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Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

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CERTIFICATION OF AUTHORSHIP

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Executive Summary

Background: Older adults are at an increased risk of developing chronic disease, and lifestyle choices and behaviors can impact these health outcomes. Community-based health care professionals (HCPs) across disciplines use interprofessional collaborative strategies to support the lifestyle wellness of older adults at risk for chronic disease. However, community-based occupational therapy (OT) presence in the preventive wellness community remains comparatively low.

Purpose: The purpose of this qualitative phenomenological study was to explore the meaning of community-based lifestyle wellness programs as perceived by non-OT community-based HCPs, and the relationship, if any, to OT.

Theoretical Framework: The Framework of Occupational Justice was used to frame and provide context for this study and support the premise that occupational choice, opportunity, and participation are human rights, and people have distinct needs influenced by complex structural and personal factors.

Methods: A qualitative descriptive phenomenological approach was used to conduct semi-structured interviews with five community-based HCPs outside the field of OT. The predominant themes expressed by the participants were identified using line-by-line open and axial coding.

Results: The qualitative data analysis revealed one primary theme, *Avenues of Awareness*, and four secondary themes, *Pigeonholed Practices, Sounds Good but Also Familiar, Bona Fide Barriers, and Pro-Teamwork*. The non-OT HCPs positively perceived lifestyle wellness programming yet had a limited understanding of OT's role in preventive wellness and no awareness of Lifestyle Redesign® but welcomed interprofessional collaboration to support the lifestyle wellness needs of clients.

Conclusion: The interprofessional knowledge gaps identified in this study may compromise community-based older adults' ability to engage in meaningful occupational pursuits supportive of lifestyle wellness. Non-OT HCPs may not be fully exploiting interprofessional collaboration opportunities with OT despite an expressed willingness to do so. OT leaders can provide education and strategic messaging to HCPs about comprehensive OT services, better position themselves on primary care teams, and establish more occupation-based interdisciplinary wellness programs in the community to constructively address this issue.

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Section 1: Nature of Project and Problem Identification

Chronic disease is the leading cause of death and disability in America (NCCDPHP, 2022a; Raghupathi & Raghupathi, 2018). An estimated 60% of adults in the United States are diagnosed with at least one chronic disease, 40% of which have more than two (NCCDPHP, 2022a). Statistics show that the prevalence of arthritis, cardiovascular disease, cancer, dementia, and Type 2 diabetes increases as a person ages (NCCDPHP, 2022d). Most chronic diseases are linked to behavior and can be avoided (NCCDPHP, 2022a; 2022b). While there is no guarantee of preventing the onset of chronic disease, healthy lifestyle behaviors can delay or reduce the risk of acquiring them. These trends are notable because, by 2040, experts project that the number of older adults living in the United States will grow to 80.8 million, and by 2060 one quarter of the population will be 65 years or older (NCCDPHP, 2022d).

Aside from the high prevalence, several other variables add to the complexity of effectively managing chronic disease within the boundaries of America's health care system. Sherman (2021) explained how structural factors, best-practice ambiguity, and conflicting priorities impede coordinated chronic disease care. Attention to social and contextual determinants, interprofessional collaboration (IPC) practice strategies, and reimagined holistic and client-centered care models hold promise for effective interventions targeting preventive health and wellness outcomes. The push to move from problem-oriented to goal-centered health care is growing (Mold, 2022). In fact, there are far-reaching measures in place targeting disease prevention, health, and wellness (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

Policymakers have recognized these chronic disease trends and the link to lifestyle behaviors and have responded by launching health and wellness campaigns nationwide

(NCCDPHP, 2022c; 2022d). A growing body of research has strengthened the argument for implementing innovative IPC practice models in primary health care for chronic disease prevention and management. In 2010, the World Health Organization (WHO) recognized the value of a team approach to primary health care and declared IPC the key to optimizing health systems (WHO, 2010). The critical dialogue to define IPC persists (Haddara & Lingard, 2013; Morgan et al., 2020), and barriers to implementation continue to be an issue (Rawlinson et al., 2021). Nevertheless, evidence is abundant on how professionals use IPC to positively transform health care, its value, and its impact on outcomes.

Health care professionals (HCPs) use IPC to seek and design avenues to efficiently coordinate care (Schot et al., 2020; Selleck et al., 2017). These efforts help reduce the fragmentation of services, foster reciprocity, mutual respect, and facilitate client-centeredness. Evidence has shown that IPC can positively impact health biomarkers like blood pressure and blood sugar, reduce hospital length of stay, and increase the quality of care (Pascucci et al., 2021). Furthermore, IPC in primary health care can increase client satisfaction, mental well-being, and perceived quality of life (Nurchis et al., 2022). While several of these studies discussed models that exclude occupational therapy (OT), there are plenty of cases where OT has proven valuable for the IPC team. Moreover, it is feasible to integrate OT services into many pre-existing community-based IPC primary health care programs (Sit et al., 2022). It takes leadership, initiative, and time to foster these collaborative relationships, but the effort is worthwhile when quality care is at stake (Wener et al., 2022).

Interventions for lifestyle wellness and prevention and management of chronic diseases for community-based older adults are well within the scope of OT practice, and OT practitioners can serve a distinct role in this interdisciplinary domain. The OT practitioners' role in primary

health care settings can be broad in scope (Wener et al., 2022), while others can be disease (Pyatak et al., 2017; Pyatak et al., 2019) or population specific (Sit et al., 2022). However, most effective OT-led community-based lifestyle wellness interventions are interdisciplinary and collaborative. Many programs in the literature were inspired by Lifestyle Redesign® (Clark et al., 1997; Clark et al., 2012), a cost-effective, occupation-based, client-centered program that has been shown to improve the health-related quality of life of community-based older adults. The Lifestyle Redesign® intervention is a product of a 1992 pilot study (Jackson, 1996) that led to the seminal University of Southern California Well Elderly Studies (Clark et al., 1997; Clark et al., 2012) cited and researched by many in more recent literature. The versatility of this high-quality evidence-backed intervention has enticed researchers across the globe to pilot and implement adaptions of the manualized Lifestyle Redesign® program (Clark et al., 2015), and these studies have produced favorable outcomes as well.

Problem Statement

Despite the supporting evidence for IPC for chronic disease prevention and management, the call for OT's clearly defined role in this area, and the mounting evidence for the effectiveness and feasibility of occupation-based lifestyle wellness programming for older adults, OT workforce presence in the wellness community remains low. The American Occupational Therapy Association (AOTA) reported that only 2.4% of OTs and 3.2% of occupational therapy assistants identified as community-based professionals (AOTA, 2019). Furthermore, it is valuable to note that these numbers also included those who reported working in adult day programs, group homes, and low vision clinics. Contrast those statistics with 28.6% of OT practitioners working in hospital settings, and it becomes evident that only a small fraction of OT practitioners venture into this nontraditional arena. With that said, there is a paucity of research

on the meaning of community-based lifestyle wellness programs as perceived by non-OT community-based HCPs and the link, if any, to OT.

Purpose Statement

The purpose of this qualitative phenomenological study was to explore the meaning of community-based lifestyle wellness programs as perceived by non-OT community-based HCPs, and the relationship, if any, to OT. *Community-based lifestyle wellness programs* were defined as strategically organized primary and secondary interventions designed to prevent, minimize, delay, slow, or reverse disease and promote health. These voluntary programs were set in the community and geared towards non-institutionalized individuals, groups, communities, or populations. The programs could include 1:1 or group-based interventions for health behavior modification, self-management training, coaching, screening, support, and resources and could be designed and led by multidisciplinary HCPs, trained personnel, service workers, or volunteers. *Non-OT community-based HCPs* were defined as licensed or authorized professionals other than OT practitioners operating within their distinct domain and scope of practice to diagnose, treat, or rehabilitate and provide health-promoting and disease-preventive interventions and services.

Research Question

This study aimed to answer the following grand research question: What is the meaning of community-based lifestyle wellness programs as perceived by non-OT community-based HCPs, and the relationship, if any, to OT? Additionally, the study sought to answer the research sub-questions: How do non-OT community-based HCPs perceive the practice of OT in community-based lifestyle wellness programs? How do non-OT community-based HCPs

perceive the use of the Lifestyle Redesign® program? What is the meaning of community-based IPC as perceived by non-OT community-based HCPs?

Theoretical Framework

This research was guided by the Framework of Occupational Justice (Stadnyk et al., 2010; Townsend & Wilcock, 2004; Townsend, 2015; Wilcock & Townsend, 2000). The framework stems from occupational science and social justice ideologies (Causey-Upton, 2015; Lewis & Lemieux, 2021). Therefore, an emphasis was placed on the premise that occupational choice, opportunity, and participation are human rights, and efforts should be made to support these rights. It was critical to recognize that people have distinct needs that are influenced by complex environmental and personal factors (AOTA, 2020b). The Framework of Occupational Justice can be used to inspire constructive dialogue and collaboration to empower others to work towards positive health outcomes (Nilsson & Townsend, 2010). Subscribers to this theory can challenge policies and practices to support and enable meaningful occupational participation for all individuals, groups, and populations (Lewis & Lemieux, 2021). Wilcock (2006) outlined five models that complement community-based practice and research. These models can be used by OT practitioners when addressing health, well-being, and chronic disease prevention and management outcomes and encourage justice-oriented and ecologically sustainable thinking and action.

Significance of the Study

AOTA (2017; 2020b) calls upon OT practitioners to lead as change agents within the community and population-based health and wellness programming domain. This directive aligns with the larger national health initiatives of Healthy People 2030 (ODPHP, n.d.). Approximately 350 Healthy People 2030 core objectives on health promotion and disease

prevention are used to guide policy, programming, and funding nationally (ODPHP, n.d.). Furthermore, it is crucial to recognize that older adults residing in the community are at risk for occupational injustices (Lewis & Lemieux, 2021) due to the potential for fragmented, overlapping, or even conflicting health care practices and attitudes (Rawlinson et al., 2021). OT is a science-driven profession, and OT practitioners should generate and use evidence to guide practice (AOTA, 2020a). Communication is key to IPC practice (Johnson et al., 2021; Sangaleti et al., 2017; Seaton et al., 2020; Sigmon et al., 2022; Wener et al., 2022). A critical line of dialogue can be opened by initiating conversation and actively listening to others' perspectives outside the occupational therapy profession about relevant mutual practice issues and working together collaboratively.

Summary

Chronic disease is deadly and prevalent in America (NCCDPHP, 2022a; Raghupathi & Raghupathi, 2018). Over 85% of people over the age of 65 have at least one chronic disease, at least 56% have at least two, and these rates are expected to rise along with this rapidly growing demographic (National Center for Health Statistics, 2015). Healthy lifestyle behaviors can reduce the risk or even prevent most chronic diseases (NCCDPHP, 2022a; 2022b). Health care paradigms and policies are changing in recognition of this wellness-behavior connection (Mold, 2022; NCCDPHP, 2022c; 2022d; ODPHP, n.d.). Managing chronic disease in older adults within community-based settings requires a collaborative effort, and IPC is a best practice strategy for HCPs (WHO, 2010). In response to national health initiatives (NCCDPHP, 2022c; 2022d; ODPHP, n.d.) and professional practice standards, HCPs use lifestyle wellness interventions as tools to prevent or manage chronic disease and to improve health-related related outcomes (Johnson-Lawrence et al., 2019; Patel et al., 2017; Soltero et al., 2018; Stoutenberg et al., 2017).

In other instances, OT practitioners collaborate with HCPs and clients to deliver effective lifestyle wellness interventions to older adults in the community (Berger et al., 2018; Smallfield & Lucas Moliter, 2018). However, OT practitioner presence in community-based health and wellness arenas remains low compared to school, hospital, outpatient, and long-term care settings (AOTA, 2019). Exploring non-OT community-based HCPs' perceptions about community-based lifestyle wellness programs, IPC, and the relationship to OT, if any, is relevant to the issues presented and addresses a gap in the literature.

