



2018

# A Review of Community Aging in Place Programs to Minimize Social Isolation in Older Adults

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A Review of Community Aging In Place Programs to Minimize Social Isolation in Older  
Adults

by

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Advisors: Lavonne Fox, PhD, OTR/L

A Scholarly Project

Submitted to the Occupational Therapy Department of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Occupational Therapy

Grand Forks, North Dakota

May, 2018

This scholarly project, submitted by Heather J. Goodwater, MOTS and Joanna M. Yutrzenka, MOTS in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Faculty Advisor

March 19th 2018

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Date

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Title: A Review of Community Aging In Place Programs to Minimize Social Isolation in Older Adults

Department: Occupational Therapy

Degree: Master of Occupational Therapy

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## ACKNOWLEDGEMENTS

The authors wish to express appreciation to our advisor, Dr. Lavonne Fox, PhD, OTR/L for her expertise and scholarly advice. We would also like to thank all of the faculty and support staff in the UND Occupational Therapy Department. They have all provided support and guidance the past three years and prepared us to complete this scholarly project. Lastly, we would like to thank Devin Olson, MLIS, who helped guide our research process.

## ABSTRACT

The aging baby boomer population calls for new solutions to enable older Americans to age in place in their communities of choice. Nine out of ten adults age 50 and older prefer to remain in their homes indefinitely as they age, or as long as they possibly can (Gonyea, & Burnes, 2013). However, program funding that supports aging in place does not come close to keeping pace with the rapid growth of the 65 and older population (American Institutes for Research, 2016). There are a limited number of programs in place to address socialization in community-dwelling older adults. The prevalence of social isolation has been well documented in the literature for community-dwelling older adults (Dickens, Richards, Greaves, & Campbell, 2011; Painter, et al., 2012; Levasseur et al., 2015; Masi, Chen, Hawkey, & Cacioppo, 2011; Sabir, et al., 2009; Steptoe et al., 2013; Vogelsang, 2016). Social isolation can have a variety of negative implications for older adults, including an increased rate of mortality, cardiovascular disease, infectious diseases, cognitive decline, diminished immune function, loneliness, depression, suicidal ideation, and suicidal behavior (Cornwell & Waite, 2009; Masi et al., 2011; Steptoe, Shankar, Demakakos, & Wardle, 2013).

A literature review was conducted to identify aging in place programs that address social isolation in older adults. Based on the results of the literature, a product entitled **The Friendly Neighbor: Community Programming for Socially Isolated Older Adults** was developed. This product is designed to provide a resource for occupational therapists to assess which aging in place programs may be the best to implement in their



community. It contains a summary of the benefits, challenges, setting, participants, cost-effectiveness, and outcomes of each program. The product includes descriptions of community programs, table summaries of the aging in place programs previously discussed, a step by step guide for application of the PEO model, and a resource section. Occupational therapists can use this resource to compare characteristics of various aging in place programs to create an evidence-based program that will meet the specific needs of the community they are working with. It is proposed that these programs can be effectively used to help older adults build social networks and increase social participation in their community.

Social isolation is a prevalent and often overlooked issue in community-dwelling older adults. This issue falls within the practice of occupational therapy, and occupational therapists have the skills necessary to create and implement community-based programs to address this issue (AOTA, 2016; Bacsu et al., 2012; Smallfield, Haag, Poston, Giger, Anderson, 2014; Dickens et al., 2011; Steultjens et al., 2004; Vogelsang, 2016). The purpose of this project was to support the implementation of aging in place programs to reduce the prevalence of social isolation in older adults that wish to remain in their homes as they age.

## CHAPTER I

### INTRODUCTION

A majority of older adults are opting to age in place rather than to move to a nursing home or assisted living facility (Lehning, Smith & Dunkle, 2015). Aging in place (AIP) is defined as “remaining living in the community, with some level of independence, rather than in residential care” (Wiles, Leibing, Guberman, Reeve, & Allen, 2011, p. 357). With the increasing age of the baby boomer generation, there is an increased demand for aging in place services (United States Census Bureau, 2017). Many factors must be considered to meet the needs of adults who wish to remain at home, such as housing, access to transportation, recreational opportunities, proximity to essential services, social interaction, and cultural engagement (Wiles et al., 2011; Vrkljan, Leuty, & Law, 2011).

***Problem:*** There are a limited number of programs in place to address social isolation in community-dwelling older adults. Socialization is defined as the activity of mixing socially with others (Merriam-Webster Online, n.d.). Older adults are more likely to experience a lack of social interaction and community participation, which may lead to social isolation. Social isolation is a noteworthy reduction or lack of frequency and length of socialization (Step toe, Shankar, Demakakos, & Wardle, 2013). The prevalence of social isolation has been well documented in the literature for community-dwelling older adults (Dickens, Richards, Greaves, & Campbell, 2011; Painter, et al., 2012; Levasseur et

al., 2015; Masi, Chen, Hawkey, & Cacioppo, 2011; Sabir, et al., 2009; Steptoe et al., 2013; Vogelsang, 2016).

Social isolation may be caused by a variety of factors, including but not limited to decreased economic resources, physical impairments, fear of falling, depression, inaccessible entry and exits to building, lack of appropriate transportation, limited community resources, death of social contacts, difficulty forming new social relationships, and social stigma relating to ageism (Dickens et al., 2011; Painter, et al., 2012; Levasseur et al., 2015; Masi, Chen, Hawkey, & Cacioppo, 2011; Sabir, et al., 2009; Steptoe et al., 2013; Vogelsang, 2016). Social isolation can have a variety of negative implications for older adults, including an increased rate of mortality, cardiovascular disease, infectious diseases, cognitive decline, diminished immune function, loneliness, depression, suicidal ideation, and suicidal behavior (Cornwell & Waite, 2009; Masi et al., 2011; Steptoe, Shankar, Demakakos, & Wardle, 2013). It may also cause a decreased sense of self-esteem and control (Cornwell & Waite, 2009).

***Assumption:*** The issue of social isolation in older adults falls within the practice of occupational therapy, and occupational therapists have the skills necessary to create and implement community-based programs to address this issue (AOTA, 2016; Bacsu et al., 2012; Smallfield, Haag, Poston, Giger, Anderson, 2014; Dickens et al., 2011; Steultjens et al., 2004; Vogelsang, 2016). One way that occupational therapists can address this issue is through aging in place programming. Overall, the purpose of this scholarly project is to assist occupational therapists in addressing social isolation in community-dwelling older adults. The product is a review of aging in place programs to

help occupational therapists determine which programs may be best suited for their community.

### **Key Terms and Concepts**

Key terms and concepts used in the product and literature review include:

- **Older adult:** for the purpose of the scholarly project, an older adult is defined as a person over the age of 65 years.
- **Aging in place:** living relatively independently within the community, making necessary adaptations or modifications to various environments or occupations as one ages, versus living in residential care or a nursing home facility (Wiles, et al., 2011, p. 357).
- **Community-dwelling:** a person who live independently in their home as opposed to a nursing home or assisted living facility (Steultjens et al., 2004). Examples include single-dwelling homes, apartments, and senior living communities.
- **Community-based services:** services occurring outside of an institutional setting to serve individuals that live in their own homes within a given community (US Legal, 2016).
- **Person Environment Occupation (PEO) Model:** an occupational therapy practice model that observes the transactive relationships between a person, the environment, and valued occupations (Hinojosa, Kramer, & Brasic Royeen, 2017).
- **Person:** within the PEO model, person is defined as a unique being who assumes many roles simultaneously and engages in valued occupations. The person is

defined through physical, cognitive, sensory, affective, and spiritual components (Hinojosa et al., 2017).

- **Environment:** within the PEO model, environment is defined as what surrounds a person. This includes physical, social, cultural, institutional, and virtual components of the environment (Hinojosa et al., 2017).
- **Occupation:** within the PEO model, areas of occupation are defined as self-care, productivity/work, leisure, and rest/sleep (Hinojosa et al., 2017).
- **Occupational performance:** a dynamic process involving coordination of person, environment, and occupation. This construct is measured based on a client's satisfaction of their performance (Hinojosa et al., 2017).
- **Socialization:** the activity of mixing socially with others (Merriam-Webster Online, n.d.).
- **Social isolation:** a noteworthy reduction or lack of frequency and length of socialization (Steptoe et al., 2013).

The remainder of the scholarly project will progress as follows; chapter II presents the results of the literature review and an overview of the final scholarly project. Chapter III presents the methodology and activities used in the development of the product. The product is available in Chapter IV in its entirety. Finally, Chapter V is a summary of the scholarly project and includes the recommendations and limitations of the scholarly project.

## CHAPTER II

### REVIEW OF LITERATURE

As the baby boomer population ages, more adults are wanting aging in place services to live at home in their communities (Golant, 2008).

The graying of Americans calls for new solutions to enable older Americans to age in place in their communities of choice. Aging services offered at the local, state, and federal levels encompass a range of programs – like transportation, meal assistance, and home modifications – to help older people stay in their communities. Ideally, the service programs would be user-friendly and comprehensive. But instead, they are frequently a complicated maze characterized by significant gaps in the types of services offered and significant constraints on eligibility. Moreover, program funding does not often close to keeping pace with the rapid growth of the 65 and older population. Against this backdrop, many community grassroots initiatives have emerged, as local leaders and older adults search for options that are not readily available (American Institutes for Research, 2016).

The purpose of this scholarly project is to create a resource for occupational therapists to address social isolation in community dwelling older adults. The targeted population for this scholarly project are occupational therapists who work with socially isolated older adults. Occupational therapists can use this resource to compare characteristics of various aging in place programs to create an evidence-based program that will meet the specific needs of the community they are working with. It is proposed that this resource can be effectively used to creatively brainstorm programming ideas to help older adults build social networks and increase social participation in their community.

The literature review begins by presenting the trends and changing demographics that seem to be driving the needs for such aging in place programs. The concept of social

isolation is then explored and then transitions into social connections. There are eleven programs that have been reviewed with each program's pros and cons identified. These eleven were chosen based on meeting the following criteria:

- Inclusion criteria: social participation is an addressed outcome, the programs are implemented at community level (not in a nursing home or assisted living facility), and the majority of participants are older adults ages 65+.
- Exclusion criteria: programs do not address socialization.

### **Trends & Demographics**

Aging in place focuses on enabling older adults to maintain independence, autonomy, and social connections. Aging in place programs differ from home health care programs; AIP programs focus on long-term care coordination, and increasing the amount of time an individual lives independently at home, versus moving into a nursing home or assisted living facility. On the other hand, home health care programs focus on short-term post-hospitalization issues (Popejoy, 2015).

With many more people wanting to age in their home, families are opting to have family members stay in the home longer, causing a growing need for nurses and other home health agencies in this setting (Hyde, Perez, Doyle, Forester, & Whitfield, 2015). Trends have started to shift in the older adult population toward aging in the home as opposed to moving into assisted living or nursing homes (Lehning et al., 2015). Nine out of ten adults age 50 and older prefer to remain in their homes indefinitely as they age, or as long as they possibly can (AARP, 2006). In qualitative interviews with older adults, researchers found participants did not fear death, but instead feared institutional care;

prompting the discussion for the need for age-friendly environments which offer infrastructure and supports to meet older adults' needs, and allow them to remain involved in the community (Lehning et al., 2015; Vrkljan, Leuty, & Law, 2011).

Occupational therapists are key professionals able to address aging in place strategies for the older adult population (AOTA, 2016; Bacsu et al., 2012).

Aging in place considerations include not only housing but also access to transportation, recreational opportunities, proximity to essential services, social interaction, and cultural engagement (Wiles et al., 2011; Vrkljan, Leuty, & Law, 2011). Black, Dobbs, and Young (2015) found older adults are more likely to successfully age in the community when they have the following: meaningful involvement in the community; can effectively age in the home; are treated with respect and inclusion; have effective communication and access to information and services; have appropriate transportation and mobility; and have opportunities to maintain or increase health and wellbeing. People that spend more years living in their current dwelling were found to report higher levels of social participation and a greater sense of belonging in their community (Levasseur et al., 2015).

### **Social Isolation**

Socialization, or the activity of mixing socially with others, may be limited for older adults (Merriam-Webster Online, n.d.). Without appropriate aging in place services, many older adults are at risk for social isolation. Social isolation, or a lack of frequency and length of socialization, is prevalent in 7-17% of older adults due to various factors including decreased economic resources, physical impairments, fear of falling, depression, inaccessible entry and exits to building, lack of appropriate transportation,



limited community resources, death of social contacts, difficulty forming new social relationships, and social stigma relating to ageism (Dickens et al., 2011; Painter, et al., 2012; Levasseur et al., 2015; Masi, Chen, Hawkley, & Cacioppo, 2011; Sabir, et al., 2009; Steptoe et al., 2013; Vogelsang, 2016). People that are older, unmarried or have limited education levels are also more likely to be socially isolated (Steptoe et al., 2013).

### **Health Risks of Social Isolation**

A variety of negative physical and psychosocial factors impact socially isolated older adults. Older adults that are socially isolated are more likely to experience cardiovascular disease, infectious diseases, cognitive decline, diminished immune function, and death (Cacioppo & Hawkley, 2009; Cornwell & Waite, 2009; Steptoe et al., 2013). Older adults have an increased mortality risk, up to 50%, when lacking strong social supports (Dickens et al., 2011; Steptoe et al., 2013). The health risks posed by social isolation may be particularly impactful on older adults because they are more likely to experience stressful life events, such as health problems and deaths of loved ones (Cornwell & Waite, 2009). Loneliness is also a risk factor for depression, suicidal ideation, and suicidal behavior (Masi et al., 2011). Older adults with adequate social connections may cope better with stressful life events and experience reduced levels of stress overall.

