilities? Are you managing to keep up with these?  
 How much contact with family/friends? How often do they telephone/visit/write?  
 Are you studying now or have any other responsibilities here?  
 What are your needs relating to your culture or religion?  
 How well are you able to \_\_\_\_\_ (for each role mentioned)?  
 (For each role mentioned) How important is \_\_\_\_\_ to you? Do you enjoy \_\_\_\_\_?  
 What else do you do? What other roles do you fill?

F	<input type="checkbox"/> Occupational roles reflect a highly productive lifestyle <input type="checkbox"/> High level of satisfaction with current roles <input type="checkbox"/> Fulfills a wide range of role responsibilities
A	<input type="checkbox"/> Occupational roles reflect a somewhat productive lifestyle <input type="checkbox"/> Some satisfaction with current roles <input type="checkbox"/> Minor difficulty in fulfilling a wide range of role responsibilities
I	<input type="checkbox"/> Occupational roles fail to constitute a productive lifestyle <input type="checkbox"/> Very little satisfaction with current roles <input type="checkbox"/> Major difficulty in fulfilling a wide range of role responsibilities
R	<input type="checkbox"/> No occupational roles <input type="checkbox"/> Alienated from roles <input type="checkbox"/> Cannot fulfill a wide range of role responsibilities

### HABITS

What would you like your routine to be like?  
 How is your sleep pattern now?  
 Describe a typical weekday (before you were admitted here).  
 Were your weekends any different?  
 What is your routine now? Are you able to do what you want to do?  
 Has your routine changed (since you index offense/admission here)?  
 If so, how?  
 Are you satisfied with your current routine?

F	<input type="checkbox"/> Highly organized daily schedule <input type="checkbox"/> Good balance between work, rest, self-care and leisure <input type="checkbox"/> Satisfied with daily routine
A	<input type="checkbox"/> Some organization of daily schedule <input type="checkbox"/> Some balance between work, self-care and leisure <input type="checkbox"/> Somewhat satisfied with daily routine
I	<input type="checkbox"/> Very little organization of daily schedule <input type="checkbox"/> Very little balance between work, self-care and leisure <input type="checkbox"/> Very little satisfaction with daily routine
R	<input type="checkbox"/> No organized daily schedule <input type="checkbox"/> No balance between work, self-care and leisure <input type="checkbox"/> Dissatisfied with daily routine

### VALUES

What do you value most in your life? (What/who is most important?)  
 Are you able to live by your values/ideals at present? If not, why not?  
 Are there any other things that are important to you?  
 Why are these things important?

F	<input type="checkbox"/> Identifies distinct and specific values <input type="checkbox"/> Strong conviction about expressed values <input type="checkbox"/> Expresses complete congruence between own values and current life situation
A	<input type="checkbox"/> Identifies somewhat ambiguous values <input type="checkbox"/> Some conviction about expressed values <input type="checkbox"/> Expresses some congruity between own values and current life situation
I	<input type="checkbox"/> Loosely identifies very ambiguous values <input type="checkbox"/> Very little conviction about expressed values <input type="checkbox"/> Expresses very little congruity between own values and current life situation
R	<input type="checkbox"/> Does not identify any values <input type="checkbox"/> No conviction/alienation about expressed values <input type="checkbox"/> Expresses no congruity between own values and current life situation

### INTERESTS

What interests/hobbies do you have? Is there anything that stops you participating?  
 (For each interest mentioned) How often do you \_\_\_\_\_? Are you satisfied with the amount of time you are able to \_\_\_\_\_?  
 Are there activities here that you would like to do in this environment?  
 (If applicable) Do you have an interest in a criminal lifestyle? (e.g. drugs/alcohol/theft)? What is good or bad about the criminal lifestyle? Would you like to live like this?  
 What would you like to do with your time when you leave the hospital?

F	<input type="checkbox"/> Participates in many interests regularly outside of work <input type="checkbox"/> High level of interest in primary occupation <input type="checkbox"/> High level of satisfaction with level of participation in an interest(s)
A	<input type="checkbox"/> Participates in few, but clearly expressed, interests regularly outside of work <input type="checkbox"/> Some interest in primary occupation <input type="checkbox"/> Some satisfaction with level of participation in an interest(s)
I	<input type="checkbox"/> Few & vaguely defined interest outside work, no regular participation <input type="checkbox"/> Very little interest in primary occupation <input type="checkbox"/> Very little satisfaction with level of participation in an interest(s)
R	<input type="checkbox"/> Does not participate in any identified interests outside of work <input type="checkbox"/> No interest in primary occupation