Section 2: Literature Review

Researchers use the Framework of Occupational Justice (Stadnyk et al., 2010; Townsend & Wilcock, 2004; Townsend, 2015; Wilcock & Townsend, 2000) to critically examine how structural and contextual factors may influence the conditions for occupationally just outcomes of individuals, groups, and populations served in the health care arena (Lewis and Lemieux, 2021). Furthermore, as the older adult demographic continues to multiply, the demand for resources and interventions that support their lifestyle wellness grows (ODPHP, n.d.). HCPs recognize and value varied IPC strategies (Bookey-Bassett et al., 2017; Doekhie et al., 2017) and integrate multidisciplinary preventive wellness programming in creative and uniquely customized ways (Johnson-Lawrence et al., 2019; Patel et al., 2017; Soltero et al., 2018; Stoutenberg et al., 2017). Additionally, occupational therapy practitioners continue to pioneer innovative lifestyle wellness interventions to improve the health-related quality of life and life satisfaction of older adults across the globe. There is no shortage of occupation-based lifestyle modification interventions, many of which are based on the landmark University of Southern California Well Elderly studies from Clark and colleagues, the Lifestyle Redesign® program (Clark et al., 1997; Clark et al., 2012). The Framework of Occupational Justice, IPC,

community-based lifestyle wellness programming, and the Lifestyle Redesign® program with related studies were examined further in the following literature review synthesis.

Framework of Occupational Justice

When occupational rights are supported and enabled, occupational justice is present. When occupational rights are denied, ignored, or suppressed, occupational injustices are present (Nilsson & Townsend, 2010). Lewis and Lemieux (2021) noted that older adults reported limited social participation opportunities resulting in low engagement rates. They highlighted the evidence on the health benefits of social participation as a rationale to explore this topic further. The researchers gathered qualitative data from twelve focus groups involving 111 participants and then used deductive and inductive thematic analysis within the context of the Framework of Occupational Justice (Stadnyk et al., 2010; Townsend & Wilcock, 2004; Townsend, 2015; Wilcock & Townsend, 2000). The emergent themes were categorized by structural and contextual factors influencing the social participation opportunities of older adults and the occupational outcomes associated with occupational justices and injustices.

The authors pointed out that occupational justices and injustices were linked to structural factors. Structural factors relate to environmental factors defined by the Occupational Therapy Practice Framework (AOTA, 2020b). This point is relevant because occupation-based lifestyle wellness programs and IPC can be categorized as structural factors. Structural factors can significantly impact occupational choices (Hadden et al. 2020) and engagement (Causey-Upton, 2015). In fact, these external influences can prove to be barriers to occupational justice for individuals, groups, and populations (Causey-Upton, 2015).

Interprofessional Collaboration

Community-based older adults with multiple chronic conditions typically required and used health care services from various community-based and multidisciplinary HCPs (Bookey-Bassett et al., 2017; Doekhie et al., 2017; Seaton et al., 2020; van Dongen et al., 2016). The complexity of care needed to address multiple chronic conditions across settings effectively and efficiently was supported by a collaborative effort (Carron et al., 2021; WHO, 2010; 2016). IPC was an evolving concept discussed extensively in the literature, yet a uniform consensus on its definition was not established (Bookey-Bassett et al., 2017; Carron et al., 2021; Haddera & Lingard, 2013; Morgan et al., 2020). In general, collaborative practice was achieved "…when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, careers and communities to deliver the highest quality of care across settings" (WHO, 2010, p. 13). Bookey-Bassett et al. (2017) provided a synthesized definition derived from an in-depth, evidence-based concept analysis to focus the IPC context to the management of chronic disease of older adults living in the community:

> An evolving interpersonal process, involving a diverse team of health care and other community providers who interdependently engage in frequent communication and shared decision-making, for the purposes of providing optimal health and social care services to CLOA [community-living older adults] and their families. Team composition and team processes are flexible and consistently evaluated to meet client needs effectively and efficiently. (p. 79)

The practice of IPC improved client outcomes (Pascucci et al., 2021), quality, safety (Sigmon et al., 2022), and satisfaction among clients (Carron et al., 2021; Nurchis et al., 2022) and HCPs (Bookey-Bassett et al., 2017). It optimized health systems by reducing health care

expenditures and streamlining services (Rawlinson et al., 2021; WHO, 2010). However, IPC models varied by setting regarding team member constitution, organization, and practice methods (Frost et al., 2020). Furthermore, the knowledge and perceptions of IPC expressed by HCPs were diverse (Doekhie et al., 2017), adding another level of complexity to understanding the phenomenon. The perceived meaning and lived experiences of IPC were individually distinct. Nevertheless, in efforts to better understand collective mindsets, researchers explored IPC perspectives from primary care practitioners (Brown et al., 2021; Doekhie et al., 2017; Sangaleti et al., 2017; van Dongen et al., 2016; Wener et al., 2022), allied health professionals (Seaten et al., 2020), and patient-family groups (Davidson et al., 2022; Morgan et al., 2020; Sigmon et al., 2022). The themes about IPC that emerged within these groups were similar across them as well.

Primary care practitioners, allied health professionals, and patient-family members reported positive experiences with and enabling characteristics of IPC. Common topics reported across groups regarding the lived experiences and perceived meanings of successful IPC included the need for: role clarity and familiarity among team members (Davidson et al., 2022; Doekhie et al., 2017; Johnson et al., 2021; Sangaleti et al., 2017; Sigmon et al. 2022; van Dongen et al., 2016; Wener et al., 2022), frequent or positive formal and informal contact among team members (Davidson et al., 2022; Sangaleti et al., 2017; Seaton et al., 2020), communication (Johnson et al., 2021; Sangaleti et al., 2017; Seaton et al., 2020; Sigmon et al., 2022; Wener et al., 2022), client-centeredness (Davidson et al., 2022; Sangaleti et al., 2017; Sigmon et al., 2022; van Dongen et al., 2016; Wener et al., 2022), shared collaborative care philosophy and values (Doekhie et al., 2017; Johnson et al., 2021; Sangaleti et al., 2017; Seaton et al., 2020; Sigmon et al., 2022; van Dongen et al., 2016; Wener et al., 2022), mutual trust and respect (Johnson et al.,

2021; Sangaleti et al., 2017; Sigmon et al., 2022; van Dongen et al., 2016), and co-location (Davidson et al., 2022; Wener et al., 2022). However, barriers to IPC were reported as well from varied HCPs.

IPC barriers existed at individual, inter-individual, organizational, and system levels (Rawlinson et al., 2021). At the inter-individual level, poor communication, diminished role clarity, and lack of a shared vision were common barriers reported (Rawlinson et al., 2021; Sangaleti et al., 2017). However, the most prominent roadblock at this level was the presence of resistant hierarchal or power discrepancies (Doekhie et al., 2017; Rawlinson et al., 2021; Sangaleti et al., 2017; Seaton et al., 2020). Environmental space (Rawlinson et al., 2021; Sangaleti et al., 2017) and funding issues (Davidson et al., 2022; Doekhie et al., 2017; Rawlinson et al., 2021; Seaton et al., 2020; van Dongen et al., 2016) were common barriers reported at the organizational and systems levels.

Community-Based Lifestyle Wellness Programs

Health promotion "is the process of enabling people to increase control over, and to improve their health" (WHO, 2021, p. 4), and wellness is the "active pursuit of activities, choices, and lifestyles that lead to a state of holistic health" (Global Wellness Institute, n.d., para. 2). Health promotion and wellness programming, also referred to as lifestyle wellness programming, has been widely implemented and studied. These programs, led by diverse and varied groups of HCPs, community leaders, or even volunteers, had disease specific-focuses or were uniquely tailored to individuals, groups, populations, or communities (Johnson-Lawrence et al., 2019; Patel et al., 2017; Soltero et al., 2018; Stoutenberg et al., 2017). More specifically, there was an abundance of promising research on occupational therapy lifestyle wellness programs geared towards the prevention and management of chronic disease in community-

based older adults. (Berger et al., 2018; Smallfield & Lucas Moliter, 2018). These occupation-based lifestyle wellness programs were shown to positively impact the health and wellness of participants.

Lifestyle Redesign® Program

The Lifestyle Redesign® program is a lifestyle modification intervention developed and researched by Florence Clark and colleagues (Jackson, 1996; Clark et al., 1997; Clark et al., 2012). This present-day manualized program was tested through a series of randomized controlled trials collectively called the University of Southern California Well Elderly Studies from 1994 through 2010 (Clark et al., 1997; Clark et al., 2012). The findings from these seminal studies illustrated that this OT preventive wellness intervention was efficacious (Clark et al., 1997), effective, affordable, and positively impacted the health-related quality of life of older adults (Clark et al., 2012). The Lifestyle Redesign® program leaders used a client-empowerment approach to help people redesign a satisfying, meaningful, and health-promoting lifestyle that enabled them to thrive (Clark et al., 2015). While the program was designed to be adaptable for targeting the specific needs of the stakeholders, some distinct attributes of this intervention are essential to regard.

The Lifestyle Redesign® is an occupation-based program that is grounded in the founding premises of several occupational science and OT visionaries (Addams, 1910/1990; Cooper, 1919; Dunton, 1915; 1919; Englehardt, 1977; Fazio, 1992; Hall, 1918; Meyer, 1977; Slagle, 1922; Tracy, 1910; West, 1990; Yerxa, 1990). Although pre-established content modules exist, each program is typically customized by OT practitioners following a stakeholder needs assessment, commonly conducted via individual and focus group interviews (Clark et al., 2015). During the University of Southern California Well Elderly Studies, the Lifestyle Redesign®

intervention was delivered at nine and six months, respectively (Clark et al., 1997; Clark et al., 2012). The authors recommended that the programs contain at least five individual sessions in conjunction with weekly group sessions lasting around two hours each (Clark et al., 2015). Another distinct feature of the Lifestyle Redesign® program is the once-monthly community outings where participants can integrate concepts processed in previous sessions. Program content is delivered through didactic presentations followed by peer exchanges, active experiences, and self-analyses.

Many contemporary community-based lifestyle modification programs were based on the Lifestyle Redesign® program model (Cassidy et al., 2017; Chatters et al., 2017; Eklund et al., 2017; Fernández-Solano et al., 2019; Gutman et al., 2019; Johansson & Björklund, 2016; Juang et al., 2018; Kuo et al., 2022; Lund et al., 2018; Lund et al., 2019a; Lund et al., 2019b; Lund et al., 2020; Mountain et al., 2017; Mountain et al., 2020; Schepens Niemiec et al., 2018; Schepens Niemec et al., 2021; Tsai et al., 2022). Budgetary, resource, and attrition concerns motivated some researchers to modify their Lifestyle Redesign®-inspired programs, yet many were still able to yield positive outcomes (Cassidy et al., 2017; Clark et al., 2012; Schepens Niemiec et al., 2018). Many researchers examined the effectiveness of their modified interventions, but few sought to scientifically examine the potent dimensions responsible for the successful results. Many authors conceded that this issue is cause for further research to refine future service delivery models based on the Lifestyle Redesign® program.

For example, researchers highlighted the need for practitioners to consider program duration carefully, targeted populations, and outcome measures and incorporate multimodal, client-centered, group-based, (Clark et al., 1997; Clark et al., 2012; Johannson & Björklund, 2016; Juang et al., 2018; Lund et al., 2019; Rees et al., 2021) or individual group combined

approaches. Some researchers recommended a program length of at least three months (Berger et al., 2018; Cassidy et al., 2017, Chatters et al., 2017; Mountain et al., 2020; Schepens Niemiec et al., 2018; Tsai et al., 2022). Some authors proposed respondent-driven sampling or targeting a population motivated by a lifestyle change or at risk for isolation or age-related decline (Chatters et al., 2017; Mountain et al., 2017). The researchers also cautioned practitioners to weigh their choices for outcome measures. While most intervention studies included some form of quantitative health-related quality-of-life outcome measure, researchers advocated for a mixed methods approach to data collection and analysis due to the complex and subjective dimensions of lifestyle wellness and personally ascribed meanings for occupations (Kuo et al., 2022; Lund et al., 2020).

Summary

Occupational outcomes can be strongly influenced by structural or environmental factors. If community supports and resources are inadequate, or if values do not align (Lewis & Lemieux, 2021), occupational justice for older adults with chronic diseases is in jeopardy. Although not consistently defined or perceived the same, IPC can enhance health care practices and improve health-related outcomes. As HCPs across settings work to serve the complex health and wellness needs of older adults in the community, lifestyle wellness programs have been established. These programs serve various purposes and are implemented by a diverse array of HCPs and trained facilitators. OT practitioners collaborate with HCPs to promote health and lifestyle wellness for individuals, groups, and populations in many settings and contexts (AOTA, 2020b). These professionals use evidence-based interventions like the Lifestyle Redesign® (Clark et al., 1997; Clark et al., 2012) program to positively impact health and wellness

outcomes, reduce occupational barriers, support healthy habits and routines, and empower the people they serve.