### **Social Connections**

Many older adults value the importance of social connections and building age-friendly communities. In a study of 121 older adults, participants identified friendships and familiarity with their surroundings as important resources for aging in place (Wiles et al, 2011). Participants reported that it was important to live near people who “look

out” for them and would come to their aid if help was needed (Wiles et. al, 2011, p. 362). In this study, aging in place was viewed as a way to maintain a sense of connection to a community, provide familiarity and security, and maintain a sense of identity through autonomy (Wiles et. al, 2011). Environmental characteristics in the community, such as availability of grocery stores, health services, banking, pharmacies, social or sports clubs, and access to transportation affect rates of social participation in a given area (Dickens et al., 2011; Levasseur et al., 2015).

Social connectedness can be facilitated through aging in place programs in order to decrease the prevalence of social isolation in older adults. The programs presented in the next section demonstrate a variety of ways that aging in place programs have been implemented to target social isolation in older adults.

### **Aging in Place Programs Facilitated by Non-Occupational Therapy Professionals**

The following programs were facilitated by a variety of disciplines but were chosen because each program addresses social isolation or social participation and involves community-dwelling older adults. These programs include The Village Model, The Aging Well At Home Program, The Aging Gracefully Program, The inter-generational Active Ageing Programme, Men’s Sheds, and Tai Chi Qigong. All of the programs are led by non-occupational therapy personnel, and address social participation as an outcome. Table 1 compares the main points and then the narrative follows with more details.

**Table 1. Aging in Place Programs Facilitated by Non-Occupational Therapy Professionals**

<b>Program Name</b>	<b>Benefits</b>	<b>Challenges</b>	<b>Environment</b>	<b>Person</b>	<b>Cost Effectiveness</b>	<b>Outcomes Measures</b>
<p>The Village Model</p> <p>(McDonough &amp; Davitt, 2011; Quaterman &amp; Boggis, 2017; Scharlach, Graham, &amp; Lehning, 2012).</p>	<p>Services are directly focused on the needs of the community members, member-run program, empowers members, facilitates community engagement and improvement, focuses on active social participation, utilizes intergenerational volunteers</p>	<p>Volunteer burnout, over-involved volunteers, difficult to involve members with physical, cognitive, and psychosocial impairments, confidentiality issues, unstable funding sources, recruiting diverse members</p>	<p>Community-based</p>	<p>Members of the community, typically age 65 and older</p>	<p>Annual dues range from \$35-\$900, with an average cost of \$425</p>	<p>Decrease in institutionalization, social relationships, sense of community, increase in quality of life and overall health, and cost effectiveness</p>
<p>The Aging Well At Home Program</p> <p>(Gonvea &amp; Burnes, 2013)</p>	<p>Community liaison, warm houses, community forums, facilitates active social engagement, strengthens social connections, opportunity to share life experiences and practical information about community, decreases stress and loneliness, increases sense of self-efficacy</p>	<p>Facilitating enrollment, did not significantly decrease depression, slow startup time of warm houses</p>	<p>Densely populated urban area near Boston</p>	<p>Community-dwelling adults age 70 and over</p>	<p>Enrollment was free due to funding provided by the Harry and Jeanette Weinberg Foundation</p>	<p>Decreased stress and loneliness, increased self-efficacy and social connections</p>

<p>The Aging Gracefully Program</p> <p>(Gerson, Dorsey, Berg, &amp; Rose, 2004)</p>	<p>Proximity of staff to residents by hosting program at community living center</p> <p>Focus on culturally relevant material</p> <p>Increased rapport building between staff and residents</p>	<p>Lack of rigor, and no formal data collection</p> <p>Difficulties coordinating resident schedules for program</p>	<p>Low income 120 unit public housing apartment in an urban setting.</p>	<p>Older adult residents 65 years and over. Predominantly African-American and female</p>	<p>Minimal costs for holiday gifts, films, and light refreshments</p>	<p>Improved social interaction, participation, and responsiveness. Improved relationships between residents and health professionals</p>
<p>The Inter-generational Active Ageing Programme</p> <p>(Health, 2004)</p>	<p>Services are flexible and responsive to community needs.</p> <p>Community programming pairs adolescents and older adults for mutual support</p>	<p>Lack of rigor and formal outcome measures</p>	<p>A local high school in Speke, Liverpool . Speke is a remote low SES community in England.</p>	<p>Community members. Primarily adolescents and older adults</p>	<p>The program is led by volunteers. Community leaders will host educational sessions. Older adults visit adolescents in the high school</p>	<p>Measured through observational report. Increased community participation, intergenerational participation, self-esteem, and self-confidence.</p>
<p>Men's Sheds</p> <p>(AMSA, 2017)</p>	<p>High rates of participation and perceived benefits from members.</p> <p>Opportunity for kinship, and building social network</p> <p>Focus on engagement in leisure activities</p>	<p>Locating a setting for a Shed</p> <p>Organizing and funding Shed resources</p> <p>Recruiting volunteers to run the Shed</p>	<p>Multiple locations in communities throughout Australia.</p> <p>Examples of Shed locations include volunteer garages or community facilities</p>	<p>Men of all ages. Majority of members are older adults</p> <p>Some Sheds do allow female members to join.</p> <p>Men's Sheds often partner with other community agencies for projects and volunteering</p>	<p>Costs include a fee or rent for space, and funding for materials. Material needs are dependent on member interests such as wood-working or bike repair.</p>	<p>Over 1, 000 Men's Sheds in Australia. Described benefits from members include improved social participation, feelings of connectedness, and satisfaction with engaging in productive activities.</p>
<p>Tai Chi Qigong</p> <p>(Chan, Yu, &amp; Choi, 2017)</p>	<p>Rigor of study</p> <p>Combination of exercise with social participation</p> <p>Sessions led by older adult peer</p>	<p>Recruitment of older adult participants and volunteers.</p> <p>One month needed for volunteer training</p>	<p>Sessions held at local non-governmental facility for older adults twice a week for 60 minutes</p>	<p>Socially isolated, community dwelling, older adults 60 years and older. Active older adult volunteers</p> <p>Nurse and social worker coordinated and developed program</p>	<p>Possible rental fee for room. Minimal costs associated with print-outs and flyers</p>	<p>Significantly decreased loneliness, and significantly improved satisfaction of social support</p>

## **The Village Model**

The Village model is a volunteer driven, grassroots movement allowing older adults to govern and provide services within their community (McDonough & Davitt, 2011; Quarterman & Boggis, 2017; Scharlach, Graham, & Lehning, 2012). Volunteers in this model are community residents who wish to age in place and establish an organization to assist in this goal; volunteers also include intergenerational community members. There are over 200 operational Villages in the U.S., with volunteers providing services (Quarterman & Boggis, 2017). A majority of Villages are free standing; some are affiliated with another agency, such as social service agencies or residential care facilities (Scharlach et al., 2012). There is an administrative role within this model, and staff for the Village are responsible for coordinating care, vetting volunteers, and providing training for care services (McDonough & Davitt, 2011; Quarterman & Boggis, 2017; Scharlach, Graham, & Lehning, 2012). Members typically pay an annual fee and the organization is nonprofit.

### **Benefits.**

The Village model allows the community to respond to the needs of its members, allowing older adults to age in place. Within this model, services are directly focused on the identified needs of community members, thus making the model flexible and adaptable as needs may change or vary (McDonough & Davitt, 2011). Fundamental aspects of this model are civic engagement and community development (McDonough & Davitt, 2011). A core concept of the model is empowerment; members are empowered to improve the community in which they live and to meet various needs. Even the most frail or disabled members are encouraged to use their talents and skills to help solve problems

and design programs, thus helping members develop a sense of personal competence (McDonough & Davitt, 2011). Members may become advocates for better services and resources within the community. This not only affects members within the model, but also members of the greater community as well.

Members of the model share a purpose, and participating in the model creates a network of social relations for the older adult (McDonough & Davitt, 2011). Within this model, members recognize the importance of social engagement and the valuable role that older adults can play in the community. Community engagement activities may vary, including potluck dinners, book clubs, and educational programs (McDonough & Davitt, 2011). These activities are facilitated in order to create a greater sense of mutual support for all community members, including those who are socially isolated (McDonough & Davitt, 2011). Volunteers may also provide companionship to members (Scharlach et al., 2012).

Villages focus on building relationships and shared experiences to encourage active social participation. This is completed through one-on-one interpersonal exchanges and through group-based activities, such as program planning. Intergenerational volunteers are also involved in this model, which helps to facilitate intergenerational relationships and enhances awareness of issues that older adults face in the community (McDonough & Davitt, 2011). Members also work to receive discounted pricing from a variety of related vendors for those who are in the program. Villages are often facilitated by an executive director and may employ a social worker or volunteer coordinator if needed. Social workers in this role may assess and identify community needs, foster a

sense of commitment to the village, connect members to resources and support, and advocate for services (McDonough & Davitt, 2011).

### **Challenges.**

A challenge that may present within this model is volunteer burnout. Each member is a unique individual with their own set of personal boundaries. If there is a dynamic of dependency on a member, he or she may experience burnout, which decreases his or her ability to serve within the model and decreases the likelihood of volunteering in the future (McDonough & Davitt, 2011). Another possible challenge is an over-involved volunteer, which may threaten the autonomy of an older adult member. It also may be difficult to involve members with physical, cognitive, and psychosocial impairment (Scharlach et al., 2012). Yet another possible challenge is a breach of confidentiality. This model depends on a sense of confidentiality when members request services, and a breach of trust may harm the relationship between members and volunteers (McDonough & Davitt, 2011). Social workers may be beneficial to address these challenges by helping members and volunteers identify boundaries at the beginning of service delivery, and by training volunteers on the importance of confidentiality and autonomy. Other possible challenges include community buy-in, funding, and sustainability. Since the model is dependent on membership dues to fund services, a solid membership base must be developed.

The sustainability of each Village may be threatened due to unstable and varying funding sources. Other potential funding sources are donations and grants (Scharlach et al., 2012). It is equally important to generate a volunteer base to serve the members of the model. Likewise, it may be difficult to implement this model in a low-income community

due to the requirement of a membership fee. Another challenge is recruiting diverse members. Models may focus on the needs of a majority of the population, without addressing needs of minority populations or economically disadvantaged older adults (Scharlach et al., 2012). Also, because the Village model is relatively new, there is little research to support efficacy (McDonough & Davitt, 2011). Research is needed to identify the effect of the model on outcomes such as premature institutionalization, quality of life, overall health, cost effectiveness, and more (McDonough & Davitt, 2011). An increased research base may facilitate policy changes and financial support for Village programs. Lastly, not all necessary aging in place services are available at a volunteer level or through community services, depending on what is available within the community.

#### **Related Factors.**

This model is conducted in a community-based setting; according to McDonough & Davitt (2011), the model has not been expanded into low-income communities. The model is typically facilitated by members of the community; volunteers within the model may be members of the model or intergenerational members of the community. A social worker may be beneficial in a variety of roles, including needs assessment, program development, volunteer training, and community advocacy. Participants in the model are community-dwelling older adults. Scharlach et al. (2012) found that 95% of Village members are white, 2% are African-American, and less than 1% are Asian, Latino, or another race/ethnicity. Nearly 90% of members are age 65 and older (Scharlach et al., 2012). Almost all members live alone or with a partner (Scharlach et al., 2012).

Members of this model are required to pay a membership fee, which may vary among communities. Annual dues range from \$35 to \$900, with an average cost of \$425



(Scharlach et al., 2012). In a study by Scharlach et al. (2012), half of the Villages offered a discounted membership fee, which ranged from zero to \$150, with an average cost of \$100. Outcomes of this may include a decrease in institutionalization, social relationships and a sense of community, an increase in quality of life and overall health, and cost effectiveness (McDonough & Davitt, 2011). In a study of 30 Villages by Scharlach et al. (2012), primary goals included aging in place, serving older adults, promoting independence, quality of life, community assessment, linking members with information and services, safety, empowerment, community and social engagement, and connecting members to volunteers.

### **The Aging Well At Home Program**

The Aging Well At Home (AWAH) Program was designed to support the physical and psychological well-being of seniors that are aging in place (Gonyea & Burnes, 2013). A key focus of the AWAH program is to “put the connection back into community” (Gonyea & Burnes, 2013, p. 333). In a study by Gonyea & Burnes (2013), three outcomes were evaluated before and 9 months after implementation of the AWAH program: perceived stress, loneliness, and depression. Stress was measured using the 10-item perceived stress scale (PSS); loneliness was assessed using the 20-item UCLA Loneliness Scale. Depression was measured using the Geriatric Depression Scale (GDS)-Short Form (Gonyea & Burnes, 2013). AWAH’s core objectives include the reduction of daily stresses and the building of social connection.

#### **Benefits.**

AWAH consisted of 3 parts: community liaison, warm houses, and community forums (Gonyea & Burnes, 2013). The community liaison connected with participants

through home visits, phone calls, and invitations to social events. The liaison was available 9 a.m. to 5 p.m. during weekdays to help participants with daily problems and hassles, such as household tasks or the loss of a loved one (Gonyea & Burnes, 2013). Warm house events were used in the AWAH program as an opportunity for community members to go to neighbor's homes for social, cultural, or recreational events, such as meals or cultural activities (Gonyea & Burnes, 2013). These events facilitated engagement among participants living in a given area. They were also used to create and strengthen social connections and provide the opportunity to share life experiences as well as practical information about community resources (Gonyea & Burnes, 2013). Community forums were used in order to gather input from participants to further refine the program.