OCAIRS Data Summary Form 2

Client: \_\_\_\_\_

Assessor: \_\_\_\_\_

Age: \_\_\_\_\_ Date Assessment Completed: \_\_\_\_\_ Signature: \_\_\_\_\_

Summary of Clients Scores

Roles	Habits	Personal Causation	Values	Interests	Skills	Short-Term Goals	Long-Term Goals	Interpretation of Past Experiences	Physical Environment	Social Environment	Readiness for Change	RATINGS KEY	
												F	Facilitates: Facilitates Participation in Occupation
F	F	F	F	F	F	F	F	F	F	F	F	A	Allows: Allows Participation in Occupation
A	A	A	A	A	A	A	A	A	A	A	A	I	Inhibits: Inhibits Participation in Occupation
I	I	I	I	I	I	I	I	I	I	I	I	R	Restricts: Restricts Participation in Occupation
R	R	R	R	R	R	R	R	R	R	R	R		

NEED FOR OCCUPATIONAL THERAPY	
4	Shows positive occupational participation, no need for OT.
3	Need for minimal intervention/consultative OT services.
2	Need for OT intervention indicated to restore/improve participation
1	Need for extensive OT intervention indicated to improve participation. Referral for follow-up services also recommended.

ANALYSIS /PLAN

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**OPHI-II (Occupational Performance History Interview –II)**- Uses interview questions that address Activity/Occupational Choices, Critical Life Events, Daily Routines, Occupational Roles, and Occupational Behavior Settings. This provides a broad and detailed appreciation of a person's life history, the impact of disability, and the direction in which the person would like to take his or her life. The therapist then rates each of these areas using a 4-point rating scale.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed-Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership/ Access</b>	<b>Validity/ Reliability</b>
45 minutes	Physical  Psychological  Social  Occupational	<b>Quantitative:</b> Activity/ Occupational Choices, Critical Life Events, Daily Routine, Occupational Roles, and Occupational Behavior Settings	<b>Closed- Ended:</b> Interview questions	<b>Rating scale:</b> 4 point  1-4	Can be purchased @ <a href="http://www.ca.de.uic.edu/mo/ho/productDetails.aspx?aid=32">http://www.ca.de.uic.edu/mo/ho/productDetails.aspx?aid=32</a> for \$43.50	Reported as good validity however, reliability has not been established

## Occupational Settings (Environment)

The Occupational Settings (Environment) section includes questions aimed at the person's occupational environments, including people, and their influence on occupation.

### Home

- Tell me about where you live.

[Or]

I understand you live \_\_\_\_\_.

[Or]

Give me a little tour of/Tell me about your home/apartment/room/dorm.

**What is it like?**

Is your home/apartment/room/dorm comfortable?

Do you have enough privacy?

Can you get around in your home/apartment/room/dorm?

Is it adequate for that?

Do you have the things there that you need in order to do what you want?

Are you ever bored there?

Do you like your surroundings?

Are they stimulating for you?

[The following overlaps with the caretaker role questions in the role section and may not need to be repeated if that section is done first]

- What do you have to do to keep up your home/apartment/room/dorm?

Do you like doing this?

Are you able to do it okay?

- Who do you live with?

[Or]

Who are the important people in your life?

[Or]

I understand you live with \_\_\_\_\_?

How do you get along?

What kind of things do you do together?

- How would you describe things where you live? (For instance, which of the following describes your home/living situation: loving, fighting, stressful, calm, chaotic, busy, boring?)

[Or]

Tell me about something that happened at home recently that would show me what things are like where you live.

Is there anyone at home/in your family who makes life stressful or difficult for you?

- If you need help with something, can you expect your family/spouse/ roommate/etc. to

## Occupational Settings (Environment) Scale

Item	Rating	Criteria	Additional Rater Notes
Home life occupational forms (tasks)	4	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities challenge/stimulate interests and abilities
	3	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities generally match interests and abilities
	2	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities somewhat mismatch interests and abilities
	1	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities poorly match interests and abilities
Major productive role occupational forms (tasks)	4	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities challenge/stimulate interests and abilities
	3	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities generally match interests and abilities
	2	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities somewhat mismatch interests and abilities
	1	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities poorly match interests and abilities
Leisure occupational forms (tasks)	4	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities challenge/stimulate interests and abilities
	3	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities generally match interests and abilities
	2	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities somewhat mismatch interests and abilities
	1	<input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Emotional <input type="checkbox"/> Time/effort required well suit available time/energy.	Demands/opportunities poorly match interests and abilities

**HPLP-II (Health Promoting Lifestyle Profile-II)**-A 52 item questionnaire that determines interpersonal, intrapersonal, and environmental barriers to health promoting activities. The client self-rates using the following scale: N-Never, S-Sometimes, O-Often, R-Routinely.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed-Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership /Access</b>	<b>Validity/ Reliability</b>
52 items	Physical  Psychological  Social  Spiritual	<b>Quantitative:</b> 52 items	<b>Closed-Ended:</b> Self-rated	<b>Rating Scale:</b> <b>N</b> -Never <b>S</b> -Sometimes <b>O</b> -Often <b>R</b> -Routinely	Available @ <a href="http://www.unmc.edu/nursing/docs/English_HPLPII.pdf">http://www.unmc.edu/nursing/docs/English_HPLPII.pdf</a>	Reported as good reliability and validity