Section 3: Methods

Project Design

A qualitative phenomenological approach (Moustakas, 1994) was used to explore participants' lived experiences and perceptions of the meaning about community-based lifestyle wellness programming, the concept of IPC, and the relationship, if any, to occupational therapy. Moustakas (1994) spoke to qualitative research using a transcendental focus to perceive things "…freshly, as if for the first time" (p. 34), of which this phenomenological approach to community-based practice and older adults attempted to do. To present the essence of meaning about this shared phenomenon, the principal investigator (PI) used Moustakas' (1994) systematic process to identify, describe, and bracket the subject matter under investigation and then outline the overarching philosophical assumptions surrounding this topic. To present the essence of the participants' perceived meanings and lived experiences, the PI identified significant statements from multiple individuals, highlighted the common themes, and provided a detailed summative description of the participants' perceived meaning of the phenomenon in question (Creswell & Poth, 2018). The Eastern Kentucky University Institutional Review Board (IRB) approval was granted December 7, 2022.

Setting

The study included two general settings: one primary care clinic and one assisted living facility located in a mid-sized metropolitan city within the East-South Central region of the United States. These varied and distinct settings were pertinent to the context of this study as many older adults received or solicited services from each of them to improve their health (Frost

et al., 2020), wellness, and quality of life (Zimmerman et al., 2022). Primary care clinics are set in the community and run by multidisciplinary HCPs. These HCPs are experts in preventing, treating, diagnosing, and managing common or chronic health conditions. Patrons of these community-based clinics can receive a broad range of services and establish long-term relationships with the HCPs. The community-based primary care clinic selected for this study was situated in a multi-office park building near a suburban shopping center. It was teamed by one physician, one physician assistant, and four family practice nurse practitioners that provided primary health care and laboratory services to clientele between the ages of two-weeks to end of life. These HCPs delivered physical activity, wellness, and disease-prevention counseling and offered physical exams and screenings, immunizations, and additional medical, and therapy referrals as needed.

Services that support health, wellness, and quality of life are also available through the personalized care model of assisted living facilities. Over 800,000 Americans aged 65 years or older reside in assisted living facilities (American Health Care Association & National Center for Assisted Living, 2020). Assisted living facilities are for-profit residential communities for individuals requiring support with daily living but not to the degree of a skilled-nursing level of care. A privately funded assisted living facility within the designated geographical area was selected for the study. The facility included comprehensive independent, assisted living, and memory care annexes. Non-skilled supported living services, luxury amenities, and social-leisure activities were available to the residents. Recreational, nursing, OT, and physical therapy services were contracted on-site.

Participants

Recruitment Procedures

To obtain credible data from a heterogenous group, a purposive sample of at least five HCPs meeting inclusion criteria were invited to participate in the study (Creswell & Poth, 2018; Polkinghorne, 1989). Participant recruitment coincided with site selection. The PI conducted a password-protected web search from a study-designated personal laptop computer for local listings and social media sites of primary care clinics and assisted living facilities catering to older adults within a 20-mile radius of the PI's residence. One primary care clinic and one assisted living facility for older adults were targeted for participant recruitment.

The PI, via telephone and in-person, consulted and collaborated with the administrative medical director and the director of health services from the two targeted settings. The PI recited a verbal recruitment script (see Appendix A), provided a descriptive one-page participant recruitment flyer (see Appendix B) highlighting the purpose and general participation requirements of the study, and provided a copy of the verified and approved IRB application for the site directors and participants to view. The directors facilitated the purposive recruitment process by identifying potential participants and granting access to the site for recruitment flyer dissemination. The participants were not met on the same day of the recruitment effort. Rather, the potential participants contacted the PI later for screening and recruitment using the designated password-protected personal mobile phone number listed on the recruitment flyer. Individuals who expressed interest in participating were screened for eligibility via a screening checklist (see Appendix C) to meet inclusion criteria, and informed consent was obtained in person before initiating data collection procedures. Five eligible participants were identified

through the initial site selections. Therefore, the contingency plan to conduct another web-based search to identify additional sites was deferred.

Inclusion Criteria

All participants were required to meet the following criteria to be included in this study:

- speak fluent English,
- be at least 22 years of age or older,
- voluntarily consent to engage in the study,
- be a current licensed HCP who has practiced full or part-time for at least five years in the state and county as identified by the PI,
- be currently employed full time or part time for at least one year in a community-based primary care clinic or assisted living setting as defined for this study, and
- currently provide health and wellness services to adults aged 65 years or older on a weekly routine basis

Exclusion Criteria

Participants were excluded from this study if one or more of the following criteria were present:

- were an occupational therapy practitioner,
- did not speak fluent English,
- were under the age of 22 years,
- did not voluntarily consent to participate in the study or interview process,
- were an unlicensed HCP,
- were an HCP who had practiced for less than five years,
- were an HCP not currently practicing in a community-based setting,

- were an HCP employed at a community-based primary care clinic or assisted living facility for less than one year, or if they
- were an HCP who did not provide health and wellness services to adults aged 65 years or older on a routine weekly basis

Data Collection

In line with Husserl's (1970) founding theories of phenomenology and Moustakas' (1994) supporting philosophical principles on transcendental phenomenology, with a conscious approach to the qualitative interview, the participants' perceived meaning of the phenomenon of community-based lifestyle wellness programming, IPC, and the relationship, if any, to occupational therapy can be translated in a trustworthy manner. Obtaining the perspectives of others via interviewing is a common strategy for data collection in phenomenology (Creswell & Poth, 2018; Polkinghorne, 1989). Therefore, semi-structured interviews of five eligible participants were conducted. For this study, the semi-structured interview was developed within the context of the Framework of Occupational Justice theory (Stadnyk et al., 2010; Townsend & Wilcock, 2004; Townsend, 2015; Wilcock & Townsend, 2000) and included questions such as, "In your day-to-day practice, how do you support your clients' choices and meaningful participation in a lifestyle that promotes health and wellness, and what factors influence this outcome?" The open-ended interview questions were designed to align with the occupational justice outcomes of choice, balance, opportunity, meaningful engagement, and the influencing structural and environmental factors (Lewis & Lemieux, 2021).

Before the PI initiated the interviews with the five participants, the PI assessed participant eligibility using a screening checklist protocol. The nature and purpose of the study were explained using the verbal script, and the written informed consent was used as a guide. Then

signed, written informed consent was obtained in person (see Appendix D). The participants provided written or verbal responses to a confidential demographic survey (see Appendix E) on the same day and just prior to the interview. Participant and separate site numbers were used to match the demographic and interview data. For example, the first participant from the first study site was given the study identifier *P1S1*. The estimated 30-minute 1:1 in-person semi-structured interviews transpired in private closed-door rooms at participants' workplaces to protect the confidentiality and minimize distractions or remotely using Zoom video conferencing technology at a mutually agreed upon date and time Monday through Saturday, between 7 a.m. and 7 p.m. Eastern Standard Time. The participants consented to as-needed follow-up interviews and member checking to maximize the study methods' credibility and confirmability (Guba & Lincoln, 1989; Shenton, 2004). However, due to the successful execution of thorough initial interviews, follow-up sessions did not occur.

The interviews were recorded using password-protected and data privacy-secured iPhone or Zoom platform software. For example, the PI enabled Zoom platform security settings, including single-use password entry to locked and private meetings, host-only recording and guest admittance option, recordings encrypted via standard Zoom account policies and controls, and no names disclosed during the interviews. The interviews included five open-ended questions and varied probes when needed by the PI to encourage in-depth responses. An interview protocol was used to provide consistency of questions across interviews (see Table 1). At one point during the interviews, when Lifestyle Redesign® was mentioned, a brief informational handout with a corresponding verbal script narrated by the interviewer was provided when participants' reported unfamiliarity with the program (see Appendix F). The participants used this information to enhance their responses to the final interview question:

Table 1: Interview Protocol for Non-OT Health Care Professionals

Occupational justice outcomes	• In your day-to-day practice, how do you support your clients' choices and meaningful participation in a lifestyle that promotes health and wellness, and what factors influence this outcome?
	• What, are your feelings about and experiences with community-based lifestyle wellness programs, if any? Probe: What do these programs mean, if anything, to you, for your practice, clients, or in general?
Structural and environmental factors	• What are your feelings about and experiences with collaborating with other HCPs in the community, if any? Probe: What does IPC mean to you, for your practice, clients, or in general, if anything?
Structural and environmental factors	• What are your feelings about and experiences with OT lifestyle wellness programs, if any?
Structural and environmental factors	• How would an OT program like Lifestyle Redesign® (Clark et al., 1997; Clark et al., 2012) impact your role as an HCP, if at all? If a participant reports unfamiliarity with Lifestyle Redesign®, ask: Based on the information provided, what would the Lifestyle Redesign® program mean to you, for your practice, your clients, or in general, or how would you envision using, if at all, Lifestyle Redesign® in your practice?
Wrap-up	• Is there anything else you would like to add to this discussion?

Note. This table represents a general interview guide of questions plus optional probes to elicit in-depth responses from the non-OT health care professional participants to explore their perceived meaning of community-based lifestyle wellness programs, interprofessional collaborative practice, and the relationship to occupational therapy. HCP = health care professional; IPC = interprofessional collaboration; OT = occupational therapy.

"Based on the information provided, what would the Lifestyle Redesign® program mean to you, for your practice, your clients, or in general or how would you envision using, if at all, Lifestyle Redesign® in your practice?" The questions aligned with the grand research question and sub-questions previously outlined in Section 1 of this report.

Data Analysis

The phenomenological reflection (van Manen, 2014) continued throughout the data analysis and reporting phase. It was critical to capture the nuanced and significant statements of all participants (Creswell & Poth, 2018; Moustakas, 1994). Therefore, the recorded interview data was initially transcribed verbatim by the PI using the Otter.ai voice-to-text (Liang & Fu, 2016) mobile and computer software application. The remote interviews were audio and video recorded with a cell phone and a laptop computer with Zoom software technology to safeguard against equipment failure or quality of recording issues. The in-person interviews were recorded with a cell phone only due to unreliable and potentially unsecure connectivity at the study site.

Otter.ai (Liang & Fu, 2016*)* transcription was completed using a password-protected laptop computer. The PI used a naturalized or intelligent verbatim transcription editing technique (McMullin, 2021) to complete the written transcription report. Specifically, the PI omitted or masked identifiable content, such as proper names and unique locations, and judiciously moderated the transcription of identifiable colloquialisms, speech patterns, or participant mannerisms. Identifiable information was blacked out on the original unedited interview transcripts. Otherwise, the data was recorded and transcribed verbatim, including verbal repetitions and fillers, laughter, and nonverbal cues, in an effort to preserve the meaning and intent of the participants' responses. This technique enhanced the ethical integrity of the study by respecting the site and participant confidentiality and privacy (Mero-Jaffe, 2011).

HyperRESEARCH Version 4.5.4 (Researchware, Inc., 2015), a commercial computer software program, was used to assist with coding and analysis procedures. A combined inductive and deductive analysis occurred via open and axial coding of the transcribed data. Specifically, significant words and statements were identified and assigned to larger units of meaning (Creswell & Poth, 2018) guided within the Framework of Occupational Justice theory.

Outcome Measures

Five participants fully completed the demographic survey and semi-structured interviews. The participants self-reported nominal data for categorization and description using a demographic survey created by the PI. The survey data was used later for descriptive reporting. The confidential survey did not include any questions that could reveal participant identities or personal information. Instead, the survey content included questions on age, gender identity, education, race, ethnic identity, employment status, and workplace setting. The questions were tailored to be nonbiased, inclusive, and neutral. For example, the participant was asked to provide an age range versus an exact age. For other questions, such as education level, employment status, and gender identity, there was an option to defer the answer if a participant did not wish to specify. Additionally, for inclusivity, the participant could select more than one category per question, as in the case of ethnic identity, for instance. The demographic surveys were marked with the participants' study identifiers, and no names were written on the form.

The seven steps of Colaizzi's (1978) phenomenological method (Morrow et al., 2015) was used to measure and evaluate the qualitative semi-structured interview data on the participants' perceived meanings of the studied phenomenon. Data summary tables present the analysis and themes in an organized and deconstructed fashion for a clear illustration of the process. The PI employed a reflexive and descriptive field note journaling strategy to promote

objectivity, reflection, and increased awareness of potential bias. Data analysis and collection followed an emergent design, with constant comparative data collection and analysis to obtain deep insight into the participants' lived experiences and perceived meanings of the phenomenon under study.