The AWAH program was found to significantly decrease stress in participating seniors (Gonyea & Burnes, 2013). It also reduced perceived loneliness in a majority of participants, although this finding was not statistically significant. A majority of participants reported a greater sense of self-efficacy and social connection after participating in the program (Gonyea & Burnes, 2013).

### **Challenges.**

One major challenge was facilitating enrollment in the program. Many community members expressed interest in AWAH, but few initially enrolled. This may be due to a strong sense of personal autonomy and independences among seniors (Gonyea & Burnes, 2013). Another challenge was that the AWAH program did not significantly decrease depression scores. Yet another challenge was the slow startup time of warm houses and community forums. These activities required a mass of participants

to facilitate; participants also had to be recruited in order to host the warm house events (Gonyea & Burnes, 2013). Due to these factors, a lesser number of community forums and warm houses were available during the AWAH program.

### **Related Factors.**

The AWAH program took place in a densely populated urban neighborhood near Boston, Massachusetts. The program was designed and facilitated by the Jewish Family & Children's Service of Greater Boston to support aging in place of low- and moderate-income seniors (Gonyea & Burnes, 2013). Participants were 70 years and older, 85% of which were white women; 33 people participated in pre- and post-program evaluations. Enrollment in the program was free due to funding provided by the Harry and Jeanette Weinberg Foundation (Gonyea & Burnes, 2013). Outcomes of the program included decreased stress and decreased loneliness. Outcomes also included an increase in perceived self-efficacy and social connections (Gonyea & Burnes, 2013).

### **Aging Gracefully Program**

Developed by the faculty at Johns Hopkins School of Nursing, the Aging Gracefully Program focuses on preventing social isolation, enhancing positive self behaviors, and offering resources to maintain independence and cope with the aging process (Gerson, Dorsey, Berg, & Rose, 2004). Group sessions were held every 6-8 weeks with 7 total sessions (Gerson, et al., 2004). The seven sessions included 1) Holidays, 2) Recognizing the Blues 3) Coping with Stress 4) Coping with Physical Changes of Aging 5) Spring Renewal 6) End- of -life 7) Love Stories (Gerson, et al., 2004). The overall theme of the sessions was on storytelling, and allowing residents to

connect with each other by focusing on positive aspects of their lives (Gerson, et al., 2004)

### **Benefits.**

The major benefit of this program includes the increase in social participation and responsiveness reported by the staff. One resident stated, “I feel at home with these nurses” (Gerson, et al., 2004, p. 274). Another benefit is the proximity of staff to residents which allows for more rapport building with the health care professionals. The program also focused on culturally relevant material and values important to the participants.

### **Challenges.**

The faculty and nursing staff did not participate in any formal data collection, and outcomes are only represented through observation. Another challenge was coordinating scheduling times with the older adults. This was resolved by having flexible starting times, and actively seeking out individuals for participation (Gerson, et al., 2004). Another factor was using a space large enough to accommodate older adults with mobility aids. Lastly, the program was developed by nursing staff, and does not reflect occupation based outcomes needed for an occupational therapy program. However, many of the themes could be revised to implement an occupational therapy perspective.

### **Related Factors.**

The program was held in a low income 120 unit public housing apartment in an urban setting for older adults 65 years and older. A partnership was formed between three faculty members at a local university, and the nursing staff at the apartment complex (Gerson, et al., 2004). The nursing staff include a community health nurse available daily,

and a nurse practitioner available 8 hours a day at the wellness center (Gerson, et al., 2004). The residents of the apartment are 65 years and older, with predominantly African American and female residents (Gerson, et al., 2004). Approximately 8-10 residents attended each session (Gerson, et al., 2004).

Though cost-effectiveness was not explicitly addressed, the program was held at the apartment complex which reduced transportation costs. Most sessions involved discussion and storytelling with minimal need for supplies. Some supplies for the sessions included small gifts for the holiday session, a film about depression for identifying the blues session, a film on end-of life decision making for the end of life session, and light refreshments provided at each session (Gerson, et al., 2004). Additional compensation was not needed, as a nurse was already present at the apartment building to implement sessions. Program outcomes included improvement in social interaction, participation, and responsiveness as well as building relationship with health professionals (Gerson, et al., 2004).

### **Inter-generational Active Ageing Programme**

Diane Brennan a nurse from Speke, Liverpool developed an inter-generational program for older adults in the community (Heath, 2004). The focus of the events hosted at the local school aim to reduce social isolation, anti-social behavior, and fear of crime in the community (Heath, 2004). Examples of sessions include discussions on dentistry, Tai Chi, healthy eating, drama productions, and computer skills. The sessions bring high school students and older adults in the community together to learn from each other (Heath, 2004).

### **Benefits.**

The benefits of this program include the flexibility to be responsiveness to community needs and desires. The event content is not a structured format, but is decided as needs arise, or interests in topics are expressed. Both the older adults and younger participants benefit. Older adults have improved self-esteem, confidence, and sense of purpose through their interactions with the younger generation. The younger generations are able to learn skills, history, and social awareness from older adults, and form relationships with older adults in their community.

### **Challenges.**

The challenges of the program include a lack of identified research for program content, and informal outcome measurement. Funding is also an issue as the program relies on volunteers to host sessions, and coordinate events. The program is developed and led by a nurse, and the sessions do not always represent an occupational perspective on health and social engagement.

### **Related Factors.**

The sessions are held at the local school every Friday throughout the school year in a classroom. The exact demographics of the participants are not explicitly stated, but are described as older adults living in the community. The examples of participants were all over the age of 65 years old. The younger generation is high school age with examples of students around the age of 15 years old. Event hosts include community leaders and health care professionals such as nurses, doctors, police officers, and firefighters. The costs of the program are not explicitly stated, but sessions are based on volunteer participation. This makes overall costs minimal. Formal outcomes are not explicitly

measured, but is reported through observation. Outcomes include increased inter-generational participation, increased community participation, and increased sense of confidence and self-esteem as reported by the program creator (Heath, 2004).

### **Men's Sheds**

Men's Sheds are locally run programs started in Australia to foster health and well-being among Australian males (AMSA, n.d.). Each shed has a unique focus including productivity, education, health, and community outreach. Men's Sheds are open to men of all ages with an emphasis on older adult males in order to increase health outcomes. Men's Sheds are an extension of the typical backyard shed. Men who are members of the shed can come and work on projects such as wood-working, bicycle repair, furniture building, learning to cook, gaining computer skills, or any other hobbies members are interested in. The secondary outcomes are men have a social network which improves feelings of connectedness and well-being. The Australian government has partnered with local sheds for educational purposes for improved health outcomes. Men's Sheds also partner with local community agencies to donate their time and resources. There are over 1,000 Men's Sheds in Australia. The described benefits from members are improved social participation, increased feelings of connectedness to the community, and satisfaction at the opportunity for productivity and meaningful engagement in activity.

#### **Benefits.**

The benefits of this program are the high rates of participation, and perceived benefits from members. Men typically have lower rates of participation in health promoting wellness activities. Culturally, men do not readily discuss feelings or emotions. Men's Sheds provide an opportunity for kinship, and a place for men to build a

strong social support network. Though the program is not managed by an occupational therapist, there is opportunity for an occupational therapist to consult with the organization or develop a program plan. As the focus of Men's Sheds are occupational engagement, occupational therapists could offer strategies and resources for adapting activities for older members.

### **Challenges.**

The challenges in implementing a Men's Shed program is locating a place for the Men's Shed within the community. Once a setting is established, a network of volunteer men will need to be recruited to oversee the facility management and address membership. There is also the need to gather some materials and equipment to facilitate the projects members are interested in completing.

### **Related Factors.**

Men's Sheds can be located at any convenient location. Some are located in volunteer garages or community facilities. Participants can be any age, but most tend to be older adults. Some sheds also allow women into the organization, but the majority of participants continue to be male. Cost-effectiveness is a concern as materials and supplies for projects can be costly. Most resources, however, are donated by the members of the shed.

### **Tai Chi Qigong**

Tai chi qigong is an ancient Chinese form of exercise focusing on meditative movement with a mind body connection, and is an evidence based form of treatment for older adults (Chan, Yu, & Choi, 2017; Rogers, Larkey, & Keller, 2009). In a community program designed to engage socially isolated older adults, a nurse and social worker



created a volunteer led tai chi qigong class for the community. The volunteers were active seniors in the community, and received four weekly training sessions before leading the classes. Groups consisted of no more than 15 participants who were 60 years of age or older. The sessions were held twice a week for 60 minutes, and participants were encouraged to self-practice 30 minutes each day. Social support outcomes were measured using the Lubben social network scale, the De Jong Gievelde loneliness scale, and revised social support questionnaire. Secondary outcomes were measured using the mental health inventory, Rosenberg self-esteem scale, and the 12 item Short Form Health Survey measuring quality of life.

### **Benefits.**

The benefits of this program include the measured outcomes on social participation and the rigor of the study. The study is a pilot randomized control trial with one group receiving standard care, and the other group participating in the tai chi qigong class.

### **Challenges.**

The challenges of the program include recruitment of older adults for both participating in the session, and leading the session. There is also a need for training of the volunteers which requires weekly sessions for a month.

### **Related Factors.**

Sessions were held at a local non-governmental older adult facility in the community. The participants of the program include 48 older adults who are socially isolated and 60 years old or older, with half participating in tai chi qigong and the other group receiving standard care. Sessions leaders were eight active older adult members of

the community, and a nurse and social worker coordinating the program. Cost-effectiveness was not explicitly stated, but could be determined as minimal expenditures due to the volunteer aspect of the sessions. Some costs associated with printing of hand-outs and possible costs associated with renting the room. The outcomes included significantly decreased loneliness, and significantly improved satisfaction of social support compared to the standard group (Chan, et al., 2017).

A variety of allied health professionals and organizations address social isolation and social connection in community-based programming. Nurses, social workers, and older adult volunteers are able to address aspects of social isolation in older adults. However, occupational therapy is another allied health profession which can positively impact social participation in this population. Occupational therapists are able to address the complex interplay of mental health and community environment influencing social participation in the older adult population.

### **OT and Social Isolation in Older Adults.**

Occupational therapy that focuses on addressing social isolation in older adults can lead to positive outcomes, such as increased social support and increased physical and mental health (Smallfield et al., 2014). In a systematic review of 32 studies aimed at reducing social isolation in older adults, three key characteristics were found in each effective intervention. Effective interventions were developed using a theoretical basis, offered social support/activity within a group format, and participants were active in the intervention (versus a passive approach, often used in educational groups) (Dickens et al., 2011). The reviewed interventions included social/physical activity programs, support

programs (discussion, counseling, therapy, education), home visits, internet training, and service provision (Dickens et al., 2011).

In another systematic review, Sabir et al. (2009) reviewed 14 randomized control trials that targeted social isolation. Targeted outcomes included the reduction of social isolation and loneliness, an increase in social activity level, network size, social supports, and social integration. Effective interventions were found to have five characteristics in common: they were group interventions, they targeted specific groups, they used experimental samples from a target population, they enabled participation control or input, and they were developed within an existing community organization (Sabir et al., 2009).

Despite the effectiveness of social isolation interventions, there are minimal occupational therapy programs targeting social isolation in the older adult population. Of these programs, five are described in detail. These include Well Elderly 2, Designing a Life of Wellness Program, Let's Go!, Aging Well by Design, and Connecting to Community Program. All of these programs are led by an occupational therapists, and have a social participation outcome.

**Table 2. Aging in Place Programs Facilitated by Occupational Therapists**

Program Name	Benefits	Challenges	Environment	Person	Cost Effectiveness	Outcomes Measures
Well Elderly 2 (Clark et al., 2012)	Consistent facilitator, facilitator training required, community outings, education on a wide variety of relevant topics	High cost per participant, on average each participant attended only 56% of program sessions	Los Angeles metropolitan area	Adults between 60-95 years old	\$783 per participant; was determined to be cost-effective by the UK National Institute of Health and Clinical Excellence	Increase in vitality, social function, and mental health
Designing a Life of Wellness Program  (Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003)	Education on a wide variety of relevant topics, facilitated group discussion related to barriers and problem-solving, used homework to generalize knowledge to real-life experience, community outings, increased social participation	Lack of adequate transportation, varied participation rates	3 senior high rise communities	Adults between 70-92 years old	Enrollment was free due to funding by two grants and an independent contract	Increase in social functioning, vitality, mental health, social and community participation, and quality of life
Let's Go  (Mulry, Papetti, De Martinis, & Ravinsky, 2017)	Resources are tailored to each individual's needs, one-on-one support, problem solving assistance	Difficult to find funding to implement program long-term	Urban areas of New Jersey	Community-dwelling older adults with aphasia who were concerned about their ability to transport themselves within the community	Enrollment was free due to outside funding	Increased frequency of community-based occupations and outings, confidence in community mobility
Aging Well by Design  (Cassidy, Richards, & Eakman, 2017)	Program based off of Lifestyle Redesign Program at USC  Extensive resources available  Occupation focused	Allotting enough time for recruitment  Scheduling 10-14 hours per week for class preparation	Conference room in rehabilitation department of large hospital  Sessions held weekly for 12 weeks	13 Community dwelling older adults aged 65 years and older who passed Mini- Cog  Led by occupational therapist	Funding provided by hospital for room and supplies. Each participant received a three ring binder with handouts	Improved social relationships, awareness of community resources, and positive attitude towards aging process
Connecting to Community Program  (Smallfield, Haag, Poston, Giger, Anderson, 2014)	AARP funded program.  Participants keep iPad after successful completion  Technology skills training to increase social participation	Recruitment of volunteers and participants for weekly sessions for 6 months	Local senior housing in South Dakota	Older adults in the community.  Volunteer OT students and social work students.  Partnered with University of South Dakota	Funded by AARP.	Increased social communication using the iPad, increased satisfaction in relationships, and increased social interaction with other course participants.