## LIFESTYLE PROFILE II

**DIRECTIONS:** This questionnaire contains statements about your *present* way of life or personal habits.

Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling:

**N** for never, **S** for sometimes, **O** for often, or **R** for routinely

NEVER

SOMETIMES

OFTEN

ROUTINELY

1. Discuss my problems and concerns with people close to me. N S O R
2. Choose a diet low in fat, saturated fat, and cholesterol. N S O R
3. Report any unusual signs or symptoms to a physician or other health professional. N S O R
4. Follow a planned exercise program. N S O R
5. Get enough sleep. N S O R
6. Feel I am growing and changing in positive ways. N S O R
7. Praise other people easily for their achievements. N S O R
8. Limit use of sugars and food containing sugar (sweets). N S O R
9. Read or watch TV programs about improving health. N S O R
10. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber). N S O R
11. Take some time for relaxation each day. N S O R
12. Believe that my life has purpose. N S O R
13. Maintain meaningful and fulfilling relationships with others. N S O R

**SF-36 (Short Form-36)**-A 36-question assessment that uses a self-rating scale to measure physical, mental, and functional health and well-being from the client's point of view.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership/ Access</b>	<b>Validity/ Reliability</b>
5-10 minutes	Physical  Psychological  Social	<b>Quantitative:</b> 36 questions	<b>Closed- Ended:</b> Self-rated	<b>Rating Scale:</b> Not reported	To access, complete and submit a brief Survey Information Request Form @ <a href="http://www.qualitymetric.com/RequestInformation/SurveyInformationRequest/tabid/263/Default.aspx">http://www.qualitymetric.com/RequestInformation/SurveyInformationRequest/tabid/263/Default.aspx</a>	<b>Reliability:</b> .82-.94  <b>Validity:</b> Good criterion and construct validity



**BHPADPS (Barriers to Health Promoting Activities for Disabled Persons Scale)**-An

18-item, 4-point scale to measure individual barriers in taking care of health.

Respondents are asked to indicate how often listed barriers keep them from taking care of their health. Items include intrapersonal, interpersonal, and environmental barriers.

Examples of barriers include being too tired, having other responsibilities, and lack of transportation. Responses are scored from 1 (never) to 4 (routinely). Scores range from 18-72. Higher score indicates greater perceived barriers.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership/ Access</b>	<b>Validity/ Reliability</b>
5-10 minutes	Physical  Psychological  Social	<b>Quantitative:</b> 18 questions	<b>Closed- Ended:</b> Self-rated	<b>Rating Scale:</b> 1-never  2-sometimes  3-often  4-routinely	Access @ <a href="http://www.utexas.edu/nursing/chpr/instruments_BHADP.html">http://www.utexas.edu/nursing/chpr/instruments_BHADP.html</a>	<b>Reliability:</b> .82-.94  <b>Validity:</b> Not reported

### Barriers to Health Promoting Activities for Disabled Persons Scale (BHPADPS)

People sometimes have problems doing what they want to do to stay healthy. Please circle the number that best indicates how much each of these problems keeps you from taking care of your health.

1 = Never

2 = Sometimes

3 = Often

4 = Routinely

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. Lack of convenient facilities           | 1 | 2 | 3 | 4 |
| 2. Too tired                               | 1 | 2 | 3 | 4 |
| 3. Lack of transportation                  | 1 | 2 | 3 | 4 |
| 4. Feeling what I do doesn't help          | 1 | 2 | 3 | 4 |
| 5. Lack of money                           | 1 | 2 | 3 | 4 |
| 6. Impairment                              | 1 | 2 | 3 | 4 |
| 7. No one to help me                       | 1 | 2 | 3 | 4 |
| 8. Not interested                          | 1 | 2 | 3 | 4 |
| 9. Lack of information                     | 1 | 2 | 3 | 4 |
| 10. Embarrassment about my appearance      | 1 | 2 | 3 | 4 |
| 11. Concern about safety                   | 1 | 2 | 3 | 4 |
| 12. Lack of support from family/friends    | 1 | 2 | 3 | 4 |
| 13. Interferes with other responsibilities | 1 | 2 | 3 | 4 |
| 14. Lack of time                           | 1 | 2 | 3 | 4 |
| 15. Feeling I can't do things correctly    | 1 | 2 | 3 | 4 |
| 16. Difficulty with communication          | 1 | 2 | 3 | 4 |

**AOF (Assessment of Occupational Functioning)**-A 42-question semi-structured, self-report screening instrument that collects information about a patients' perceptions of their strengths and limitations in the areas of values, personal causation, interests, roles, habits, and skills. The therapist then rates each of these areas using a 5-point scale.