The researcher kept a decision trail (see Appendix G) to improve confirmability and document the study's process and path to analysis, findings, and interpretation. The PI solicited peer-checking from faculty mentors to further improve the trustworthiness of the research process, method, and analysis. The PI also revisited all participants per their method of choice, remotely or in-person, at the end of the data collection and analysis period and provided a debriefing on the study's findings to extend reciprocity for their collaboration.

Ethical Considerations

The benefits of participation in this study outweighed the risks. The participants were able to contribute to the research process and safely and confidentially shared their experiences and perceptions of the phenomenon's meaning. There was limited access to the data, and all electronic data was void of personal identifiers other than participants' masked study identifier code, which further enhanced the human subjects' confidentiality. The study report was presented honestly, professionally, and written with bias-free language according to the American Psychological Association (2020) guidelines.

The PI reported no conflicts of interest pertaining to this study. The PI had no vested interest or affiliation with sites or participants involved in the study which minimized the risk of selection bias. The selection of the site and participants was based on the pre-established recruitment and methods criteria. The PI consciously bracketed personal worldviews and experiences using reflexive strategies such as journaled notes and peer-checking to reduce the

risk of flawed or biased data collection and analysis. For example, an interview protocol was used as a guide to ensure questions remain focused, neutral, and open-ended. The PI referred to Colaizzi's (1978) phenomenological data analysis methods to add rigor to the research procedures and refrained from censoring or altering the results to fit a pre-determined narrative or personal bias.

The PI employed strategies of respect and reciprocity towards the participants. The participants were informed of the study expectations and their rights through a formal consent procedure and periodically throughout the research process. Respect for confidentiality occurred when the PI masked the participants' identifiers within the transcribed data, with the use of secure data management strategies outlined in this chapter, and active attempts to collect data one-on-one with the participants. The PI verbally expressed gratitude to the participants for engaging in the study, invited their feedback, and shared the executive summary of results once formally completed.

Timeline

Table 2: Research Timeline

Study Procedure	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023
IRB Application	Nov 29					
IRB Approval		Dec 7				
Participant Recruitment		Dec 7 – Dec 29				
Data Collection		Dec 17 –	Jan 10			
Data Analysis			Jan 10 –		Mar 1	
Finalize Report					Mar 5 –	Apr 27
Formal Research Summary Presentation						Apr 10

Note. This table represents the study procedure timeline of Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach.

Section 4: Results and Discussion

Approval from the Eastern Kentucky University Institutional Review Board was obtained on December 7, 2022. Participant recruitment and data collection transpired from December 17, 2022, through January 10, 2023. One primary care physician administrative medical director, one nurse practitioner, two licensed practical nurses, and one licensed practical nurse director of nursing voluntarily engaged in an individual, private, and recorded semi-structured interview. Prior to their interview, all five participants completed a demographic survey. The following section outlines the results of data analysis, evaluation of study objectives, discussion of findings, strengths, limitations, implications for occupational therapy practice, and future research.

Data Analysis

Participant Characteristics

According to the demographic survey results, participants' ages ranged from 33 to 65 years (see Table 3). All five participants self-identified as White, and the majority as female. Three participants worked full-time in an assisted living facility, one in a primary care clinic and an assisted living facility. One participant indicated they worked full-time in a primary care clinic but had an employment affiliation with an assisted living facility. Education levels ranged from an associate degree to a Doctor of Medicine degree.

Interviews

Five semi-structured interviews were conducted, and according to participant preference, four of these interviews occurred via Zoom, and one in-person, at a pre-scheduled time Monday through Saturday between 7 a.m. and 7 p.m. (see Table 4). The duration of the recorded interviews ranged from approximately 21 to 55 minutes, with an average length of 31 minutes.

Table 3: Participant Demographic Survey Results

Characteristics	Sub-Category	N
Age range	Between 33 and 43 years	2
	Between 44 and 54 years	1
	Between 55 and 65 years	2
Gender identity	Male	1
	Female	4
Race or ethnic identity	White	5
Employment setting	Primary care clinic	1*
	Assisted living facility	3
	Both	1
Employment status	Full-time	5
Education level	Doctor of Medicine	1
	Master's degree	1
	Bachelor's degree	1
	Associate degree	2

Note. This descriptive table of demographic characteristics is a product of the participant self-report survey administered prior to each of the five interviews.

* Participant self-identified their employment setting as a primary care clinic with an affiliation to an assisted living facility for direct client referrals and consultations.

Table 4: Interview Schedule and Related Details

Participant code	P1S1	P2S1	P1S2	P2S2	P3S2
Interview date	Tuesday, 1/03/2023	Saturday, 12/17/2023	Tuesday, 1/10/2023	Saturday, 1/07/2023	Tuesday, 1/10/2023
Start time	12:20 p.m.	10:03 a.m.	11:28 a.m.	2:54 p.m.	12:22 p.m.
Stop time	12:53 p.m.	10:57 a.m.	11:50 a.m.	3:14 p.m.	12:46 p.m.
Interview duration	33:08	54:57	22:20	20:55	24:52
Interview mode	Zoom; participant at home	Zoom; participant traveling in car as a passenger with one family member present and driving; participant used earbuds	Zoom; participant at the IRB approved worksite, in a private office	Zoom; participant at home	Face-to-face, in a closed-door private meeting room at the IRB approved worksite
Initial transcription	1/03/2023 at 3:43 p.m.	12/19/2022 at 9:27 a.m.	1/11/2023 at 1:49 p.m.	1/07/2023 at 4:49 p.m.	1/11/2023 at 2:19 p.m.
Transcription edited for accuracy and masking identifiers	1/06/2023 through 2/02/2023	12/20/2022 through 1/04/2023	1/12/2023 through 2/03/2023	1/08/2023 through 2/03/2023	1/12/2023 through 2/02/2023

An additional estimated 10–15-minute discussion occurred for each interview session before and after for conversational icebreakers and briefing purposes.

Open Coding

The coding process occurred in four stages. First, all transcripts were carefully read at least three times, and notes were taken for text familiarization. Then, open coding, line-by-line, to establish a list of distinct words repeated within each transcript. A threshold was set at three occurrences, meaning the words or short phrases had to repeat at least three times in a single transcript to qualify as a code. Using this technique, 4010 individually highlighted words, word variations, and short phrases were selected to generate an initial master list of 300 initial codes (see Table 5; Appendix H). Second, the list was condensed to 20 final codes after examining all the transcripts to locate the words, word variations, and short phrases that repeated a minimum of three times per transcript and across four to five transcripts (see Table 6).

Axial Coding

The third stage involved axial coding. Six categories were named based on the frequency of open-coded words that cut across all transcripts, grouped by similar meanings, and supported by direct participant quotations (see Table 7). The frequency threshold for this data was set at a minimum of 14 total occurrences across transcripts. In this way, the data was reduced and merged, but not so much as to lose sight of the meanings. Finally, one primary theme, or predominant idea, and four secondary themes were named by examining the evidence: the coded data and categories across all transcripts (see Table 8). This systematic review and recording of the data at each stage of analysis provided evidentiary support in naming the categories, themes, and secondary themes presented hereafter.

Table 5: Initial Master Code List [Sample]

Repeated words, word variations, and short phrases with total frequency of use			
a lot/lots, 49	benefit/beneficial, 9	consultation/consult, 10	engineering, 6
ability/abilities, 14	better, 11	conversation, 5	environment, 4
able to, 13	blood pressure, 8	conversation topic, 3	established, 3
about, 21	building, 6	COVID, 3	every, 20
active, 3	called/call, 12	daily, 17	everybody, 8
activity/inactivity, 20	can't, 6	days, 32	everyone, 3
ADLs, 3	capture your audience, 3	decided, 5	everything, 8
aerobics, 3	care, 57	dementia, 12	example/for example, 13
aggravate, 3	caregiver, 8	desires, 3	exercise, 15
Alcoholics Anonymous/AA/	certain, 3	develop/develops/	experience, 4
alcohol, 7	change, 22	developed, 3	exposure, 4
always, 23	children/child, 5	diabetes, 5	extension, 4
Ambien®, 3	cholesterol, 4	diet, 8	facility, 6
anything, 3	choose/choice, 3	different, 24	fact, 3
apartment, 5	chronic condition/	director, 3	factor, 3
appointments, 3	medical condition/	disciplines, 3	familiar/familiarity, 3
ask, 9	condition, 4	discontinue, 3	family, 11
aspect, 3	class/classes, 12	discuss/discussion, 7	feel, 7
assess/assessment, 17	client/clients, 3	do/doing, 11	financial/finances, 14
assist/assistance, 14	clinic, 3	doctor, 11	find, 11
assisted living, 11	come, 18	document, 3	fitness/fit, 13
attend, 4	comment, 3	don't, 11	focus/focusing, 9
aware/awareness, 10	communicate/	drive, 3	forms, 4
back to, 7	communication, 3	eating, 7	free, 4

Note. This is a sample list of the initial open coded words, word variations, and short phrases obtained from five participant interview transcripts. Refer to Appendix G for the complete initial open code list.

Table 6: Final Master Code List

Code	Total #	P1S1 #	P1S2 #	P2S1 #	P2S2 #	P3S2 #
a lot/lots	49	3	4	27	3	12
always	23	12	-	4	4	3
because	54	7	9	20	11	7
different	24	-	4	8	4	8
every	20	-	5	6	4	5
get/getting/got	103	10	10	36	26	21
good	44	14	13	17	10	-
group	33	3	3	8	-	19
have	128	15	36	60	17	-
have to	34	-	9	6	10	9
help/helping/helpful	39	5	6	16	6	6
how	38	5	7	12	7	7
I don’t	37	11	9	11	-	6
know/knowing	69	12	18	14	11	14
meeting	20	-	8	4	3	5
need/needs	58	9	3	18	28	-
OT/occupational therapy/occupational therapist	32	3	4	22	-	3
therapy/therapist	32	4	9	7	3	9
time	46	-	7	31	4	4
work/works/worked	37	-	6	8	18	5

Table 7: Axial Categories Meanings and Context

Category	Code	Meaning	Sample Quotation
Lasting Impressions	know/knowing, therapist/therapy, OT/occupational therapy/therapist	Familiarity and experiences with therapy providers impacted referrals, recommendations, and clinical practices; limited to no awareness of community-based lifestyle wellness programs, Lifestyle Redesign®, and the relationship to occupational therapy; decreased communication with therapy providers impacted clinical practice strategies and perceived collaboration; narrowed perceptions of physical and occupational therapy roles and settings	"Generally, you … get to know certain practices, and the outcomes seem to be … consistently good and the patient has had a good experience and you kind of refer back to those people that you know do a good job." (P1S1) "I mean, that's what I look for occupational therapy to help me with as a nurse, is more of ADLs, upper body type things." (P3S2)
Been There, Done That	a lot, group, time/times	Frequent lifestyle wellness-related client conversations, care-planning, consultative actions, or opportunities; generalized interactions or experiences with community-based therapy and medical service provider groups, perceived as beneficial to clients; experiences with referrals, recruitment, planning, leading, or observing peer support groups perceived to be similar to Lifestyle Redesign® programming	"But just a lot of a lot of conversation, definitely not something that's very scripted." (P2S1) "No, … I really think the dementia support groups is a lot like this [Lifestyle Redesign®]. So, … a lot of these topics … get brought up." (P3S2)
This is How (and Why) it's Done	always, because	Inclination to refer clients to outpatient physical therapy with occupational and speech therapy referrals reserved for hospital, inpatient rehabilitation, home health, or skilled nursing settings when acute changes in client function, recent hospitalizations, illnesses occur, or when outpatient services for these disciplines were not available or known; common for outside medical and therapy service providers to monitor, screen, and treat age-related chronic conditions in the assisted living setting; outside providers commonly addressed residents' health and wellness needs in a convenient way and caregivers were invited to interdisciplinary meetings; interdisciplinary communication and teamwork strategies perceived as beneficial to clients and workflow	"Well, I guess the most common one that I refer to from the primary care level is probably physical therapy because … there may be … circumstances with a specific patient that I might need to refer to a speech therapist or an occupational therapist … if they were to suddenly develop problems with just routine daily activities of daily living … eating, dressing, that sort of thing." (P1S1) "So, if somebody had an OT need that I could identify they would … probably go back to the hospital because that's where I send my speech." (P2S1)
Jumping Through Hoops	I don't	Limited understanding of lifestyle wellness programming; supporting clients' lifestyle wellness and addressing health risk factors was routine, necessary, and not hard, but the	"I don't know the specifics about any individual wellness program." (P1S1)