## **Aging in Place Programs Facilitated by Occupational Therapists**

### **Well Elderly 2**

The Well Elderly 2 program is a preventative lifestyle-oriented intervention aimed at improving well-being in older adults (Clark et al., 2012). In this study, participants were randomly assigned to intervention or non-treatment control groups. The intervention participants received both group and individual sessions. The program consisted of weekly 2 hour small group sessions and up to 10 individual sessions over a 6 month period (Clark et al., 2012).

#### **Benefits.**

Each group session had between 6-8 members and was lead by a consistent facilitator throughout the program. Monthly community plannings were also used in the program so that participants could gain direct experience implementing what they learned, such as using public transportation (Clark et al., 2012). The program content focuses on:

- Impact of everyday activity on health
- Time use and energy conservation
- Transportation utilization
- Home and community safety
- Social relationships
- Cultural awareness
- Goal setting
- Changing routines and habits (Clark et al., 2012, p. 783).

**Challenges.**

On average, each participant attended only 56% of program sessions. The cost of the program was an average of \$783 per participant (Clark et al., 2012). Although significant improvement was demonstrated in a variety of outcomes, no intervention effect was reported for cognitive outcomes.

**Related Factors.**

The program took place at community-based sites in the Los Angeles metropolitan area. Each session in the program was facilitated by an occupational therapist. Facilitators completed 40 hours of training on the program protocol prior to carrying out interventions. Participants were 460 older adults ages 60-95 years old. Participants were recruited through sign-up booths, presentations at meeting and social events, and by handing out flyers and posters (Clark et al., 2012). The intervention cost was \$783 per participant, or a total of \$41,218. However, according to a cost per quality-adjusted life year (cost per QALY), this program was determined to be cost-effective by the UK National Institute of Health and Clinical Excellence standards (Clark et al., 2012).

Outcomes of the study included: perceived mental and physical health, mental (psychosocial) well-being, and cognition measures (Clark et al., 2012). Perceived physical health and well-being were measured using the 36-Item Short-Form Health Survey. The Center for Epidemiologic Studies Depression (CES-D) was used to assess depressive symptoms. The Life Satisfaction Index-Z was used to measure life satisfaction. Cognitive outcomes were measured using the Consortium to Establish a Registry of Alzheimer's Disease (Clark et al., 2012). After completing the program, participants demonstrated a significant improvement in perceived body pain, vitality,

social function, and mental health (Clark et al., 2012). Overall, the program had a greater impact of mental, rather than physical, well-being. This program demonstrated that a 6-month preventative lifestyle intervention has positive effects on a sample of ethnically diverse older adults (Clark et al., 2012).

### **Designing a Life of Wellness Program**

The Designing a Life of Wellness Program is a pilot occupational therapy program created to educate older adults on the importance of social and community participation and to reduce barriers to participation (Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003). The program took place over an 18-month period; 6 months of weekly educational classes were given at 3 separate senior communities. Each class was 1 ½ hours long.

#### **Benefits.**

At each site, a program syllabus was provided to participants discussing the topics that would be covered, including transportation, aging, safety and falls prevention, stress, lifestyle balance, and communication (Matuska et al., 2003). Participants discussed barriers for each relevant topic and problem-solved solutions in a group format. Participants were also given “homework” related to each topic to apply to their everyday lives (Matuska et al., 2003). At the end of each session, time was given for spontaneous socialization. Once per month, each group arranged a community outing to a place of their choosing, in place of meeting at the typical site. After completing the program, participants reported increased frequency of communicating with family, friends, and supports at least 3 times per week (Matuska et al., 2003). Participants were also reporting doing more frequent outdoor, social, and community activities.

### **Challenges.**

Lack of adequate transportation was an issue for participants who no longer drove; participants who were unable to drive attended fewer sessions and community outings than participants with a license. Thus, nondrivers reported less significant increases in quality of life from the program. There were varied participation rates for each session.

### **Related Factors.**

The programs were held in community rooms at three different senior high rise communities. Each class within the program was facilitated by at least two occupational therapists and was assisted by occupational therapy students on a Level II fieldwork. The program was funded by two grants and an independent contract. Participants did not have to pay for the program. A total of 65 participants ages 70-92 took part in the program; participants were Midwestern urban and suburban communities (Matuska et al., 2003). Outcomes were measured using the SF-36 health survey, which measures general health, social functioning, role performance, mental health, bodily pain, and vitality (Matuska et al., 2003). After the program, participants' scores were significantly higher in the areas of social functioning, vitality, and mental health. Participants also reported an increased frequency of social and community participation and an increased overall quality of life (Matuska et al., 2003).

### **Let's Go**

The Let's Go program is a community-based program in which participants identify their community-based occupations and examine the barriers and supports they experience related to community mobility (Mulry, Papetti, De Martinis, & Ravinsky,



2017). The focus of the Let's Go program is to help older adults understand alternative transportation, encourage its use, and facilitate practice. Practice occurs through homework and peer-supported trips (Mulry et al., 2017). The program is 4 weeks long and consists of 45-minute group education sessions, followed by 15- to 30-minute one-on-one sessions. In the final week of the program, participants attended community outings using the alternative transportation options. The session topics were: benefits of and barriers to community mobility, alternative transportation options, and community safety (Mulry et al., 2017).

### **Benefits.**

Resources in the Let's Go program are tailored to each participant's individual needs; participants in the program receive one-on-one support and problem solving assistance (Mulry, et al., 2017). During group sessions, participants used collaborative problem solving to overcome barriers, which helped build their confidence to engage in community mobility (Mulry et al., 2017).

### **Challenges.**

Third party payers, such as insurance, do not typically fund community mobility training. Thus, it may be difficult to find funding to implement this program in the long-term. There is a lack of funding for wellness and prevention programs in general, and so the availability of community mobility programs to older adults is limited (Mulry et al., 2017).

### **Related Factors.**

The program took place in urban areas of New Jersey. The program was facilitated by a team of occupational therapists. Participants were 52 community-dwelling

older adults with aphasia who were concerned about their ability to transport themselves within the community. The program was free to participants. Outcome measures included the Impact on Participation and Autonomy Questionnaire (IPAQ), a participant survey, and semistructured interviews (Mulry et al., 2017). The IPAQ measures someone's perception of the impact of chronic disability on participation (Mulry et al., 2017). After the program, participants reported significant increases in frequency of community-based occupations, confidence in community mobility, and community outings (Mulry et al., 2017). Other qualitative themes included decreased feelings of social isolation and increased peer support. Participants' perception of autonomy and satisfaction with their social life also improved.

### **Aging Well by Design**

Cassidy, Richards, and Eakman (2017) examined the feasibility of implementing an Aging Well by Design program based off of Lifestyle Redesign for community dwelling older adults. The original Lifestyle Redesign is a 6-9 month resource intensive program. The Aging Well by Design program was tested to determine the feasibility of a 3 month program covering the same topics as Lifestyle Redesign including:

- The Power of Occupation
- Health and Aging: Changes in Occupation
- Meaning and Identity
- Life Balance: Time and Energy
- Health through Occupation: Physical and Mental Activity
- Dining as an Occupation
- Transportation and Occupation

- Social Relationships
- Community and Home Safety
- Celebration and Closing (Cassidy, et al., 2017).

The program was led by an outpatient occupational therapist in collaboration with a large hospital. Participants were encouraged, but not required, to attend individual sessions to identify goals. In the exit interviews, the researchers identified three themes from participants including the benefit of social relationships formed from the program, the awareness of community resources, and the change in attitude towards aging (Cassidy, et al., 2017).

### **Benefits.**

The Aging Well by Design program offers multiple benefits for occupational therapists. It is based off the Lifestyle Redesign program created by USC which has a variety of research backing its efficacy, as well as continuing education and resources. The program offers a more compressed time frame compared to the Lifestyle Redesign program, and covers one topic per week (Cassidy, et al., 2017). The program offers a variety of information and resources relating to aging in place which is beneficial to older adults living in the community. Though not explicitly measured as an outcome, social participation was described as a benefit of the program through qualitative interviews with participants.

### **Challenges.**

There are a few challenges related to implementation of the program. One challenge is allotting enough time for participant recruitment. The researchers spent four weeks advertising, and suggested this amount should be increased (Cassidy, et al., 2017).

Another challenge is advocating for the time needed to implement the program as approximately 10-14 hours is need per week to prepare for and run the classes. Another factor to consider is the location of the meetings, as the meeting room is the study was free to the researcher, centrally located, and conveniently located for participants

### **Related Factors.**

Meetings were held in a conference room in the rehabilitation department at a large hospital setting (Cassidy, et al., 2017). Thirteen community dwelling older adults participated in the program which was led by an occupational therapist (Cassidy, et al., 2017). Researchers determined the program was a feasible option for a large hospital setting, and the shortened length decreased costs for the facility (Cassidy, et al., 2017). Supplies for the program included three ring binders for each participant, name tags, dry erase markers, dry erase board, photocopied hand-outs, and light refreshments. The occupational therapist was allowed work time for the program which amounted to about 10 hours per week, and an additional 4 hours per week was needed per a hospital volunteer to assist with various tasks.

The program was determined to be effective and feasible in the shortened three month period (Cassidy, et al., 2017) with 13 participants attending an average of 10 of 12 sessions with group sessions each week for 12 weeks (Cassidy, et al., 2017). Participants described the benefit of social relationships resulting from the program, as well as awareness of community resources, and a more positive attitude towards aging after completing the program (Cassidy, et al., 2017)

## **Connecting to Community Program**

Many older adults do not use virtual technology for social participation; this may be due to a lack of knowledge about virtual technology use and the benefits that it may offer. The AARP Foundation pilot tested a program to help older adults learn how to use technology for social participation in order to decrease social isolation, which is known as the 'Connecting to Community' program. The 6-month, 3 part program helped participants learn how to run an iPad, operate applications and social networking sites, and use wireless Internet (Smallfield, Haag, Poston, Giger, Anderson, 2014). Participants that completed the full program were allowed to keep their iPad; public wireless Internet access was also made available at each facility. Participants reported an increase in self-esteem and confidence in their ability to learn new things and a more positive outlook on technology. Participants also used their iPads for other meaningful activities, such as reading the news, discovering new recipes, blogging about the weather, playing games, completing puzzles, reading online books from the local library, and sharing inspirational quotes (Smallfield, Haag, Poston, Giger, Anderson, 2014).

### **Benefits.**

The benefits of this program include the focus on meaningful social participation through technology, and increased technology skills. This is also an AARP piloted program, with access to funding and program resources. Participants have a financial incentive to participate and complete the program in order to keep the iPad at the end of the program.

### **Challenges.**

The main challenges, though not explicitly stated, would be recruitment of both volunteers and participants. In this article, the program paired the University of South Dakota Departments of Occupational Therapy and Social Work with local senior housing. The coordination of volunteers with participants would be the main challenge especially considering the 6 month length of the program with session and lab each week.

### **Related Factors.**

Participants met at a local senior housing community. This program involved 55 older adult participants from senior housing communities in South Dakota. The program was put on by 11 occupational therapy graduate students, 6 older adult volunteers, and 1 social work student. The program is cost-effective due to funding from AARP which pays for the iPads and wireless internet. The most resource intensive aspect of the program is the time committed to both weekly lab times and weekly 90 minute program sessions. The outcomes of this intervention included increased communication with family, friends, and former co-workers, increased satisfaction in relationships from digital media exchange (for example, a video of a grandchild taking her first steps), increased social participation with other participants in the course, and intergenerational relationships between the course instructors and the participants (Smallfield, Haag, Poston, Giger, Anderson, 2014).

There are a variety of programs available which aim to address the needs of the older adult population. Many of the programs are being implemented by various allied health professionals and community organizations including social workers, community volunteers, nurses, and students. In addition, occupational therapists have the skills and

knowledge to address these issues. However, only 2% of occupational therapists identified as working in a community-based setting, despite the need for these services (AOTA, 2015).

### **Introduction to Community-Based Occupational Therapy**

As the research has shown, aging in place services are in demand and occupational therapists are well equipped to meet the needs of older adults within the community. Community-based occupational therapy targets the needs of a the older adult population and focuses on health promotion and prevention (Scaffa, 2014). A systematic review of occupational therapy for community dwelling older adults concluded that comprehensive community-based occupational therapy can have significant positive outcomes on functional ability, socialization, and quality of life (Steultjens et al., 2004; Vogelsang, 2016).

Older adults want to age in their community. In order to age in place effectively, communities require the infrastructure to meet the needs of older adults. These needs include age-friendly transportation, accessible housing and communities, and programs addressing health and wellness issues for older adults (Black, Dobbs, and Young, 2015; Wiles et al., 2011; Vrkljan, Leuty, & Law, 2011). Without these systems in place, older adults are at risk for decreased health outcomes and social isolation.

Occupational therapists are well equipped to meet these community needs. However, some occupational therapists may feel at a loss on how to begin implementing aging in place programming to address social isolation. Busy practitioners benefit from having information organized in one convenient location. A model creates an easy to use framework to organize information, and a common language to address various aspects

of occupation. For this program, the Person-Environment-Occupation Model is utilized to organize the product.