<b>Time Required to Administer/ Number of questions</b>	<b>Domain Assessed</b>	<b>Qualitative/ Quantitative</b>	<b>Open/ Closed- Ended Questions</b>	<b>Type of Assessment</b>	<b>Ownership /Access</b>	<b>Validity/ Reliability</b>
42 questions	Psychological  Social  Occupational	<b>Quantitative:</b> 20 questions  <b>Qualitative:</b> 22 questions	<b>Open- Ended:</b> Self- reported  <b>Closed- Ended:</b> Rated by therapist	<b>Self-report rating scale:</b> 1-Very little 2-Little 3-Moderately 4-Highly 5-Very Highly	Available @ <a href="http://www.sahp.vcu.edu/occu/ot/aofinstrument2.pdf">http://www.sahp.vcu.edu/occu/ot/aofinstrument2.pdf</a>	<b>Reliability:</b> Not reported  <b>Validity:</b> .36

## **Assessment of Occupational Functioning**

### **Collaborative Version**

#### **Administration Protocol**

The AOF-CV is a screening tool designed to collect a broad range of information believed to influence and indicative of a person's occupational performance and to identify areas needing more in-depth evaluation. It is based directly on the Model of Human Occupation (Kielhofner, 1995) and measures aspects of the human system as defined by this practice model. Therapists using this instrument should be familiar with the practice model. The AOF-CV does not attempt evaluation of specific daily living skills or environmental variables directly, but aims to efficiently generate a picture of numerous complex and interrelated factors likely to influence a person's ability to function.

#### Administration

The AOF-CV may be therapist-administered or self-administered with therapist follow-up. Either way, proper administration assumes use with clients capable of responding to an interview, therapist interviewing skill, and knowledge of the Model of Human Occupation since AOF-CV instrument development research is derived from this theoretical framework.

Therapist administration. Interview the person following this format. Parenthetical probes or clarifications should be used as needed. These are indicated if use of the specified question resulted in either no reply, a request for clarification, an answer suggesting interviewee misunderstanding, a superficial response, or other indications of poor communication. No other questions, probes, or clarifications are to be used. Note responses on this form. Responses from this interview will provide the information for you to mark the rating form.

(V) What activities do you value or what activities give you a sense of purpose to your life? Please be specific in identifying these meaningful activities.

(H) What do you do in a typical weekday? Pick this typical weekday from a relatively current, stable period of time during which you had some control over determining the routine. Start with waking up and end with bed time. Be sure to specify when this typical weekday occurred.

(PC) Do you feel in control of your life? For example, do you make your own decisions?

(S) Do you have any physical limitations that interfere with daily activities? (Mention not only major limitations, but also limitations that only you may notice, such as

incoordination when handling small objects that may interfere with typing, sewing, and detail painting, or limited energy or strength to participate in vigorous physical activities, etc.)

(R) Some people are workers or students. What kinds of things (that is, roles) are you involved in in everyday life? (In other words, what do you spend most of your time doing; with whom do you spend most of your time; and how often do you do these things?)

(I) Name at least 5 things you enjoy doing. Why do you like to do these things?

SAMPLE

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## Appendix D

### Health and Wellness Assessment Inventory Evaluation

Please provide feedback regarding the evidence-based Health and Wellness Assessment Inventory.

Please rate the following:					
<b>1. Organization</b>	Poor	Fair	Satisfactory	Good	Excellent
<b>2. Usefulness</b>	Poor	Fair	Satisfactory	Good	Excellent
<b>3. Thoroughness</b>	Poor	Fair	Satisfactory	Good	Excellent
<b>4. Readability</b>	Poor	Fair	Satisfactory	Good	Excellent

5. On a scale of 1 to 3, how useful were the categories in the inventory in helping to determine an appropriate Health and Wellness Assessment?

3 – Very useful

2 – Somewhat useful

1 – Not useful

Time Required to Administer/Number of questions	1	2	3
Domain Assessed	1	2	3
Qualitative/Quantitative	1	2	3
Open/Closed-Ended Questions	1	2	3
Type of Assessment	1	2	3
Ownership/Access	1	2	3
Validity/ Reliability	1	2	3



6. Would you recommend this Health and Wellness Assessment Inventory to other healthcare professionals who work with community-dwelling older adults? (Circle one) Yes/No. If not, why?

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7. Did you find that this inventory would be helpful in guiding the decision making process for the Healthy Seniors program?

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8. Any other comments about this Health and Wellness Inventory may be addressed in the space provided below.

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