Category	Code	Meaning	Sample Quotation
		referral process to outside providers could be difficult due to communication and procedural barriers; limited time for some best-practice strategies; decreased communication with therapy providers impact service provision, knowledge of therapy process, client performance, and was perceived as a hindrance	"I know they're doing … therapy with them, that they have PT-OT, but beyond that … I don't get communication like how they're progressing. I rarely get a note unless I asked for it. Sometimes, I don't even know they've discontinued them, honestly … I don't even know they're not being seen anymore to know to get home health back in the hallways." (P1S2)
Welcomed Support	get/getting/got, have	Diverse practice strategies, access to specialty medical and therapy services, groups that support socialization through shared interests, interdisciplinary staff, and client-centered care plan meetings, and teamwork was perceived as supports to clients and clinical practice.	"But I think what they mostly mean to me is if I can get them to engage at another level … with other people that are interested in their health model, then I'll get support, along with the patient support, for hoping that this will drive their … health model into a … more complete and … more comprehensive model for their long-term fitness, emotional fitness as well as physical fitness sometimes." (P2S1) "Whether it be something for nausea or an x-ray … all of us work together, the DON, the caregivers, the nurses … we have a great team, we work together, and we make the residents feel at home … our number one priority is their care." (P2S2)
If You Ask Me	good, help/helping/helpful, needs	Knowing more about community-based lifestyle wellness programs would be helpful; community-based lifestyle wellness programs and Lifestyle Redesign®-inspired programs could provide opportunities for peer support, information exchange, help clients increase functional independence, maintain, or strive for physical and mental health, and ease burdens on stakeholders; interprofessional collaboration could support varied care approaches, plans for care, treatment, and meeting clients' needs	"So, knowing about these programs … knowing more specifics … would probably help me … be more active, proactive about wellness referrals and that sort of thing, if they're, when they're necessary, because generally, my experience … if they need help with … even basic activities of daily living after they've had a hospitalization or an illness, it's always been the sense of referring to a home health type extension or provider or nursing care." (P1S1) "It's a support for me so I can do other things, hopefully, than have to just cheer them on single-handedly. … So, I think that the way it helps me the most." (P2S1)

Table 8: Primary and Secondary Themes

Primary Theme	Meaning	Category
Avenues of Awareness	Participants' perceptions of exposure, experience, practice, and communication revealed avenues of awareness about clients' lifestyle wellness, community-based lifestyle wellness programming, and its relationship to OT.	Lasting Impressions Been There, Done That This is How (and why) it's Done Jumping Through Hoops Welcomed Support If You Ask Me
Secondary Themes		
1: Pigeonholed Practices	Participants' impressions of OT were linked to ADLs, not lifestyle wellness programming. Limited knowledge of lifestyle wellness programming and therapy service options led to habitual referrals.	Lasting Impressions This is How (and Why) it's Done
2: Sounds Good but Also Familiar	Participants believed they already supported clients' lifestyle wellness behaviors. They were open to the concept of Lifestyle Redesign®, lifestyle wellness programming, yet reserved or skeptical about the implementation and perceived it to be like other programs.	Been there Done That If You Ask Me
3: Bona Fide Barriers	Participants perceived real barriers to interdisciplinary communication, workflow, and understanding comprehensive OT interventions.	Jumping Through Hoops
4: Pro-Teamwork	Participants welcomed IPC and diverse team practice strategies but understood the limitations.	Welcomed Support

Open codes were examined in context to extract the meanings of words, word variations, and short phrases from the participants' perspectives. Axial codes, the assigned labels, signaled underlying meanings derived from the recurring text across transcripts. Although there were 20 final open codes, only 14 were reduced into six axial coded categories based on the frequency of use across transcripts. As a result of this process, six axial categories emerged after the qualitative data analysis: *Lasting Impressions, Been There, Done That, This is How (and Why) it's Done, Jumping Through Hoops, Welcomed Support,* and *If You Ask Me.*

In the category *Lasting Impressions*, participants explained how their habitual referral practices were based on outcomes and familiarity with therapy providers and influenced by barriers to IPC; they had a limited or skewed understanding of community-based lifestyle wellness programming, no awareness of Lifestyle Redesign®, and narrowed views of OT. *Been There, Done That* contained commentaries about participants' use of strategic conversation, care planning, and referrals to support clients' lifestyle wellness; community-based health care interventions were perceived as beneficial to clients, and other non-OT-led lifestyle wellness programs were viewed as comparable to Lifestyle Redesign®. Participants in primary care referred clients to OT in four main settings based on acute functional changes; therapy services were commonplace and convenient in assisted living; and inclusive, multidisciplinary care plan meetings, teamwork, and communication facilitated workflow and client care, in the secondary theme *This is How (and Why) it's Done*. In *Jumping Through Hoops*, participants perceived their methods for supporting clients' lifestyle wellness as straightforward and necessary but identified IPC barriers with referral processes, therapy communication, and time for best practice strategies. In *Welcomed Support*, participants invited and used IPC strategies, cited examples of multidisciplinary teamwork, and perceived referrals to specialty and therapy services and client-

centered care plan meetings as IPC strategies that support clinical practice and clients' socialization, health, and wellness. Finally, in *If You Ask Me*, participants felt they needed more information about Lifestyle Redesign® and OT lifestyle wellness programming but thought these programs could provide clients with opportunities for socialization, learning, and improved function and health, ease stakeholders' burden of care, and improve IPC for best practice strategies.

Themes

As participants shared their perceptions about supporting clients' lifestyle wellness, IPC, community-based lifestyle wellness programming, and the relationship, if any, to OT, one overarching or primary theme prevailed. Degrees of awareness were distinct among the participants of this study, yet the data revealed common threads that cut across all axial categories. As a result, the all-encompassed theme, *Avenues of Awareness,* was named and organized by perceptions of exposure, experience, practice, and communication, four avenues of awareness about the multi-faceted study topic.

Four secondary themes were also identified and supported by the data: *Pigeonholed Practices, Sounds Good but Also Familiar, Bona Fide Barriers,* and *Pro-Teamwork.* Participants' responses contained similar descriptions of OT's role and reports of habitual referral practices. Also, participants believed they adequately supported clients' lifestyle wellness. They were open to the Lifestyle Redesign® concept but perceived it was like other non-OT-led programs. The participants discussed barriers to interdisciplinary communication, workflow, and achieving a comprehensive understanding of OT interventions. Finally, participants welcomed IPC yet acknowledged existing limitations.

Primary Theme: Avenues of Awareness

Participants revealed varied degrees of awareness about community-based lifestyle wellness programming and its relationship to OT. The participants cited examples and provided explanations as context to illustrate avenues of exposure, experience, practice, and communication that led to their understanding of this topic. These four avenues, or pathways to awareness from the participants' perspective, proceed as follows:

Exposure. Participants' awareness of community-based lifestyle wellness programming, Lifestyle Redesign®, and the relationship to OT, if any, was partly related to exposure. In total, all five participants spoke to having exposure to community-based lifestyle wellness programming and OT services in general, yet none to Lifestyle Redesign®. Furthermore, four out of five participants did not associate OT with community-based lifestyle wellness programs, "Well, I know about occupational therapy. I don't know about … [OT] wellness programs per se because I've just never dealt, worked with that" (P3S2). P2S1 commented, "I don't really see it, an OT in a support-type group in the community … nothing really community based. It's kind of more like individually, you know, situational, and nursing home or something like that."

Experience. Some participants were aware of community-based lifestyle wellness due to direct experience. For example, after receiving a brief synopsis of the Lifestyle Redesign® approach, two participants shared their past involvement in what they perceived as comparable community-based lifestyle wellness programs. P2S1 described collaborating with another HCP to coordinate a tobacco cessation program, "I'd see a patient say, hey, by the way you're smoking. I'm doing actually a little kind of like tight knit group. It's just people from my practice, it's kind of you know, it's gonna be … community based." P3S2 described experience leading a dementia support group, "We would talk about experiences. Let people tell their stories. You

know, it was just support just to hear that someone was going through the same thing that you were going through."

Practice. All five participants spoke to how the practice helped them gain clinical awareness about their clients' lifestyle wellness. Each participant described distinct practice strategies such as completing comprehensive care plan assessments, attending daily team meetings, performing client-family assessment interviews, using strategic conversations, and establishing a good rapport. One described a typical client encounter:

> But I think from start to finish, you always have to have a plan … the history the physical assessment … discussing … our outcomes … as far as health outcomes, and just general health status outcomes and how to maintain and how to preserve that versus having a decline in somebody's function. (P1S2)

For another participant, awareness about clients' lifestyle wellness was obtained through the art of strategic conversation and establishing a good rapport. This technique was honed over years of practice:

> But just a lot of a lot of conversation, definitely not something that's very scripted. …I would say the first 10 years or so might have been more difficult, not something we were trained as much on as we were trained to recognize weight as a factor, or inactivity is a factor, things like that, but see you have to kind of … find ... your own mojo on the way you present it to the patient, so you don't piss them off in the process of discussing it with them. So, a lot of open-ended questions. After 23 years of practice, I've seen a lot of my patients very … often for a long time and so we have a good rapport. ... A lot of times, they come to see me to not ... to be told what they didn't know but lots of times to be

> reminded of what they do know, just need to hear it from a different sounding board, they need to hear it from a different microphone. (P2S1)

Communication. Overall, all participants described communication as another route to awareness. For three participants, daily meetings, shift reports, and sharing care plans proved to be vital avenues for understanding clients' lifestyle wellness statuses and needs. P1S2 commented, “We use care plans here. So, I would say ... that's kind of how we gauge what we need to do on a daily basis.” This participant further explained how interdisciplinary communication via staff meetings also enhanced awareness, “I mean, we have a meeting every day. ... So, it is kind of a dialogue between all the care staff about what somebody may need.” (P1S2)

Secondary Theme 1: Pigeonholed Practices

Pigeonholed Practices was coined to characterize participants' OT role categorization and pre-defined referral proclivities. In sum, no one made statements linking OT to lifestyle wellness. However, every participant provided descriptions of OT centered on references to activities of daily living, fine motor, or upper body interventions. To illustrate, P1S1 commented, “I might need to refer to a speech therapist or an occupational therapist ... if they were to suddenly develop problems with just routine daily activities of daily living ... eating, dressing, that sort of thing.” P3S2 remarked, “I mean, that's what I look for occupational therapy to help me with as a nurse, is more of ADLs, upper body type things.” In addition, four participants commented on habitual referral practices. One participant described it as:

> There's a lot of choices as far as referrals go, you know, in terms of who you can choose and where you want to send your patient. And generally, you just you get to know certain practices, and the outcomes seem to be ... consistently good and the patient has had a

> good experience and you kind of refer back to those people that you know do a good job…because you've had a good experience with them doing a good job. (P1S1)

Secondary Theme 2: Sounds Good but Also Familiar

Sounds Good but Also Familiar was based on participants' explanations of their clinical practice strategies compared to their perceptions of Lifestyle Redesign®. All participants provided examples of supporting clients' lifestyle wellness individually and as a team. Three participants described how they support clients' health and wellness lifestyles in their practice setting. P2S1 described one strategy as, "But just a lot of a lot of conversation ... generally about their lifestyle, and sometimes about what their health model is, what their expectations are, and what they're willing to give in order to get some return." Three participants explained how they worked with others to support clients' needs, choices, and meaningful engagement in a healthy lifestyle. Two participants reported that their strategies for supporting clients' lifestyle wellness were not difficult but indeed a professional responsibility.

During the interview, all participants were allowed to view a Lifestyle Redesign® Summary Protocol (see Appendix F). This summary protocol briefly described the Lifestyle Redesign® program's origin, general study outcomes, general purpose, custom program possibilities, and sample learning module topics. Four participants were unfamiliar with the Lifestyle Redesign® approach but commented that the program was a good concept after viewing the summary protocol. However, one participant raised questions and concerns about the target population and incentivization for participation, "I think this educational portion is missing for a lot of our children, and therefore, as they grow as an adult as well" (P2S1). This participant added:

> So, I mean, all these things are things that seem to be things that I first got exposure to in my education and health class in junior high. And ... that seems to be something that folks definitely should get reeducated on. But at the same time, it's not something that I see people spending their time in any kind of formal fashion learning about. ... My question is how do you incentivize them to do that? (P2S1)

This participant also alluded to the importance of proper needs assessments and shared decision-making between program facilitators and client participants to increase the odds of retention and sustainability. P3S2 compared the Lifestyle Redesign® program to an existing peer support group program, "You know, when I'm sitting here reading this. I've been doing those for years." Nonetheless, all participants were open to supporting a Lifestyle Redesign® program and collaborating with providers. However, one participant pointed out that training staff and caregivers on recommended Lifestyle Redesign® strategies would facilitate carryover and be a gesture of professional courtesy and welcomed communication.