## **The Friendly Neighbor: Community Programming for Socially Isolated Older**

### **Adults**

#### **Theory**

The Person-Environment-Occupation Model (PEO), offers a framework for understanding the unique needs of individuals, populations, and communities (Turpin & Iwama, 2011). PEO focuses on the relationship between the person, environment, and occupation factors unique to the given client. Each domain is analyzed separately, and then the interactions among the three domains are analyzed to guide intervention. These interactions include the relationship between person factors and the environment, person factors and occupations, and occupations with the environment. The goal is to improve occupational performance by improving the fit between these three components.

This product includes an analysis of the older adult population by analyzing the person, environment, and occupation factors of community dwelling, socially isolated, older adults. The person factors include physical, cognitive, sensory, affective, and spiritual components. When determining programming for this population, it's important to note older adults may have decreased strength and endurance, impaired memory and judgment, and decreased sensation. Older adults are at a life stage which focuses on reflection of relationships over the lifespan, and emphasis on values and beliefs relating to spirituality. The environmental factors to consider for programming include the physical, social, cultural, institutional, and virtual aspects. Community dwelling older adults may live in single family homes, apartments, condos, or senior only housing. The



social environment may be limited or robust depending on the specific community. Generational factors such as valuing autonomy and independence will impact intervention techniques, as well as motivation for social connection in the virtual world. Institutional factors such as insurance, Medicare, and AARP will also influence areas such as funding and support for programming. Lastly, areas of occupation will need to be analyzed including productivity/work, self-care, leisure, and rest/sleep. Older adults will have different patterns of engagement including desire for volunteerism and issues with retirement, assistance with self-care tasks, exploration of leisure interests, and the impact of aging on rest and sleep.

The PEO model emphasizes the importance of how all three domains interact to impact occupational performance. It is the responsibility of the therapist to analyze the relationships between the domains to optimize the fit of these factors for the client. In the product, a table analyzes the relationship between person and environment, person and occupation, and occupation and environment. The person-environment relationship shows possible barriers relating to older adults having difficulty navigating their community, reluctance to utilize services, and limited access to services. The person-occupation relationship shows possible barriers including decreased participation due to age related changes, social participation may be limited to decreased feelings of self-efficacy, and a desire for occupations to align with values and beliefs. The occupation-environment relationship also shows possible barriers related to insurance reimbursement, funding from community or government agencies, access to community activities, and decreased opportunity for social engagement in socially isolated older adults.

The proposed product is a summary of the benefits, challenges, environment, person factors, cost-effectiveness, and outcomes of each program. The information was placed in chart format so programs could be easily compared. Thorough descriptions, as well as easy to read charts, compare the various programs that are already available to address social isolation in this population. Occupational therapists can use these descriptions of programs that were already successfully implemented in order to determine which programs, or program aspects, may be applicable to the setting in which they are planning to start a program. The summaries of each program can be used to determine which methods may be most beneficial to address the specific needs of socially isolated community-dwelling older adults.

Two charts were created in order to separate programs facilitated by occupational therapists from programs facilitated by non-occupational therapy professionals. In addition, an application of the Person-Environment-Occupation (PEO) Model is available. The person is defined as socially isolated, community-dwelling older adults. The environment is defined as a community-based setting, and the occupation is social participation. An overview of each element in the PEO model is available in Table 3, and an application of PEO transactions is shown in Table 4. The last element of the product is a step-by-step guide for occupational therapists to choose which program, or which aspects of various programs, may be beneficial to apply when creating an aging in place program to address social isolation for a specific population or setting in which they work. In addition, there is a resource guide available for occupational therapists who want more information regarding program development, theory application, and more detailed information for the summarized programs.

## Organization

### *The Friendly Neighbor: Community Programming for Socially Isolated Older*

*Adults* is organized into five separate sections:

- I. Programs Facilitated by Non-Occupational Therapy Professionals
- II. Programs Facilitated by Occupational Therapists
- III. Model Application
- IV. Resources
- V. References

The sections are organized in a way to encourage reflective thinking about program development by introducing broader concepts first, and then narrowing the focus on application of the information. The first section introduces programs facilitated by non-occupational therapy professionals. This allows the therapist to think creatively about different approaches to addressing social isolation. The second section introduces programs facilitated by occupational therapy professionals. This allows the therapist to think about social isolation from an occupation-based focus. The third section introduces the PEO model application. The utilization of the model helps therapists to systematically analyze the person, environment, and occupation factors impacting social isolation in the older adult population in their community. This application section offers easy to use worksheets, a case study, and additional resources to assist the therapist in the initial steps of program development.

Specifically, the manual is organized into the following headings:

- I. Programs Facilitated by Non-Occupational Therapy Professionals
  - The Village Model

- The Aging Well At Home Program
- Aging Gracefully Program
- Inter-generational Active Ageing Programme
- Men's Sheds
- Tai Chi Qigong

- Table 1. Aging in Place Programs Facilitated by Non-Occupational  
Therapy Professionals

## II. Programs Facilitated by Occupational Therapists

- Well Elderly 2
- Designing a Life of Wellness Program
- Let's Go
- Aging Well by Design
- Connecting to Community Program

- Table 2. Aging in Place Programs Facilitated by Occupational  
Therapists

## III. Model Application

- Table 3. Application of Person Environment Occupation (PEO) Model
- Table 4. PEO Transactions
- Table 5. Application of PEO Worksheet
- Table 6. PEO Transactions Worksheet
- Table 7. Comparison of Programs Worksheet
- Table 8. Case Study Application of PEO
- Table 9. Case Study PEO Transactions

IV. Resources

V. References

In Chapter IV the product is presented in its entirety. Chapter III will present the methodology and activities used to develop the product.

## CHAPTER III

### METHODOLOGY

Both authors have an interest in the older adult population, and the role occupational therapy can have in geriatric care. Through personal experience with older relatives, fieldwork experiences with older adult clients, and the knowledge gained through geriatrics coursework, both authors recognized the demand and need for aging in place services. A google search, past coursework, and previous scholarly projects showed an abundance of resources on home modification, and home safety for community dwelling older adults. A discussion with our advisor led to the idea of focusing our topic on aging in place within the community instead of the home.

Once the decision was made, a more thorough search of the literature was required to comprehensively find all the aging in place programs related to social isolation. A variety of databases were utilized including Pubmed, Academic search premier, CINAHL, SocIndex, Cochrane, Google, Google Scholar, and OTsearch. After meeting with the department librarian, search terms, mesh terms, headings, and phrases were identified to more thoroughly find all relevant articles. Articles were found using a combination of terms including *independent living, social isolation, “aging in place”, health promotion, occupational therapy, aged, aged 80 & over, wellness, community living, program development, psychotherapy group, older people, and community health services for older adults*. After reviewing the literature, there were clear problems that needed to be addressed such as:

- The aging U.S. population wants to age in place instead of living in nursing care facilities (AARP, 2006; Lehning, Smith, & Dunkle, 2015).
- Community dwelling older adults are at higher risk for social isolation (Dickens, Richards, Greaves, & Campbell, 2011; Painter, et al., 2012; Levasseur et al., 2015; Masi, Chen, Hawkey, & Cacioppo, 2011; Sabir, et al., 2009; Steptoe et al., 2013; Vogelsang, 2016).
- There are a limited number of community based programs addressing social isolation for older adults.

After identifying these problems, it became clear more resources and information was needed regarding community programs specifically addressing social isolation.

Through the literature review, some interesting and creative programs were identified which did in fact address social isolation. The authors decided a review of these programs would be helpful for occupational therapists wanting to address this issue. Abstracts were reviewed, and programs were included if they included a majority of participants being over 65 years old, addressed social participation as an outcome, and programs were implemented at a community level. Of the 1, 513 results found on the various databases, a total of 11 programs were chosen to include in the review. Of the 11 programs, six programs were developed by non-occupational therapy professionals, and five programs were created and implemented by occupational therapists.

Due to the minimal amount of occupation based programs, the authors decided to use the program descriptions as a means to facilitate creative thinking about program ideas for social isolation. In addition, the PEO model was utilized to help therapists determine the environmental, personal, and occupational factors impacting the older

adults in their community. Many occupational therapists have minimal experience with the use of theory, therefore, PEO was chosen due to its ease in conceptual understanding and application to practice. Step by step instructions with tables were provided to assist therapists in the application of knowledge gained from the preceding sections. Therapists are able to determine their population needs through PEO transactions, and compare how previous programs addressed those issues. A case study is presented at the end as an example of how to use the charts and process. Once therapists have brainstormed creative solutions and programming ideas, a resource section is provided for more information on how to implement and develop the program.



## CHAPTER IV

### PRODUCT

As the population continues to age, this product offers a guide to therapists for meeting the social needs of the older adults in their community. Older adults are at a higher risk of social isolation, and benefit from skilled occupational therapy to address social participation. Community programming is a growing niche for occupational therapists, and it is within the scope of practice to address social isolation with older adults living in the community.

**The Friendly Neighbor: Community Programming for Socially Isolated Older Adults** is a user-friendly guide to first introduce community programming for social isolation, and then guide therapists through the idea planning stages of creating programming for their own community. The product introduces a variety of programs which all address social isolation, and are targeted to adults age 60 years and older. Some programs are facilitated by other health professionals, while some are led by occupational therapists. Programs can be nation-wide, or local. With the wide variety of options, occupational therapists can use the reflective question boxes to think about what aspects of various programs would work for their community needs.

# The Friendly Neighbor: Community Programming for Socially Isolated Older Adults

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# Purpose and Organization

The purpose of the product *The Friendly Neighbor: Community Programming for Socially Isolated Older Adults* was to create a resource for occupational therapists to develop community programming ideas for socially isolated older adults. The manual was designed for occupational therapist who recognize a community need for aging in place services addressing social isolation, but are in the beginning stages of program development. The information within the manual is organized along a continuum from broad descriptions to specific application. This allows the occupational therapist to creatively consider various programming ideas for their specific community needs.

The product is divided into five sections.

- **Section I: Programs Facilitated by Non-Occupational Therapy Professionals**
- **Section II: Programs Facilitated by Occupational Therapists**
- **Section III: Model Application**
- **Section IV: Resources**
- **Section V: References**

# Purpose and Organization

**Section I** provides descriptions of programs led by non-occupational therapy professionals. The following programs were facilitated by a variety of disciplines but were chosen because each program addresses social isolation or social participation and involves community-dwelling older adults. These programs include The Village Model, The Aging Well At Home Program, The Aging Gracefully Program, The Inter-generational Active Ageing Programme, Men's Sheds, and Tai Chi Qigong. All of the programs are led by non-occupational therapy personnel, and address social participation as an outcome.

**Section II** includes descriptions of programs led by occupational therapists. Despite the effectiveness of social isolation interventions, there are minimal occupational therapy programs targeting social isolation in the older adult population. Of these programs, five are described in detail. These include Well Elderly 2, Designing a Life of Wellness Program, Let's Go, Aging Well by Design, and Connecting to Community Program. All of these programs are led by occupational therapists and address social participation as an outcome.

# Purpose and Organization

Each program description gives a general overview of the program, and if applicable, session outlines. The descriptions vary in detail specificity as some programs are nationally established programs, others are locally run, and some are developed as pilot programs for research. Unique aspects of each program are provided, along with checkpoint boxes for reflective thinking. This allows the occupational therapist to consider whether aspects from a particular program would be useful for the older adults in their community. Two of the programs have a star in the description, indicating a high rigor program. These programs, Tai Chi Qigong and Well Elderly 2, use randomized control trials to measure program outcomes. The tools used to measure these outcomes are outlined for occupational therapists who are considering performing research for their program. At the end of each section is an easy to use table comparing the benefits, challenges, environment, person factors, cost effectiveness, and outcome measures of each program.

After reading through the general descriptions of community programs, **Section III** of the product focuses on the application and creation of program ideas. The occupational therapist is able to view a table of the person, environment, and occupation factors impacting social participation in socially isolated older adults before completing their own chart specific to the population they are developing programming for. Another table is provided to allow the occupational therapist to write down notes about various programs which could be used to address the barriers addressed in the previous table. A case study is also included to showcase the step by step process for developing programming ideas.

# Purpose and Organization

A resource list is provided in **Section IV** with books and links regarding program ideas, models, and program implementation. For program development, Joy Doll (2010) published *Program Development and Grant Writing in Occupational Therapy. Making the Connection*, with thorough and comprehensive steps, tips, and strategies to create a tangible program. Linda S. Fazio (2017) recently published, *Developing Occupation-Centered Programs With the Community*.

AARP created two applicable resources. The first contains relevant literature, statistics, and interventions about isolation in adults aged 50 years and older. The other is a toolkit for local governments about planning for aging in place in the community. Two websites are listed, the National Association of Area Agencies on Aging, and Connect 2 Affect which provides resources for social and health promoting activities, aging issues, and methods to reconnect to the community. An online document is also presented titled, *There's No Place Like Home: Models of Supportive Communities for Elders*, which provides current aging trends, models, programs, and alternative services for older adults aging in place. Lastly, **Section V** is a comprehensive reference list for resources cited throughout the product.

# Theory

The Person Environment Occupation (PEO) model was chosen to guide the development of this manual due to its focus on the fit between the domains of person, environment, and occupation factors to improve occupational engagement. The model allows for flexibility in descriptions of the domains, which is ideal given the wide variety of details of the 11 reviewed programs. PEO is known for its ease of use in both conceptual understanding and application. The person domain is divided into physical, cognitive, sensory, affective, and spiritual factors. The environment domain is divided into physical, social, cultural, institutional, and virtual environments. The occupation domain is divided into productivity/work, self-care, leisure, and rest/sleep.