Secondary Theme 3: Bona Fide Barriers

As the title of this secondary theme, *Bona Fide Barriers*, implies, participants reported barriers to interdisciplinary communication, workflow, and understanding of comprehensive OT interventions. Participants provided concrete examples and described scenarios where contextual barriers impeded their ability to provide optimal and efficient care supportive of lifestyle wellness to their clients. Two participants verbalized time-related workflow barriers, "I could pull like a caregiver, their caregiver that they typically have into a meeting, if I was actually having the meetings but I don't have time to have the meetings right now" (P1S2). All participants reported interdisciplinary communication roadblocks:

> I know they're doing ... therapy with them, that they have PT-OT, but beyond that, I don't, I don't get communication like how they're progressing. I rarely get a note unless I asked for it. ...I don't really get the information. ... Sometimes I don't even know they've discontinued them, honestly ... I don't even know they're not being seen anymore to know to get home health back in the hallways. (P1S2)

All participants conceded that they did not have a comprehensive understanding of community-based lifestyle wellness programs and OT-driven interventions like Lifestyle Redesign®, "You know, I think it's, I don't have a problem with people being a part of a wellness program or ... provider ... I don't fully understand everything that they do" (P1S1).

Secondary Theme 4: Pro-Teamwork

In *Pro-Teamwork*, participants invited IPC opportunities for lifestyle wellness interventions and in general. They also acknowledged the value of diversity in teamwork for comprehensive health care and lifestyle wellness practices yet understood there were existing limitations to consider. Five participants affirmatively responded to the concept of an interdisciplinary Lifestyle Redesign® inspired program. For instance, one participant commented:

> But I think what they mostly mean to me is if I can get them to engage at another level ... with other people that are interested in their health model, then I'll get support, along with the patient support, for hoping that this will drive their ... health model into a ... more complete and a ... more comprehensive model for their long-term fitness, emotional fitness as well as physical fitness sometimes. (P2S1)

Three participants welcomed more teamwork for supportive lifestyle wellness interventions, “It’s a support for me so I can do other things, hopefully, than have to just cheer them on single-handedly” (P2S1). Another participant framed it this way:

> The therapists are the ones coming in once or twice a week, you know, so we have to know what to do while you're [*sic*] not here for that hour. ... So, I do feel like it would be better for the staff, you know, easier for the resident, if we're just kind of all on the same page. (P1S2)

Three participants emphasized how they frequently relied on teamwork strategies to perform their job duties and meet the lifestyle wellness needs of their clients. P3S2 concluded, “You know, you have to kind of have like an interdisciplinary team to take care of the residents that live in an assisted living.” Additionally, three participants commented on the value of a diverse and individualized approach, “Yeah, I think it's very important, helpful, you know, we all have a, a different approach” (P3S2). However, two participants spoke about existing teamwork limitations. One participant used this analogy to explain:

> Engineering is very much a group, team sport. If we're gonna design a bridge or design a dam, or roadway, we all collaborate and we kind of divide and conquer, and when we get back together, we ... put the pieces back together figure out what pieces don't fit, what pieces are maybe forgot. You know that we have managing type of engineers that come in and basically kind of oversee the whole project so we know that all the overlapping parts are fulfilled and the set of specifications are written to include all the products, all things we do, and medicine is much more of a lone wolf kind of thing, where you are kind of out in your little fiefdom doing the best you can for patients. (P2S1)

Results

Primary Theme: Avenues of Awareness

The primary theme, *Avenues of Awareness*, provided a glimpse into the distinct perspectives of five multidisciplinary non-OT HCPs. The participants' responses implied that awareness was vital to supporting clients' choices and meaningful participation in a lifestyle that promotes health and wellness. These health care providers presented some awareness of community-based lifestyle wellness programs, listing several programs led by nursing, but did not cite any occupation-based, OT-driven programs inspired by Lifestyle Redesign®. Moreover, the analysis of participants' responses revealed that degrees of awareness impacted clinical reasoning and practice strategies. As one participant explained, “So, knowing about these programs, specific, knowing more specifics about these programs would probably help me ... be more active, proactive about wellness referrals and that sort of thing, if they're, when they're necessary” (P1S1).

Additionally, participants believed that they successfully supported clients' lifestyle wellness needs, and some indicated this to be a straightforward, uncomplicated process. All participants shared how *experience*, *communication*, and effective *practice* methods helped them understand and address their clients' health and wellness motivators and necessities. Vreugdenhil and colleagues (2023) presented an onion model to describe the complexities of the clinical reasoning process. They highlighted layers of contributing and confounding variables and contrasted the literature across health care disciplines. This systematic integrative review's findings further validate the significance of obtaining diverse perspectives on multidimensional and shared concepts like lifestyle wellness and IPC.

Secondary Theme 1: Pigeonholed Practices

Participants did not offer associations linking OT with primary preventive lifestyle wellness practice models other than identifying community-based service providers known to them. Participants presented their OT awareness by service delivery contexts, such as home health, skilled nursing, and hospital-based programs. They described OT interventions for ADLs, upper body, and fine motor tasks. Even when the participants were provided with a Lifestyle Redesign® summary, they did not associate it with any familiar program. This finding aligns with recent evidence suggesting occupational therapy stereotypes and misconceptions exist among allied health care professionals (Darawsheh, 2018).

Participants also described habitual referral practices. These HCPs indicated that they repeatedly referred clients to site-based therapy groups or providers with a record of positive outcomes and experiences. Potthoff and colleagues (2022) referred to routine clinical practices as non-reflective processes resistant to change. However, facilitating role clarification, shared visions, motivation, and providing cues and reminders can alter clinical routines and habits (Potthoff et al., 2022).

Secondary Theme 2: Sounds Good but Also Familiar

The Lifestyle Redesign® approach was foreign to all participants. After learning more about the evidence-based program, these non-OT HCPs endorsed the general concept but responded with some reservations and skepticism. Some participants sought more clarification and details, while others speculated whether this program mirrored other non-OT spearheaded programs. A few participants provided examples of how they and others supported clients' lifestyle wellness and how these interventions appeared to be like the sample Lifestyle Redesign® program module topics presented to them. However, the participants' examples of

lifestyle wellness interventions differed from the approach and philosophy of Lifestyle Redesign® programming. Lifestyle Redesign® is unlike other standard peer support groups or educational health-related seminars. Clark and colleagues explained that the Lifestyle Redesign® approach was designed to support a transformational process for the client. The occupation-based program focus is set apart from other traditional learning group formats (Clark et al., 2015).

Secondary Theme 3: Bona Fide Barriers

Participants provided examples of structural and contextual barriers to interdisciplinary communication and workflow. Some participants expressed frustration with these roadblocks as they perceived them as negatively impacting clinical practice, optimal client care, and service delivery. One participant described repeated difficulties connecting clients with specialty medical services. This participant provided an example of personal time and increased effort required to confirm a referral had been received and the client scheduled for a consultation. Another participant described the interdisciplinary communication breakdown as follows:

> So, it's like on my end ... I have to reach out, and I really am too busy to constantly reach out [laughs]. That I don't really get the information. So, it's like they pick them up and then they discontinue them. Sometimes I don't even know they've discontinued them, honestly. So, that's a hindrance ... and then we start to see a decline. (P1S2)

Participants also indicated that they were unaware of other lifestyle wellness-affiliated program details or client experiences due to time constraints or because they did not oversee or receive information concerning that. Furthermore, participants acknowledged their limited understanding of OT lifestyle wellness interventions. The IPC barriers presented by participants of this study were similar across disciplines and settings. This pattern aligns with recent evidence

indicating that common themes of IPC barriers are perceived at many levels by multidisciplinary HCPs in primary care (Rawlinson et al., 2021).

Secondary Theme 4: Pro-Teamwork

Ansa et al. (2020) found that 546 survey respondents, 99.1% of the study sample, believed that IPC ultimately benefits the client. In the same study, communication was the top-ranked prerequisite to IPC. El-Awaisi et al. (2021) found that multidisciplinary HCPs are open and inclined to IPC practices. The findings from these studies align with the current study, as participants indicated that they welcomed and appreciated interdisciplinary collaborative opportunities. Some stated they would collaborate more with other HCPs if given more chances, time, and information. Despite reports of limitations and barriers, many described their reliance on IPC strategies for day-to-day practices. This commentary provided insight into existing structural and contextual supports for IPC and lifestyle wellness interventions.

Discussion

The grand research question for this study was: What is the meaning of community-based lifestyle wellness programs as perceived by non-OT community-based HCPs, and the relationship, if any, to OT? The three sub-questions were: 1) How do non-OT community-based HCPs perceive the practice of OT in community-based lifestyle programs? 2) How do non-OT community-based HCPs perceive the use of the Lifestyle Redesign® program? 3) What is the meaning of community-based IPC as perceived by non-OT community-based HCPs? The grand research question and first sub-question can be answered definitively in that the community-based non-OT HCPs are aware of community wellness programs but unaware of the relationship to OT lifestyle wellness programs in the community other than what is and has been familiar to them in their practice. They do not realize that the OT services they routinely rely on for clients

are indeed comparable to evidence-based OT community wellness programming. Examining this interprofessional knowledge gap through an occupational justice filter suggests that clients in these community-based settings may grapple with "inadequate occupational engagement" (McColl et al., 2015, p. 62). If HCPs could make the OT-wellness association, perhaps their clients' occupational engagement could be more thoroughly examined and addressed.

In support of the second research sub-question, the non-OT HCPs perceive Lifestyle Redesign® programming as separate, or absent, from OT community-based intervention and IPC. The inability to connect Lifestyle Redesign® to the OT services they know or think they know further reinforces the communication and knowledge challenges between them and other practitioners, including OT practitioners. Again, occupational justice supports the individual's right to (a) occupational participation, (b) lifestyle balance, and (c) choices for health and wellness. If the non-OT HCPs do not perceive knowledge or usefulness of Lifestyle Redesign®, then the main tenets of occupational justice may not be met for these clients. For example, relative to *occupational participation*, clients are receiving community-based interventions but perhaps not to the level they could be with an evidence-based program like Lifestyle Redesign®. Perhaps the non-OT HCPs in this study unknowingly impact clients' ability to achieve *lifestyle balance* because Lifestyle Redesign® strategies are not emphasized in wellness intervention. C*hoices for health and wellness* may be hampered by filtered access and incomplete information provided by the non-OT HCPs.

To add to the understanding of the third research sub-question, the non-OT HCPs perceive that they understand the value of IPC, yet they indicate that they are already doing this, potentially challenging common beliefs about how to address health and wellness as part of the full spectrum of interprofessional intervention and planning. After answering the study research

questions, the PI believes that further understanding of what optimal engagement in meaningful and diverse community occupations could be is valuable, given that the non-OT HCPs ultimately believe in the power of IPC and seem open to learning more about community-based OT lifestyle wellness programming.

Strengths and Limitations

Trustworthiness is a strength of this study and was addressed by the PI to maximize credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). The PI followed all institutional research approvals, conducted an in-depth literature review, utilized an evidence-based theory (Occupational Justice) to frame study methods, and adhered to a purposive sample of five participants, which is aligned with a basic phenomenological approach (Creswell & Poth, 2018; Dukes, 1984; Emmel, 2015). The PI also conducted routine peer debriefing and extensively documented these steps with a decision-trail methodology, strengthening the study's dependability. Additionally, the PI is familiar with and has access to community-based settings, non-OT HCP service provision, and OT services. This positionality allowed the PI to gain access to the field in a logical and uninterrupted way (Parse, 2009; Polkinghorne, 1989; Ray, 1994; Smith et al., 2009). The study's limitations were centered on feasibility issues pertaining to the length of time and access to follow-up participant interviews. While the PI remained close to the data to help preserve the participants' perceptions and meanings of the phenomenon, this may or may not have reduced PI bias. The PI gained access to the field and participants because of her experience; however, this could have also led to some bias during data collection and analysis. Additionally, during data collection, the participants' perceptions of Lifestyle Redesign® were based on a one-page general summary provided during the interview; this could have introduced bias due to participants' misunderstanding of Lifestyle

Redesign® or preconceived notions of Lifestyle Redesign®. Finally, although not the primary aim of qualitative inquiry (Creswell & Creswell, 2018), this small exploratory study is not generalizable to the larger population of community-based non-HCPs because of the relatively small number of participants and interviews (Tipton et al., 2017; Vasileiou et al., 2018).

Implications for OT Practice

The study's findings affirm that non-OT HCPs are not definitively able to distinguish preventive wellness OT programming and Lifestyle Redesign® in the community from other OT services. However, they are amenable to IPC in this domain. This incomplete understanding and reduced level of awareness can have clinical repercussions, as substantiated by the themes identified in the study. Specifically, due to this knowledge gap, non-OT HCPs could impede access to wellness interventions and limit opportunities for vital occupational engagement for community-based clients. When non-OT HCPs base their OT referrals on the presence of physical and cognitive impairments or exclude services for well-clients absent of acute illness, injury, or functional decline, they can be contributing, albeit inadvertently, to the adverse outcomes of occupational injustices. Moreover, just as the clients face potential occupational injustices, the non-OT HCPs confront structural and contextual barriers to best practices contributing to the health and wellness outcomes of those they serve.

To address and improve non-OT HCPs' ability to associate community-based OT lifestyle wellness programming with the OT services familiar to them in practice, OT professionals can take an educational approach. OT practitioners can inform non-OT HCPs about OT's role in preventive care and emphasize the core tenants of the Lifestyle Redesign® method steeped in occupational science and OT theory; that best practice means promoting and supporting choice, balance, and engagement in meaningful and diverse occupations which can in turn positively

impact health and wellness outcomes. This knowledge gap can be bridged through enhanced messaging via traditional marketing strategies, but perhaps even more effectively through direct consultative services.

To optimize community-based IPC, OT practitioners can consider an increased primary care presence. As community-based primary care team members, visibility and proximity could facilitate role clarity and collaboration. Additionally, OT practitioners can implement more occupation-based lifestyle wellness programming in the community using a multidisciplinary team approach. Diversifying the community-based wellness program teams with multiple disciplines could help non-OT HCPs comprehensively address clients' health and wellness needs in an efficient, streamlined, and consistent manner. Funding issues should not be a deterrent. State and local funding can be accessed, and grant opportunities are available. Hospital and corporate stakeholders often want to establish community outreach satellite programs or find creative marketing methods. In some circumstances, people are willing to pay out-of-pocket for services not traditionally covered by third parties.

From the non-OT HCP perspective and within the context of Occupational Justice, the existing structural and contextual barriers brought to light in this study are perceived to impede best practices supportive of health and wellness for the community-based older adult population. OT practitioners can become the figurative supports and roadblock minimizers confronting this issue in an impactful way. The core tenants of AOTA's Vision 2025 (2017) support the notion that OT practitioners must take action to improve the accessibility of evidence-based lifestyle wellness interventions through collaboration. After all, OT practitioners are conditioned as change agents, advocates, and leaders in these complex equations.

Future research

The PI gathered rich data using a phenomenological approach to the semi-structured interviews in this study. However, additional research is indicated to confirm saturation on this topic. Further research exploring the perceptions of how non-OT HCPs' awareness of comprehensive OT services impacts clinical practice and clients' lifestyle wellness outcomes, supports and barriers to community-based IPC for primary preventive care, and how to optimally access and use OT wellness programming like Lifestyle Redesign® for community-based older adult clientele would build on the results of this small primary exploratory study. Specifically, a mixed methods survey appealing to a larger and more diversified sample could potentially confirm and strengthen the findings from this research. A series of focus groups could be conducted to change the conversational dynamic and add depth to the qualitative data. It would also be advantageous to conduct a second study that targets alternative settings or integrates the perspectives of occupational, speech, and physical therapy practitioners for added contrast. However, completing a participatory action research project for a more direct and local impact should be strongly considered. This research approach would complement the critical elements of IPC and occupational justice and mesh nicely with future multidisciplinary community programming plans.

Summary

The findings from this study provide evidence that the non-OT HCP participants positively perceived lifestyle wellness programming but had a limited understanding of OT's role in this area and no awareness of Lifestyle Redesign® but were open to IPC to support the lifestyle wellness needs of older adults. This interprofessional knowledge gap may compromise community-based older adults' ability to engage in meaningful occupations optimally. Further

indicative of the findings, non-OT HCPs may not be taking full advantage of OT IPC opportunities supportive of lifestyle wellness in primary care despite their expressed willingness to do so. Further research could add clarity to this topic and provide direction for OT practitioners and non-OT HCPs vested in occupationally just outcomes for community-based older adults at risk for health disparities. Windows of opportunity exist for OT leaders to provide enhanced education and messaging to HCPs about comprehensive OT services, better position themselves on primary care teams, and establish more occupation-based interdisciplinary wellness programs in the community.

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Appendices

Appendix A

Verbal Script

Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

The following is a verbal recruitment script for the study entitled Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach.

Hi, my name is Christina Buchignani, and I am an occupational therapist and a post-professional occupational therapy doctoral student at Eastern Kentucky University. I am conducting a research study on what community-based lifestyle wellness programs and collaborating with other health care disciplines mean to healthcare professionals like yourself. Furthermore, I want to know if there is a perceived link to occupational therapy as it relates to lifestyle wellness programming and interprofessional collaboration in the community. I am particularly interested in hearing the perceptions of health care professionals outside the field of occupational therapy who are currently practicing in community settings such as primary care clinics or assisted living facilities that serve older adults with chronic diseases on a regular basis.

As a participant in the study, you would be asked to complete a brief demographic questionnaire and engage in an estimated 30-minute semi-structured interview consisting of around five open-ended questions. There are no personal questions, your name will not be recorded, and active safeguards are in place to keep your identity confidential. The interview questions will center on the purpose of the study. For example, one question could be, “What is your definition of a community-based lifestyle program?” You may be asked to participate in 1-2 follow-up interviews lasting about 15-20 minutes to discuss your initial interview statements further. It would be an opportunity for you to verify or add to your initial statements on the topic and ensure that I have interpreted your responses accurately.

Participation is voluntary, and you may stop at any time. You will not be penalized in any way for choosing to stop before we are finished or choosing not to participate at all. There is no compensation for participating or cost to you except your time.

If you are interested in seeing if you qualify for the study and would like to arrange a time to meet for an interview, please call me at (859) [redacted]. If you have any questions about your rights as a research volunteer, you can contact the Division of Sponsored Programs staff at Eastern Kentucky University at 859-622-3636.

Health Care Professionals,

Let's Talk

If you are a health care professional working in the community providing health and wellness services to adults aged 65 years or older you may be eligible to participate in a research study.

Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

The purpose of this study is to explore health care professionals' views on community-based lifestyle wellness programs, collaborating with health care professionals from other disciplines working in the community, and the relationship it has, if any, to occupational therapy.

If you are interested in being a part of the conversation, please contact **Christina Buchignani**, Post-Professional OTD Student, OTR/L, CLT at **(859)** [redacted]

Location

Meet virtually or in-person for a brief interview at your workplace at a time convenient to you

Are you eligible?

- age 22-75 years,
- English-speaking,
- licensed or legally authorized health care professional practicing at least five years
- working full or part-time in a community-based primary care clinic or assisted living setting for at least one year, and
- currently providing health and wellness services to adults aged 65 years or older on a regular basis

Appendix C

Screening Checklist

Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

The following is a screening checklist to assess participant eligibility for the study, Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach. All items for the inclusion criteria and no items for exclusion criteria must be confirmed and checked before proceeding to the informed consent and formal recruitment phase of the study.

Inclusion

_____ aged 22 to 75 years
_____ English-speaking
_____ willing to voluntarily consent to participate in the study and interview process
_____ licensed or legally authorized health care professional
_____ licensed or legally authorized health care professional practiced for five years minimum
_____current community-based primary care clinic or assisted living facility service provider for at least one year
_____ currently providing health and wellness services to adults aged 65 years or older on a weekly routine basis

Exclusion Criteria

_____occupational therapy practitioner
_____ under the age of 22 or over the age of 75 years
_____ non-English speaking
_____unwilling to voluntarily consent to participate in the study and interview process
_____unlicensed or legally unauthorized health care professional
_____health care professional practiced less than five years
_____not currently practicing in a community-based primary care clinic or assisted living facility
_____community-based primary care clinic or assisted living facility employee for less than one year
_____ not currently providing health and wellness services to adults aged 65 years or older on a weekly routine basis

Appendix D

Consent to Participate in a Research Study

Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

Key Information

You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have.

Do I have to participate?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of about five people in the study.

What is the purpose of the study?
The purpose of the study is to explore health care professionals' views on community-based lifestyle wellness programs, collaborating with health care professionals from other disciplines working in the community, and the relationship it has, if any, to occupational therapy. You have been selected to participate in this study because you are a licensed or legally authorized health care professional who is between the ages of 22 to 75 years old, capable of speaking English, willing to voluntarily engage in this study and interview process, who has practiced full or part-time for at least five years. Also, you have provided services in a community-based primary care clinic or assisted living setting for at least one year and are currently providing health and wellness services to adults aged 65 years or older on a weekly routine basis.

Where is the study going to take place and how long will it last?

The research procedures will be conducted virtually using Zoom video conferencing technology or in a private area within your workplace during a convenient and mutually agreed upon time, Monday through Saturday, between 7 a.m. and 7 p.m. Eastern Standard Time. The initial interview will take about 30 minutes. You may be called for an additional 1-2 follow-up interviews to review, clarify, and confirm your statements and how they have been categorized and provide any additional feedback you deem necessary. These follow-up interviews are estimated to take about 15-20 minutes. Therefore, the total time you will be asked to volunteer for this study is estimated to be 70 minutes over 1-3 meetings between December 1, 2022, and March 15, 2023.

What will I be asked to do?
You will be asked to participate in a confidential, recorded interview containing around five open-ended questions about community-based lifestyle wellness programs, working collaboratively with other health care professionals in the community, and the link, if any, to occupational therapy. There are no right or wrong answers, but you may be asked additional follow-up questions if additional information is needed to better understand your point of view on the topic. If you are asked to participate in a follow-up interview, the interview will be confidential but, again, recorded. The follow-up interviews will likely occur within eight weeks of your initial interview and no later than March 15, 2023. The follow-up interview will include questions about your previous statements on the topic. You will be asked to review, clarify, confirm, or elaborate on your statements, and to provide any additional feedback you deem necessary.

Are there reasons why I should not take part in this study?
You will not be selected to participate in the study if you are not between the ages of 22 to 75 years old, do not speak English, or do not voluntarily consent to engage in this study and interview process. You will not be selected as a participant in this study if you have not practiced full or part-time for at least five years. Also, you will not be selected to participate in this study if you have not provided services in a community-based primary care clinic or assisted living setting for at least one year or not currently providing health and wellness services to adults aged 65 years or older on a weekly routine basis.

What are the possible risks and discomforts?
To the best of our knowledge, the things you will be doing have no more risk of harm or discomfort than you would experience in everyday life. You may, however, experience a previously unknown risk or side effect.

What are the benefits of taking part in this study?
You are not likely to get any personal benefit from taking part in this study. Your participation is expected to provide benefits to others contributing to an important scientific conversation about meaning of health care programs focused on lifestyle wellness and working collaboratively with other professionals in the community.

If I don’t take part in this study, are there other choices?

If you do not want to be in the study, there are no other choices except to not take part in the study.

Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below.

Other Important Details

Who is doing the study?
The person in charge of this study is Christina Buchignani, Post-Professional OTD Student, OTR/L, CLT at Eastern Kentucky University. She is being guided in this research by Christine Privott, PhD, OTR/L, Professor, Faculty Research Advisor. There may be other people on the research team assisting at different times during the study.

What will it cost me to participate?
There are no costs associated with taking part in this study.

Will I receive any payment or rewards for taking part in the study?
You will not receive any payment or reward for taking part in this study.

Who will see the information I give?
Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key.

However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court. Also, we may be required to show information that identifies you for audit purposes.

We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data obtained via the Internet. Third-party applications used in this study may have terms of service and privacy policies outside of the control of the Eastern Kentucky University.

Can my taking part in the study end early?

If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the University or agency funding the study decides to stop the study early for a variety of reasons.

What happens if I get hurt or sick during the study?
If you believe you are hurt or get sick because of something that is done during the study, you should call Christina Buchignani, Post-Professional OTD Student, OTR/L, CLT at (859) [redacted] immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

What else do I need to know?
No companies or institutions other than Eastern Kentucky University are affiliated with this study. No entities will provide funding, cooperative research, supplies, or equipment for this study.