The product includes an analysis of the older adult population by analyzing the person, environment, and occupation factors of community-dwelling, socially isolated older adults. The person factors include physical, cognitive, sensory, affective, and spiritual components. When determining programming for this population, it is important to note older adults may have decreased strength and endurance, impaired memory and judgment, and decreased sensation. Older adults are at a life stage that focuses on reflection of relationships over the lifespan, and emphasis on values and beliefs relating to spirituality. The environmental factors to consider for programming include the physical, social, cultural, institutional, and virtual aspects. Community-dwelling older adults may live in single-family homes, apartments, condos, or senior housing facilities. The social environment may be limited or robust, depending on the specific community.

# Theory

Generational factors such as valuing autonomy and independence will affect interventions techniques, as well as motivation for social connection in the virtual world. Institutional factors such as insurance, Medicare, and AARP will also influence areas such as funding and support for programming. Lastly, areas of occupation that will need to be analyzed include productivity/work, self-care, leisure, and rest/sleep. Older adults will have different patterns of engagement including desire for volunteerism, issues with retirement, assistance with self-care tasks, exploration of leisure interests, and the impact of aging on rest and sleep. The PEO model emphasizes the importance of how all three domains interact to impact occupational performance. It is the responsibility of the therapist to analyze the relationships between the domains to optimize the fit of these factors for the client.

In the product, Table 4 (pg. 29) analyzes the transactional relationship between person and environment, person and occupation, and occupation and environment. The person-environment relationship shows possible barriers relating to older adults having difficulty navigating their community, reluctance to utilize services, and limited access to services. The person-occupation relationship shows possible barriers including decreased participation due to age-related changes, social participation possibly being limited due to decreased feelings of self-efficacy, and a desire for occupations to align with values and beliefs. The occupation-environment relationship also shows possible barriers related to insurance reimbursement, funding from community or government agencies, access to community activities, and decreased opportunity for social engagement in socially isolated older adults.



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# Aging in Place Programs Facilitated by Non-Occupational Therapy Professionals

## Village Model

The Village Model is a volunteer and membership driven grassroots movement. The model encourages older adults within their community to govern and provide services for other older adult members. Services include transportation, health and wellness programs, home repair, service coordination, and social activities. Villages can be freestanding or affiliated with other community organizations such as social services. The Village staff assess the needs of members and the community to provide programming and recruit volunteers. Volunteers are trained and vetted to help older adults age in place.

- There are over 200 villages in the U.S. and Australia
- Annual dues for members range from \$35-\$900 with an average of \$425
- For more information visit Village to Village Network at <http://www.vtvnetwork.org/>

### **Checkpoint**

- ✓ How can occupational therapy play a role in this model?

(McDonough & Davitt, 2011; Quaterman & Boggis, 2017; Scharlach, Graham, & Lehning, 2012)

## The Aging Well At Home Program

The Aging Well At Home Program (AWAH) was created by the Jewish Family & Children's Service of Greater Boston. The program took place in a densely populated urban neighborhood near Boston, Massachusetts to facilitate community engagement in low to moderate income older adults.

### 3 Parts of AWAH

- Community Liaison: available 9 am- 5pm Monday- Friday to connect participants for home visits, telephone calls, and invitations to social event, and help participants with daily problems.
- Warm Houses: Events hosted by participants to invite other older adult participants to their home for social, cultural, and recreational activities
- Community Forums: used to gather input from participants to refine program

For more information on this program visit the Jewish Family & Children's Service website at <http://www.jfcsboston.org/Our-Services/Older-Adults/Aging-Well-at-Home>

### **Checkpoint**

- ✓ What community programs could you partner with to provide similar programming as an OT?

## Aging Gracefully Program

The Aging Gracefully Program was developed by faculty at Johns Hopkins School of Nursing. Faculty partnered with nursing staff at a 120 unit, low income, senior housing apartment complex in an urban area for older adults 65 years and older. The program consisted of 7 sessions held every 6-8 weeks at the apartment complex. Approximately 8-10 residents attended each session, with participants being primarily African American female residents.

### Session outline

- 1) Holidays: Asked residents to select a gift from gift table, and describe memory evoked by the gift.

Used storytelling process to reduce holiday loneliness and acknowledge cultural beliefs

- 2) Recognizing the Blues: Showed film about depression, and finished with discussion
- 3) Coping with Stress: Residents collaborated and made a list of daily stressors, and posted list on bulletin board
- 4) Coping with Physical Changes of Aging: Using storytelling, residents described ways they approached age related changes in mobility
- 5) Spring Renewal: Residents brought various projects they worked on during the winter to share with the group. Examples include art, poetry, and writing.
- 6) End- of -life: Showed film on end of life decision making, and discussed with group

### Checkpoint

✓ How would an OT make these sessions occupation-based?

(Gerson, Dorsey, Berg, & Rose, 2004)

## Inter-generational Active Ageing Programme

Diane Brennan, a nurse from Speke, Liverpool, created a community program for inter-generational collaboration among older adults and teens. Speke, Liverpool is a remote area and has high rates of crime, unemployment, and poor educational attainment. Many older adults are intimidated by the groups of young people who gather outside their homes, and young people have minimal interaction with adults older than 65 years. Brennan created an intergenerational programme where older adults connect with students every Friday throughout the school year. A formal schedule of sessions isn't created, and is instead responsive to group needs. Brennan seeks out volunteers from the community to host health and wellness programming. Students also share their experiences with the older adult volunteers by hosting plays and teaching computer skills. Older adult volunteers are able to share their stories and experiences with the younger generation.

Example sessions include:

- Tai chi
- Healthy eating
- Dentistry
- Computer skills
- Drama productions

### Checkpoint

✓ What other settings would benefit from inter-generational programming?

### Checkpoint

✓ What are the pros and cons of having a formal vs informal session schedule?

(Heath, 2004)

## Men's Sheds

Men's Sheds are locally run, volunteer driven programs started in Australia to foster health and wellbeing for Australian males. Men's Sheds offer membership to community males of all ages, with most participants being older adults (some Sheds do allow female members). Men's Sheds are reminiscent of the nostalgic shed in the backyard, a place where Dad or Grandpa would build and fix various items, and have a litany of on-going projects. The purpose of these sheds is to foster kinship for males in the community, and offer a space to participate in such projects. Each shed has a different focus and resources depending on the needs and desires of the members. Some Men's Sheds focus on carpentry projects, others work on bicycle repairs, others offer a place to learn computer skills. The possibilities are endless. Men's Sheds have become increasingly more popular, and the Australian government has partnered with local Sheds to target health and wellness programming. Men's Sheds also partner with local community agencies to volunteer their time and resources.

There are over 1,000 Men's Sheds in Australia

### **Checkpoint**

✓ What is a possible cultural difference between Australia and the United States that may impact the implementation of this program?

### **Checkpoint**

✓ How does occupational therapy fit into the purpose of Men's Sheds?

For more information visit the Australian Men's Shed Association at <https://mensshed.org/>

(AMSA, 2017)

## Tai Chi Qigong

Tai Chi Qigong is an ancient Chinese form of exercise that focuses on specific exercises and movements to improve life energy and flow. This form of exercise is an evidence based form of treatment to increase overall physical and mental wellbeing in older adults.

Using tai chi qigong as a focus for social participation, a community program was created by a nurse and social worker targeting socially isolated older adults in the community. The program was hosted at a local non-governmental older adult facility. The program directors recruited eight active older adult volunteers to host sessions, and provided training sessions weekly for one month prior to leading a session. Tai chi qigong sessions were held twice a week for 60 minutes, and participants were encouraged to practice at home daily for 30 minutes. No more than 15 older adults participated in each group session, for a total of 48 participants who participated throughout the course of the program.

### Outcome measures included:

- Lubben social network scale
- The De Jong Gievelde loneliness scale
- Revised social support questionnaire
- Mental health inventory
- Rosenberg self-esteem scale
- 12 item Short Form Health Survey measuring quality of life

★ High rigor - a pilot randomized control trial

### Checkpoint

✓ How can Tai Chi Qigong be incorporated into your programming?

### Checkpoint

✓ How can physical activity be incorporated into your programming to address social isolation?

For more information on Tai Chi Qigong visit the American Tai Chi and Qigong Association at <http://www.americantaichi.org/>

(Chan, Yu, & Choi, 2017; Rogers, Larkey, & Keller, 2009)

**Table 1. Aging in Place Programs Facilitated by Non-Occupational Therapy Professionals**

Program Name	Benefits	Challenges	Environment	Person	Cost Effectiveness	Outcomes Measures
<p>The Village Model</p> <p>(McDonough &amp; Davitt, 2011; Quaterman &amp; Boggis, 2017; Scharlach, Graham, &amp; Lehning, 2012).</p>	<p>Services are directly focused on the needs of the community members, member-run program, empowers members, facilitates community engagement and improvement, focuses on active social participation, utilizes intergenerational volunteers</p>	<p>Volunteer burnout, over-involved volunteers, difficult to involve members with physical, cognitive, and psychosocial impairments, confidentiality issues, unstable funding sources, recruiting diverse members</p>	<p>Community-based</p>	<p>Members of the community, typically age 65 and older</p>	<p>Annual dues range from \$35-\$900, with an average cost of \$425</p>	<p>Decrease in institutionalization, social relationships, sense of community, increase in quality of life and overall health, and cost effectiveness</p>



<p>The Aging Well At Home Program</p> <p>(Gonyea &amp; Burnes, 2013)</p>	<p>Community liaison, warm houses, community forums, facilitates active social engagement, strengthens social connections, opportunity to share life experiences and practical information about community, decreases stress and loneliness, increases sense of self-efficacy</p>	<p>Facilitating enrollment, did not significantly decrease depression, slow startup time of warm houses</p>	<p>Densely populated urban area near Boston</p>	<p>Community-dwelling adults age 70 and over</p>	<p>Enrollment was free due to funding provided by the Harry and Jeanette Weinberg Foundation</p>	<p>Decreased stress and loneliness, increased self-efficacy and social connections</p>
<p>The Aging Gracefully Program</p> <p>(Gerson, Dorsey, Berg, &amp; Rose, 2004)</p>	<p>Proximity of staff to residents by hosting program at community living center. Focus on culturally relevant material.</p> <p>Increased rapport building between staff and residents</p>	<p>Lack of rigor, and no formal data collection</p> <p>Difficulties coordinating resident schedules for program</p>	<p>Low income 120 unit public housing apartment in an urban setting.</p>	<p>Older adult residents 65 years and over. Predominantly African-American and female</p>	<p>Minimal costs for holiday gifts, films, and light refreshments</p>	<p>Improved social interaction, participation, and responsiveness. Improved relationships between residents and health professionals</p>

<p>The Inter-generational Active Ageing Programme</p> <p>(Health, 2004)</p>	<p>Services are flexible and responsive to community needs.</p> <p>Community programming pairs adolescents and older adults for mutual support</p>	<p>Lack of rigor and formal outcome measures</p>	<p>A local high school in Speke, Liverpool . Speke is a remote low SES community in England.</p>	<p>Community members. Primarily adolescents and older adults</p>	<p>The program is led by volunteers. Community leaders will host educational sessions. Older adults visit adolescents in the high school</p>	<p>Measured through observational report. Increased community participation, intergenerational participation, self-esteem, and self-confidence.</p>
<p>Men's Sheds</p> <p>(AMSA, 2017)</p>	<p>High rates of participation and perceived benefits from members.</p> <p>Opportunity for kinship, and building social network</p> <p>Focus on engagement in leisure activities</p>	<p>Locating a setting for a Shed</p> <p>Organizing and funding Shed resources</p> <p>Recruiting volunteers to run the Shed</p>	<p>Multiple locations in communities throughout Australia.</p> <p>Examples of Shed locations include volunteer garages or community facilities</p>	<p>Men of all ages. Majority of members are older adults</p> <p>Some Sheds do allow female members to join.</p> <p>Men's Sheds often partner with other community agencies for projects and volunteering</p>	<p>Costs include a fee or rent for space, and funding for materials. Material needs are dependent on member interests such as wood-working or bike repair.</p>	<p>Over 1, 000 Men's Sheds in Australia. Described benefits from members include improved social participation, feelings of connectedness, and satisfaction with engaging in productive activities.</p>

<p>Tai Chi Qigong (Chan, Yu, &amp; Choi, 2017; Rogers, Larkey, &amp; Keller, 2009)</p>	<p>Rigor of study  Combination of exercise with social participation  Sessions led by older adult peer</p>	<p>Recruitment of older adult participants and volunteers.  One month needed for volunteer training</p>	<p>Sessions held at local non-governmental facility for older adults twice a week for 60 minutes</p>	<p>Socially isolated, community dwelling, older adults 60 years and older  Active older adult volunteers  Nurse and social worker coordinated and developed program</p>	<p>Possible rental fee for room. Minimal costs associated with print-outs and flyers</p>	<p>Significantly decreased loneliness, and significantly improved satisfaction of social support</p>
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# Aging in Place Programs Facilitated by Occupational Therapists

## Well Elderly 2

The Well Elderly 2 is a preventative lifestyle-oriented program for older adults. The program consists of weekly two hour small group sessions, up to 10 individualized sessions, and monthly group outings over a six month period in the Los Angeles area. Each group had 6-8 members, and was led by an occupational therapist. Each occupational therapist completed 40 hours of training on the program prior to implementing sessions. For more information check out the book *Lifestyle Redesign: The Intervention Tested in the USC Well Elderly Studies* by Florence Clark.

### Program content:

- Impact of everyday activity on health
- Time use and energy conservation
- Transportation utilization
- Home and community safety
- Social relationships
- Cultural awareness
- Goal setting
- Changing routines and habits
- (Clark et al., 2012, p.783).

★ High  
rigor study -  
randomized  
control trial

### Outcome measures

- 36 item Short Form Health Survey for perceived physical health and well-being
- The Center for Epidemiologic Studies Depression for depressive symptoms
- The Life Satisfaction Index-Z to measure life satisfaction
- Consortium to Establish a Registry of Alzheimer's Disease for cognitive outcomes

(Clark et al., 2012)

## Designing a Life of Wellness Program

The Designing a Life of Wellness Program was created to educate older adults on the importance of social and community participation, and to reduce barriers to social participation. Participants engaged in weekly 1 ½ hour educational sessions for six months in community rooms at senior high rise communities. Facilitators of the sessions were occupational therapists and occupational therapy students on level II fieldwork. Participants discussed barriers for each topic, and problem-solved in a group format. Afterwards, participants were assigned homework to apply to their everyday life. Group community outings were also arranged once per month.

### **Checkpoint**

✓ How could you incorporate fieldwork students into your program?

### Session topics:

- Transportation
- Aging
- Safety and Falls Prevention
- Stress
- Lifestyle Balance
- Communication

## Let's Go

Let's Go is a community based program in urban New Jersey where participants identify their community-based occupations, and examine the barriers and supports related to community mobility. A total of 52 community dwelling older adults with aphasia completed the program. The program consists of four weekly 45 minute group education sessions led by an occupational therapy team, followed by a 15-30 minute individual session. In the final week, participants attended community outings using alternative transportation options. Funding for the program was provided through grants, and therefore, was free to participants.

### Session topics:

- Benefits and barriers to community mobility
- Alternative transportation options
- Community safety

### Checkpoint

✓ What other populations would be concerned with community mobility?

### Checkpoint

✓ How would this program differ in a rural environment?

### Checkpoint

✓ What types of grants could fund your

(Mulry, Papetti, De Martinis, & Ravinsky, 2017)

# Aging Well by Design

The Aging Well by Design program is a condensed version of the Lifestyle Redesign program created by faculty and occupational therapists at USC. The Aging Well by Design program condenses the 6-9 month Lifestyle Redesign program into a 3 month program with weekly educational sessions discussing various health and wellness topics. The program was led by an outpatient occupational therapist at a large hospital, with sessions being hosted in a conference room in the rehabilitation department. A total of 13 community dwelling older adults completed the program averaging 10-12 sessions each. For more information on Lifestyle

Redesign programs visit <http://chan.usc.edu/patient-care/faculty-practice/about>

## Session topics:

- The Power of Occupation
- Health and Aging: Changes in Occupation
- Meaning and Identity
- Life Balance: Time and Energy
- Health through Occupation: Physical and Mental Activity
- Dining as an Occupation
- Transportation and Occupation
- Social Relationships
- Community and Home Safety

## Checkpoint

✓ Does your facility have space to host your program sessions?

## Checkpoint

✓ Could you partner with a local hospital or other community agency?

(Cassidy, et al., 2017)

## Connecting to Community Program

The Connecting to Community Program focuses on teaching community dwelling older adults computer skills in order to facilitate social engagement. The AARP foundation funded the program, and paid for each participant to receive their own iPad once they completed the program. The program lasted six months with both weekly lab times, and weekly 90 minute programs sessions. Sessions focused on how to run and care for the iPad, operate applications and social networking sites, and how to use wireless internet. The program involved 55 older adult participants in senior housing communities in South Dakota. All sessions were held at the senior housing community, and facilitated by 11 occupational therapy graduate students, 6 older adult volunteers, and 1 social work student.

### Occupational uses for the iPad:

- Social participation through social media sites
- Reading the news and online books
- Discovering new recipes
- Blogging
- Playing games, and creating puzzles
- Sending emails
- Sharing inspirational quotes

For more information on older adult needs visit the American Association of Retired Persons at <http://www.aarp.org>

### **Checkpoint**

- ✓ How could you incorporate iPads in your program to increase social participation?

(Smallfield, Haag, Poston, Giger, Anderson, 2014)



Table 2. Aging in Place Programs Facilitated by Occupational Therapists

Program Name	Benefits	Challenges	Environment	Person	Cost Effectiveness	Outcomes Measures
Well Elderly 2 (Clark et al., 2012)	Consistent facilitator, facilitator training required, community outings, education on a wide variety of relevant topics	High cost per participant, on average each participant attended only 56% of program sessions	Los Angeles metropolitan area	Adults between 60-95 years old	\$783 per participant; was determined to be cost-effective by the UK National Institute of Health and Clinical Excellence	Increase in vitality, social function, and mental health
Designing a Life of Wellness Program (Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003)	Education on a wide variety of relevant topics, facilitated group discussion related to barriers and problem-solving, used homework to generalize knowledge to real-life experience, community outings,	Lack of adequate transportation, varied participation rates	3 senior high rise communities	Adults between 70-92 years old	Enrollment was free due to funding by two grants and an independent contract	Increase in social functioning, vitality, mental health, social and community participation, and quality of life

	increased communication and participation in social activities					
Let's Go (Mulry, Papetti, De Martinis, & Ravinsky, 2017)	Resources are tailored to each individual's needs, one-on-one support, problem solving assistance	Difficult to find funding to implement program long-term	Urban areas of New Jersey	Community-dwelling older adults with aphasia who were concerned about their ability to transport themselves within the community	Enrollment was free due to outside funding	Increased frequency of community-based occupations and outings, confidence in community mobility
Aging Well by Design (Cassidy, Richards, & Eakman, 2017)	Program based off of Lifestyle Redesign Program at USC  Extensive resources available  Occupation focused	Allotting enough time for recruitment  Scheduling 10-14 hours per week for class preparation	Conference room in rehabilitation department of large hospital  Sessions held weekly for 12 weeks	13 Community dwelling older adults aged 65 years and older who passed Mini- Cog  Led by occupational therapist	Funding provided by hospital for room and supplies. Each participant received a three ring binder with handouts	Improved social relationships, awareness of community resources, and positive attitude towards aging process

<p>Connecting to Community Program</p> <p>(Smallfield, Haag, Poston, Giger, Anderson, 2014)</p>	<p>AARP funded program.</p> <p>Participants keep iPad after successful completion</p> <p>Technology skills training to increase social participation</p>	<p>Recruitment of volunteers and participants for weekly sessions for 6 months</p>	<p>Local senior housing in South Dakota</p>	<p>Older adults in the community.</p> <p>Volunteer OT students and social work students.</p> <p>Partnered with University of South Dakota</p>	<p>Funded by AARP.</p>	<p>Increased social communication using the iPad, increased satisfaction in relationships, and increased social interaction with other course participants.</p>
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## Person-Environment-Occupation (PEO) Model Application

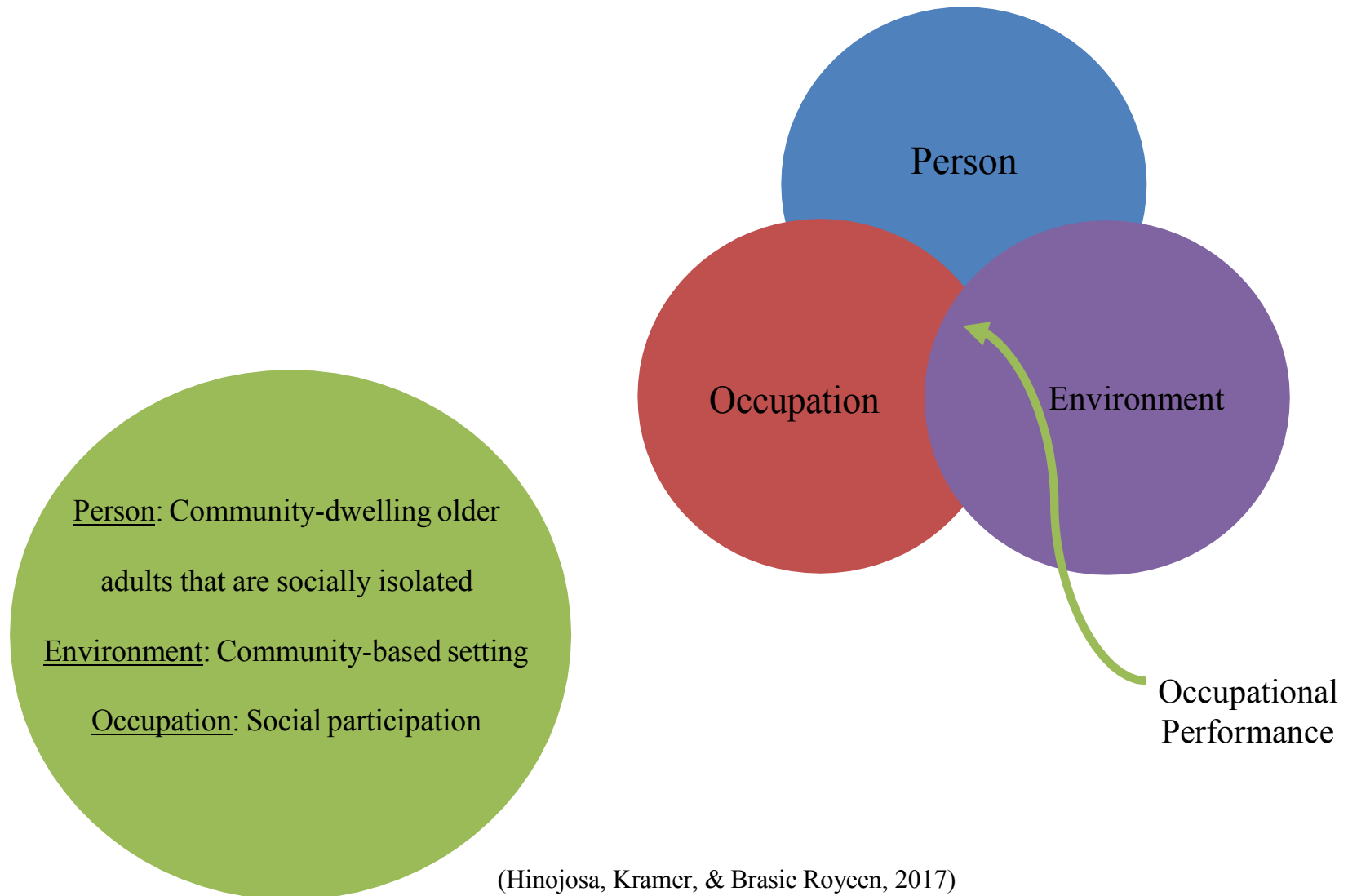


Table 3. Application of Person Environment Occupation (PEO) Model

Person	Environment	Occupation
<p><u>Physical</u>: older adults may experience decreased strength and endurance</p> <p><u>Cognitive</u>: older adults may experience decreased performance in the areas of thought, memory, and judgment</p> <p><u>Sensory</u>: older adults may have decreased sensation, such as touch, smell, sight, and hearing</p> <p><u>Affective</u>: at this stage of life, older adults are in the ego integrity vs despair stage. Older adults appreciate relationships developed over the life time, and reflect on their life overall (Cole and Tufano, 2008).</p> <p><u>Spiritual</u>: older adults may have a defined set of values and beliefs due to their many life experiences</p>	<p><u>Physical</u>: Independent housing including homes, condos, and apartment as well as senior only housing facilities and communities.</p> <p><u>Social</u>: Decreased social interaction, limited social support</p> <p><u>Cultural</u>: Baby Boomer generation has a strong sense of autonomy and value independence (Gonyea &amp; Burns, 2013)</p> <p><u>Institutional</u>: Medicare and Medicaid benefits. Different insurance affects reimbursement. Programs such as AARP and other older adult programs can offer funding and resources.</p> <p><u>Virtual</u>: Social media, including Facebook, Instagram, Snapchat, and Twitter</p>	<p><u>Productivity/Work</u>: older adults are more likely to be retired or working part-time</p> <p><u>Self-care</u>: older adults may experience difficulties related to self-care</p> <p><u>Leisure</u>: older adults may have more time to explore and participate in desired leisure activities</p> <p><u>Rest/Sleep</u>: older adults may experience more difficulty falling asleep and may need more sleep than when they were middle aged</p>

Table 4. PEO Transactions

P x E	P x O	O x E
<p>Older adults may experience difficulty navigating in their communities due to age-related changes that impact their ability to drive</p> <p>Older adults may be unaware of how to utilize alternative transportation services for community mobility</p> <p>Older adults may be reluctant to attend community programs for support due to a strong sense of autonomy and high value placed on independence</p> <p>It may be difficult for older adults to utilize virtual environments, such as social media and email</p> <p>Due to an overall lack of community wellness programs, older adults may not have access to programs addressing social isolation</p>	<p>Older adults may participate less often in valued occupations, such as social participation, due to age-related changes</p> <p>The occupations that socially isolated older adults participate in may be limited due to a lack of support</p> <p>Older adults may feel ill equipped to make new social connections due to their current state of social isolation and a decreased sense of self-efficacy</p> <p>Older adults may feel motivated to engage in social activities if it aligns with the ego integrity vs despair stage including reflecting on one's life and relationships.</p>	<p>The physical environment can act as a barrier or facilitator of social participation through the access and availability of social activities.</p> <p>Baby boomers have a cultural value of independence and autonomy and are motivated to engage in productivity focused activities</p> <p>Socially isolated older adults with limited social support will have less opportunity to engage in leisure activities.</p> <p>Virtual environments, such as social media, can be used to facilitate social participation</p> <p>Medicare, Medicaid, and private insurance can facilitate or hinder engagement in occupations depending on the ability for reimbursement of services</p> <p>Government, and funded agencies can provide funding and resources to enable participation in occupations.</p>

## Implementing a Program: Using the PEO Model as a guide

Step 1: identify specific factors of each domain of your anticipated population. Use Table 3 as a guide

Table 5. Application of PEO Worksheet

<b>Person</b>	<b>Environment</b>	<b>Occupation</b>
<u>Physical</u>	<u>Physical:</u>	<u>Productivity/Work</u>
<u>Cognitive</u>	<u>Social:</u>	<u>Self-care:</u>
<u>Sensory:</u>	<u>Cultural:</u>	<u>Leisure:</u>
<u>Affective:</u>	<u>Institutional:</u>	<u>Rest/Sleep:</u>
<u>Spiritual:</u>	<u>Virtual:</u>	

Step 2: Determine the relationships between each domain to identify barriers and facilitators to program development. Use Table 4 as a guide

Table 6. PEO Transactions Worksheet

<b>P x E</b>	<b>P x O</b>	<b>O x E</b>



Step 3: Review Table 1 and Table 2. Identify programs which meet the needs to optimize fit for your population. Write down aspects of the program you like, and aspects of the program that would not work for your population

Table 7. Comparison of Programs Worksheet

Program	Pros	Cons

Step 4: Create a program using aspects of the program that meet your population's needs, or implement an existing program if it is appropriate for your population

Done!