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

We will give you a copy of this consent form to take with you.

Consent

Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Christina Buchignani, Post-Professional OTD Student, OTR/L, CLT at (859) [redacted]. If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636.

If you would like to participate, please read the statement below, sign, and print your name.

I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.

_____

Signature of person agreeing to take part in the study Date

_____

Printed name of person taking part in the study

_____

Name of person providing information to subject

Appendix E

Demographic Survey

Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

The following is a confidential demographic survey to be completed by the participants of study, Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach.

Survey

Your responses to the following questions will be used for categorization and descriptive purposes only. Your identity associated with these responses will remain confidential.

Please do not write your name on this form.

Please check the appropriate responses.

I am between the ages of:

_____ 22 and 32 years

_____33 and 43 years

_____44 and 54 years

_____55 and 65 years

_____66 and 75 years

I identify as:

_____Female

_____Male

_____Non-binary

_____Transgender

_____Other

_____Prefer not to answer

I identify as:

_____American Indian or Alaska Native

_____Asian

_____Black or African American

_____Hispanic or Latinx

_____Native Hawaii or other Pacific Islander

_____White

_____Two or more races

_____Other; Please specify:_____

_____I prefer not to answer

I am currently employed as a health care professional in a:

_____Primary care clinic

_____Assisted living facility

I am currently employed:

_____Full-time; working 30 to 40+ hours weekly

_____Part-time; working less than 30 hours weekly

My highest level of education achieved is:

_____Some high school

_____High school diploma or equivalent

_____Bachelor's degree

_____Master's degree

_____Doctorate degree

_____Doctor of Medicine

_____PhD or higher

_____Trade school

_____Apprenticeship

_____Prefer not to answer

Appendix F

The Lifestyle Redesign® Program Summary Protocol
Exploring the Perceived Meaning of Community-Based Lifestyle Wellness Programs, Interprofessional Collaboration, and the Relationship to Occupational Therapy: A Phenomenological Approach

Lifestyle Redesign® is an intervention developed by Florence Clark and colleagues (Clark et al., 1997; Clark et al., 2012). This intervention was tested through a series of randomized controlled trials, collectively called the University of Southern California Well Elderly Studies, from 1994 through 2010. In a nutshell, the findings from these studies showed that this occupational therapy preventive wellness intervention is effective, feasible, and affordable, and improves the health-related quality of life of older adults. The Lifestyle Redesign® program uses a client-empowerment approach to help people redesign a satisfying, meaningful, and health-promoting lifestyle that enables them to thrive (Clark et al., 2015). The program typically consists of weekly individual and group sessions that include educational instruction, peer exchange, direct experience, and personal exploration. Popular topics include:

- the power of occupation
- the link between occupation, aging, and health
- physical activity and exercise
- nutrition,
- sleep hygiene
- medication management
- stress management and coping
- time management and daily balance
- social relationships
- cultural awareness
- finances
- community transportation
- safety and fall prevention in the home and community
- and more!

The Lifestyle Redesign® program is adaptable and can be tailored to meet the specific needs of the individual, groups, or populations. The content can be disease specific. For example, program modules could center around diabetes, cardiovascular, or pulmonary health. Programs can also be centered around specific age groups and settings. For example, the content could be tailored to address the needs of community-based older adults striving to age in place. The possibilities for a customizable Lifestyle Redesign® are robust. Furthermore, it is a multidisciplinary-friendly program, meaning health care professionals from other disciplines are welcomed as team members.

Lifestyle Redesign®:

- is evidence-based, effective, feasible, and affordable
- improves the health-related quality of life of older adults
- empowers clients to take charge of their lifestyle and thrive
- harnesses the power of occupation to improve health and well-being
- is customizable based on the needs of the client, group, or population
- is a multidisciplinary team effort

References

Clark, F. A., Azen, S. P., Zemke, R., Jackson, J., Carlson, M., Mandel, D., Hay, J., Josephson, K., Cherry, B., Hessel, C., Palmer, J., & Lipson, L. (1997). Occupational therapy for independent-living older adults: A randomized controlled trial. *Journal of the American Medical Association, 278*(16), 1321-1326. https://doi.org/10.1001/jama.1997.03550160041036

Clark, F. A., Blanchard, J., Sleight, A., Cogan, A., Florídez, L., Gleason, S., Heymann, R., Hill, V., Holden, A., Murphy, M., Proffitt, R., Niemiec, S. S., & Vigen, C. (2015). *Lifestyle redesign: The intervention tested in the USC well elderly studies* (2nd ed.). AOTA Press.

Clark, F., Jackson, J., Carlson, M., Chou, C. P., Cherry, B. J., Jordan-Marsh, M., Knight, B. G., Mandel, D., Blanchard, J., Granger, D. A., Wilcox, R. R., Lai, M. Y., White, B., Hay, J., Lam, C., Marterella, A., & Azen, S. P. (2012). Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: Results of the Well Elderly 2 randomised controlled trial. *Journal of Epidemiology & Community Health, 66*, 782-790. https://doi.org/10.1136/jech.2009.099754

Appendix G

Sample Decision Trail

Date	Event	Topic	Resolution
9/11-9/12/2022	Email correspondence with faculty mentor/chair	Exploring option to integrate community-based health care professionals (HCPs) and the concept of interprofessional collaboration (IPC) into study	Independent and dependent variable proposed/accepted; option to integrate Lifestyle Redesign® (Clark et al., 1994; Clark et al., 2012) into a qualitative case study proposed/approved; options for literature review proposed/approved: IPC, community-based lifestyle wellness programs, and Lifestyle Redesign®
10/16-10/17/2022	Email correspondence with faculty mentor/chair	Mentor meeting preparation: Manuscript Section 1 draft rough outline and notes, mentor feedback	Study topic, design, and methods discussed
10/17/2022	Mentor meeting	Mentor meeting via Zoom: Manuscript Section 1, study design	Study topic, design, and methods established
10/19/2022	Personal notes	Section 1 brainstorm	Rough outline of manuscript Section 1 completed
11/01/2022	Draft submission	Section 1 draft submitted	Draft accepted
11/06/2022	Draft submission	Signed draft of the authorship agreement submitted	Draft accepted
11/06/2022	Draft submission	Section 2 draft submitted	Draft accepted
11/14/2022	Mentor meeting	Review Methods section, interview protocol	Submit Methods section revision and IRB application draft by 11/17/2022; focus on interview protocol, timeline, ethics considerations; add Framework of Occupational Justice (Stadnyk et al., 2010) to Section 2 literature review
11/18/2022	Email correspondence with faculty mentor/chair	Letters of authorization for on-site research; study settings	Obtained two letters of authorization; dropped number of settings from three down to two; one primary care clinic and one assisted living facility
11/21/2022	Mentor/chair meeting	Research proposal presentation draft	Feedback: Phenomenological approach, be ready to give rationale for five participants and one interview; relate Lifestyle Redesign® to the USC Well Elderly Studies and explain; define terms

Appendix H

Initial Master Code List

Repeated words, word variations, and short phrases with total frequency of use

a lot/lots, 49
ability/abilities, 14
able to, 13
about, 21
active , 3
activity/inactivity, 20
ADLs, 3
aerobics, 3
aggravate, 3
Alcoholics Anonymous/AA/ alcohol, 7
always, 23
Ambien®, 3
anything, 3
apartment, 5
appointments, 3
ask, 9
aspect, 3
assess/assessment, 17
assist/assistance, 14
assisted living, 11
attend, 4
aware/awareness, 10
back to, 7
bad, 3
basic, 3
because, 54
bed, 5
benefit/beneficial, 9
better, 11
blood pressure, 8
building, 6
called/call, 12
can't, 6
capture your audience, 3
care, 57
caregiver, 8
certain, 3
change, 22
children/child, 5
cholesterol, 4
choose/choice, 3
chronic condition/ medical condition/ condition, 4
class/classes, 12
client/clients, 3
clinic, 3
come, 18
comment, 3
communicate/ communication, 3
community-based/ community, 15
companion, 3
condition, 14
consultation/consult, 10
conversation, 5
conversation topic, 3
COVID, 3
daily, 17
days, 32
decided, 5
dementia, 12
desires, 3
develop/develops/ developed, 3
diabetes, 5
diet, 8
different, 24
director, 3
disciplines, 3
discontinue, 3
discuss/discussion, 7
do/doing, 112
doctor, 11
document, 3
don't, 11
drive, 3
eating, 7
education/educate, 16
educator, 3
encourage, 4
engaged/engaging, 4
engineering, 6
environment, 4
established, 3
every, 20
everybody, 8
everyone, 3
everything, 8
example/for example, 13
exercise, 15
experience, 4
exposure, 4
extension, 4
facility, 6
fact, 3
factor, 3
familiar/familiarity, 3
family, 11
feel, 7
financial/finances, 14
find, 11
fitness/fit, 13
focus/focusing, 9
forms, 4
free, 4
function, 4
generally/in general, 16
get/getting/got, 103
give, 27

Appendix H Continued

Repeated words, word variations, and short phrases with total frequency of use			
go, 4	incentivized/incentive, 4	managing, 3	outcomes/health outcomes, 7
goal/goals, 4	include, 6	mean, 9	outpatient, 3
going through, 3	incorporate/incorporated/	medical, 21	outside, 3
going to, 28	incorporate, 9	medication, 8	own, 9
good, 44	independent, 8	medicine, 7	parts, 14
great, 7	individual/individually, 8	meet, 14	patients/patient, 66
group, 33	information, 10	meeting, 20	peer, 4
habit/habits, 8	insurance, 3	memory care, 6	people, 9
hard, 9	insurers, 6	mental, 3	performing, 3
have, 128	interested, 4	model, 3	person, 8
have to, 34	involved, 3	more, 35	phone, 8
health , 50	it takes, 5	morning, 3	physical, 24
health care, 7	junior high, 5	most/mostly, 12	physician, 3
health model, 14	kind of, 7	need/needs, 58	pick, 3
healthier, 5	know/knowing, 69	need to do, 4	pill, 9
healthy, 14	lead, 3	never, 12	place, 6
hear, 8	learning/learn/learns/	new, 3	plan of care/care plan/
height-weight ratio, 3	learned, 4	note, 3	plan, 36
help/helping/helpful, 39	level, 17	now, 7	portion, 3
history/history and	life, 4	nurse/nurses/nursing, 20	practice, 15
physical, 9	lifestyle, 10	nutrition, 3	prepare/preparing, 3
home, 8	Lifestyle Redesign®, 4	of course, 4	primary care, 6
home health, 14	like, 59	offer, 5	probably, 11
hoping/hopefully, 3	like that, 4	office, 6	problem/problems, 13
hospital, 3	live/lives, 3	often, 3	professionally/
how, 38	long-term, 4	only, 3	professional, 10
I don't, 37	looks like, 4	open, 8	program, 36
idea, 3	maintain, 7	OT/occupational therapy/	provide, 9
identifying, 7	make, 14	therapist, 32	provider, 9
improve, 11	management, 3	other things, 3	PT, 6

Appendix H Continued

Repeated words, word variations, and short phrases with total frequency of use			
questions, 16	simple, 13	talk, 15	typically, 9
quitting, 3	situation, 4	teach/taught, 10	understanding, 6
referral/refer, 19	sleep, 6	team, 4	update, 4
remember, 6	smoking/smoke/vaping/	techniques, 3	use/utilized, 8
require, 6	nicotine, 22	tell, 7	very, 6
resident/residents, 43	social worker, 3	them, 47	visit, 8
review, 3	socialize/social, 3	therapy/therapist, 32	walk, 3
risk/risk factor, 5	something, 23	they, 359	walker, 10
routine, 10	something like that, 8	things, 29	want to, 27
same, 12	sometimes, 12	things like that, 22	way, 10
schedule, 3	specialty, 4	think, 29	weeks, 5
schools/school/schooler, 9	specific, 12	time/times, 46	weight/overweight/
see/seeing, 14	speech, 11	to give, 3	weight loss, 19
seems, 14	spend/spending, 7	together, 10	wellness, 21
seen, 10	staff, 11	told, 4	what, 13
sending/sent, 10	start, 8	topic, 6	why, 3
service, 21	store/stores/supermarket, 4	trained, 5	willing, 6
setting, 5	supportive/support, 17	transfers/transferring, 8	work/works/worked, 37
should, 7	supposed, 3	treatment, 6	worry, 3
sick, 5	tailored/tailor/tailors/	try, 16	years, 23
sign it, 8	tailoring, 6	type, 8	