(Caldwell, 2014)  
(The importance of socialization to the overall well-being of seniors, 2015)

## Case Study Example

A community garden was just implemented in your town. As a home health occupational therapist you know many of your older adult clients are both socially isolated and not receiving proper nutrition.

- How can you use the PEO Model and other program examples to address this need?

Tips: Remember to conduct a needs assessment of your population

Table 8. Case Study Application of PEO

Person	Environment	Occupation
<p><u>Physical:</u> Decreased strength and endurance</p> <p><u>Cognitive:</u> slower processing, decreased memory</p> <p><u>Sensory:</u> decreased sensation for vision, hearing, and touch</p> <p><u>Affective:</u> Many older adults have feelings of loneliness and isolation</p> <p><u>Spiritual:</u> many older adults in the community find meaning in nature. Most older adults identify as Christian.</p>	<p><u>Physical:</u> Community garden located on the edge of town near a field. Garden is 1 acre with multiple plots for use</p> <p><u>Social:</u> A variety of people use the garden- different ages and backgrounds</p> <p><u>Cultural:</u> There are various cultural implications for using the garden such as cleaning up after yourself, possessing a friendly demeanor towards other gardeners, and developing a sense of kinship with other members.</p> <p><u>Institutional:</u> The land is developed and maintained by members of the garden. Each member is allotted one plot. At this time, membership is free</p> <p><u>Virtual:</u> The community garden maintains a facebook page for members to connect, and learn about gardening tips</p>	<p><u>Productivity/Work:</u> Gardening can be considered both a work activity and leisure activity. Gardening can be a productive task if the primary purpose is for creating food, or donating time and food for volunteer/altruistic purposes.</p> <p><u>Self-care:</u> Gardening requires wearing appropriate clothing, cleaning up after yourself, and grooming tasks afterwards</p> <p><u>Leisure:</u> Gardening can be considered a leisure activity if the main purpose is for a relaxing hobby, or to connect with friends and neighbors at the garden.</p> <p><u>Rest/Sleep:</u> Gardening can be a laborious task. Adequate rest and sleep is needed for full engagement.</p>

Table 9. Case Study PEO Transactions

P x E	P x O	O x E
<p>Older adults may experience difficulty navigating the garden due to age-related changes that impact their ability to drive</p> <p>Older adults may be unaware of how to utilize alternative transportation services for community mobility</p> <p>Older adults may be reluctant to receive support to attend the garden for due to a strong sense of autonomy and high value placed on independence</p> <p>It may be difficult for older adults to utilize virtual environments, such as social media and email</p> <p>Older adults may not have access to the garden due to financial, cultural, psychosocial, or physical barriers.</p> <p>Older adults may not have the social support to assist them in maintaining the garden plot</p>	<p>Older adults may have difficulty gardening due to age-related changes</p> <p>Older adults may feel motivated to participate in gardening as it contributes to occupations of productivity, leisure, and social participation</p> <p>Older adults may have difficulty completing all the tasks associated with gardening such as bending, stooping, and carrying.</p>	<p>The physical environment is well suited for gardening. Plots are large enough for a modest garden. The soil is high quality for growing flowers and produce.</p> <p>Baby boomers have a cultural value of independence and autonomy and are motivated to engage in productivity focused activities</p> <p>The community garden provides an opportunity for socially isolated older adults to engage in the community.</p> <p>The facebook page can be used to facilitate social participation, and find gardening resources</p> <p>Government, and non-government agencies can provide funding for gardening resources and transportation.</p>

Table 10. Case Study Comparison of Programs Worksheet

Program	Pros	Cons
The Village Model	Older adults in the community address issues of community mobility and engagement. The village would provide transportation and resources for older adults wishing to utilize the garden	Cost of membership.
Inter-generational Active Ageing Program	Facilitate inter-generational relationships at the community garden	How to recruit high school students during summer break?
Men's Shed	Creates a network of social support, and provides resources for gardening. Focus is on the occupation of gardening	Expensive and time consuming to facilitate
Designing a Life of Wellness Program	Educational sessions provided on aging. Problem solving occurred in a group format.  Facilitated with help from Level II students	Topics need to be tailored for relevance to community gardens
Let's Go	Focus on community transportation if that is main barrier to accessing garden	Bus does not stop directly at community garden- talk to city about possible bus stop closer to garden

## Case Study Conclusion

**Conclusion:** After reviewing relevant programming, the Designing a Life of Wellness Program seems most relevant to meet client needs identified by the PEO transactions. The older adults I work with can increase social participation by attending education sessions, and participating in outings to the community garden. Session topics can be modeled after the original program, and tailored to the needs of clients.

**Session topics** described below with the relevant transaction it is addressing:

- **Transportation:** Safety tips for driving and/or using the bus system, especially when traveling to the garden. (PxE, OxE transaction)
- **Aging:** discuss common age-related changes, and how that may impact gardening. (PxO transaction)
- **Safety and Falls Prevention:** how to safely walk on various surfaces, and move in and out of different positions. Apply information to the garden setting, and use of any applicable adaptive equipment to facilitate gardening (PxO, OxE transaction)
- **Stress:** stress management techniques, and how gardening can be used for relaxation (PxO transaction)
- **Lifestyle Balance:** how to manage time for occupational balance, and the importance of incorporating social activities into the day. (PxO, PxE transaction)
- **Communication:** how to use social media for communication, with the community garden Facebook page as an example (PxE, PxO transaction)

Once the group meets, an outing schedule can be determined for participants to apply the knowledge they've learned within the sessions to the community garden. Outings can occur weekly or bi-weekly as applicable to group needs. With these ideas in mind, I can use the resources provided for specific steps and strategies for implementing the program idea.

## Resources

These resources may be helpful when analyzing aging in place programs or designing an aging in place program in a new setting.

### Program Development and Grant Writing in Occupational Therapy: Making the Connection

By Joy Doll

- A resource guide for program development and grant writing. It explains the process of turning an idea into a tangible program.
- It also contains practical information about conducting a needs assessment, strategies for grant writing, and how to gain support for a program.

### Framework for Isolation in Adults Over 50

[https://www.aarp.org/content/dam/aarp/aarp\\_foundation/2012\\_PDFs/AARP-Foundation-Isolation-Framework-Report.pdf](https://www.aarp.org/content/dam/aarp/aarp_foundation/2012_PDFs/AARP-Foundation-Isolation-Framework-Report.pdf)

- This is a resource for literature specific to isolation in Americans over 50 years of age. It contains an introduction to isolation and prevalence in the given population, risk factors and causes, interventions, and methods of measuring isolation.



## Resources

### National Association of Area Agencies on Aging

[www.n4a.org](http://www.n4a.org)

- This website provides resources and a range of social and health promotion activities for those who wish to assist older adults live dignified lives in their communities.
- It lists information about aging services for older adults, best practice in a variety of areas, and current advocacy issues related to aging programs.

### Connect 2 Affect

[www.connect2affect.org](http://www.connect2affect.org)

- This is a resource featuring tools and information to evaluate isolation risk, reach out to those who may be isolated or feeling disengaged, and find practical ways to reconnect to the community.

## Resources

### Aging in Place: A Toolkit for Local Governments

<https://www.aarp.org/content/dam/aarp/livable-communities/plan/planning/aging-in-place-a-toolkit-for-local-governments-aarp.pdf>

- This is a tool designed to help local governments plan for their aging populations. It describes programs, techniques, and practices that expand the options available to older adults in the community.
- It also gives examples of neighborhood and supportive services that help to facilitate older adults to age in place.

### There's No Place Like Home: Models of Supportive Communities for Elders

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20N/PDF%20NoPlaceLikeHomeModelsCommunitiesElders.pdf>

- This resource discusses trends affecting community-dwelling older adults, aging in place models, programs and waivers for services alternative to nursing home care, and national and state policy affecting older adult populations.

## Resources

### Developing Occupation-Centered Programs With the Community

By Linda Fazio

- This book provides a step-by-step approach to designing and implementing a program within a community.
- The book also highlights how to identify community assets and how to create a sustainable program.

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## CHAPTER V

### SUMMARY

The purpose of this scholarly project was to address social isolation in community dwelling older adults. This purpose was accomplished by first identifying the demands for service, understanding the risk factors of social isolation, determining the impact of occupational therapy for this population, and identifying relevant community programming.

After reviewing the literature, a strong demand for services was found as 9 out of 10 older adults age 50 years and over prefer to age in place indefinitely or as long as they can (AARP, 2006). There is a 7-17% prevalence of social isolation for community dwelling older adults, and older adults are at a higher risk for social isolation (Dickens, Richards, Greaves, & Campbell, 2011; Painter, et al., 2012; Levasseur, et al., 2015, Masi, Chen, Hawkey, & Cacioppa, 2011; Sabir, et al., 2009, Steptoe, et al., 2013, & Vogelsang, 2016). Older adults have a variety of negative health risks associated with social isolation including but not limited to: a 50% increased risk of mortality, cardiovascular disease, infectious disease, cognitive decline, diminished immune function, loneliness, decreased sense of self-esteem, depression, suicidal ideation, and suicidal behavior (Cornwell & Waite, 2009; Dickens, et al., 2011; Masi, et al., 2011; & Steptoe, et al., 2013). However, occupational therapy, specifically addressing social isolation, leads to positive outcomes including increased social participation and increased physical and mental health (Smallfield, et al., 2014). In addition, after reviewing 1, 513 article abstracts, 11 community programs for older adults addressing social isolation were analyzed for review.

All of the information was compiled as a resource, and a step by step guide for occupational therapists working with socially isolated, community dwelling older adults titled *The Friendly Neighbor: Community Programming for Socially Isolated Older Adults*. The product begins with an overview of six programs facilitated by non-occupational therapy professionals. A brief description and reflective questions are included on each program to facilitate creative brainstorming about possible program ideas. The second section is formatted similar to the first section, but is an overview of five programs facilitated by occupational therapy professionals. The third section includes the model application, and step by step guide for brainstorming program ideas. Therapists can analyze the PEO components and transaction of their community population, and compare those needs to the previously reviewed programs. Lastly, there is a resource section for further steps and information on program development and aging in place services.

### **Implementation**

*The Friendly Neighbor: Community Programming for Socially Isolated Older Adults* can be implemented in a variety of communities. The product was designed for occupational therapists who want to address social isolation in community-dwelling older adults. This product starts the process of identifying needs and barriers within the community, and creatively brainstorming possible solutions and program plans. An occupational therapist in a variety of settings would be able to utilize this manual including hospital-based, home health, skilled nursing facility, mental health, and community based.

Occupational therapists may face barriers when implementing program plan ideas. There are potential financial barriers to starting a new program including start up fees, costs of services, and insurance reimbursement. Other barriers include a lack of time, whether it is the time needed to create the program, time needed to prepare for program sessions, or the time needed to run session. Another issue is a barrier to accessing services. Older adults may have trouble accessing the program, and occupational therapists must be diligent in removing potential barriers which may inhibit participation from clients.

### **Limitations**

There are some identified limitations of the product including, but not limited to:

- A lack of occupational therapy specific research makes it hard to generalize outcomes and create program suggestions.
- The available research focusing on current programming, lacked a high degree of rigor. This makes it challenging to ascertain effectiveness of the program.
- The product was not implemented, and therefore, its efficacy is not validated

### **Conclusions**

Despite these limitations, a demand for aging in place services exists for the current and aging population. Older adults want to stay in their communities, but are at an increased risk for social isolation. This social isolation can have a myriad of negative health consequences for older adults. Programs for socially isolated older adults have increased social participation, and improved physical and mental health, across a range of settings. Occupational therapists have the skills and abilities to address the needs of older adults as they continue to age in place.

## **Recommendations**

In summary, there are a few recommendations for further action and research to supplement this scholarly project and product. More research is needed to determine the efficacy of community based programs for older adults. In addition, more occupational therapy specific research is needed for aging in place service for older adults, and social isolation interventions for this population. Another recommendation is for more therapists to publish the interventions and techniques they use in everyday practice. Of the 1,513 articles reviewed, only five programs were facilitated by occupational therapists addressing social isolation in older adults. Occupational therapists are working with this population, and publishing their findings would significantly grow the professional body of literature. Lastly, it is recommended that therapists or students implement the manual to determine its efficacy.

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