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Promoting Productive Aging among Low-Income Older Adults

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PROMOTING PRODUCTIVE AGING AMONG LOW-INCOME OLDER ADULTS

by

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A Capstone Project Proposal Presented in Partial Fulfillment

of the Requirements of the Degree of

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University of St. Augustine for Health Sciences

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Table of Contents

Introduction	5
Background	5
Statement of Problem	6
Rationale	7
Significance of Proposed Project	9
Preliminary Project Objectives	11
Definition of Terms	11
Assumptions and Limitations	12
Literature Review	13
Community Mobility	13
Social Participation	17
Proposed Methods	21
Proposed Planned Analysis	25
Actual Methods and Timeline	25
Results and Analysis	27
Community Mobility	29
Home Establishment and Management	30
Leisure Participation	30
Social Participation	31
Discussion	32
Limitations	35
Implications for Occupational Therapy	38

Future Research and Projects.....	39
Conclusion	41
References	42
Appendix A	50
Appendix B	53
Appendix C	55
Appendix D	58
Appendix E	61
Appendix F	63
Appendix G	67
Appendix H	70
Appendix I	77

Introduction

Background

According to American Occupational Therapy Association (AOTA), there has been an increasing need to focus on productive aging as the older population in the United States is said increase to 20% of the population by 2030 (Leland & Elliott, 2012). Productive aging has been defined as the ability to remain independent and safe at home and within the community with a focus on health and wellness (American Occupational Therapy Association [AOTA], n.d.). Productive aging refers to individuals not only remaining in their homes, but able to participate in the community and engage in occupations, with an emphasis on wellness and prevention (Mulry, Papetti, De Martinis, & Ravinsky, 2017). This term also includes the physical and the social environments, and the importance each has for an individual (Chippendale & Bear-Lehman, 2011). Occupational therapy provides a unique view of approach by using holistic and client-centered approaches that not only address the physical needs, but also social, psychological, environmental, and more. Old age is often associated with a decrease in independence and an increase in dependence on others (Hunter & Kearney, 2018). Occupational therapy can improve the health and quality of life for older adults by increasing and maintaining their participation in meaningful occupations through a client-centered, holistic approach (Orellano, Colón, & Arbesman, 2012). According to Spillman (2004), a loss of instrumental activities of daily living (IADLs) performance can lead to decreased quality of life and poor self-efficacy. Areas that have been a focus in productive aging include health and wellness prevention, community mobility, IADLs, fall prevention, social participation, sleep, and home modifications (Chippendale & Bear-Lehman, 2011; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Sithong, 2016; Wilkins, Jung, Wishart, Edwards, & Shelley, 2003).

The environment plays a significant role in an individual's participation in occupations. Occupation refers to self-directed activities the individual wants and needs to perform daily or regularly (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 38; Cole & Tufano, 2008, Chapter 10). The environment refers to where the individual performs occupations and can be physical (built environment, natural environment), cultural (societal, social and economic systems), and social (social interaction) (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 38; Cole & Tufano, 2008, Chapter 10). The environment can support an individual's performance in desired occupations, or it can limit participation due to the environment not meeting the needs of the individual. An individual who is able to perform desired occupations has a balance between the personal and environmental demands (Cole & Tufano, 2008, Chapter 10). Productive aging is a process of constant adaptation of the occupation and environment to meet the needs of the older adult (Stevens-Ratchford & Diaz, 2003). An example of the environment limiting participation comes from Eckel (2012), based on elderly women's participation in meal preparation. The participants had lived in the same community for years, but with a decline in their physical bodies, the kitchen environments no longer supported their participation in meal preparation. It became important to adapt the kitchen environment for these women to continue to participate in meal preparation (Eckel, 2012).

Statement of Problem

In Northern San Diego, Interfaith Community Services, a non-profit organization, has helped older adults with lower socioeconomic status to maintain their independence by providing resources and programs to enhance their quality of life. Programs through Interfaith include programs such as minor home repairs, access to senior services, social services, and food security (Interfaith Community Services, n.d.). Through a productive aging lens, aging entails

maintaining activities as described in the Occupational Therapy Practice Framework (OTPF) as instrumental activities of daily living (IADLs), such as community mobility; health management and maintenance; social participation; meal preparation; home establishment and management; religious and spiritual activities; sleep; and leisure (AOTA, 2014).

With aging, there are a number of factors that can limit an individual's participation in meaningful occupations, and having limited income can increase the number of factors and reasons for limited participation (Waldersen et al., 2017). This proposal will work to understand occupations that are not participated in, reasons why participation has decreased, and how occupational therapy can help increase participation for the older adults participating in Interfaith Community Services' low-income senior programming. It is also important to understand strengths the community members have that have increased occupational participation and have helped individuals continue to participate in occupations. Possible areas of interest for the older adult population include social participation, health, nutrition and diet, exercise, safety, and community mobility (Berger, Escher, Mengle, & Sullivan, 2018; Cassidy, Richards, & Eakman, 2017).

Rationale

This proposal is based on the Person-Environment-Occupation-Performance (PEOP) model and Motivation of Human Occupation (MOHO) model. According to PEOP, there are three areas of importance—the person, the environment, and the occupation. Based on an interaction between the three elements, it results in the performance aspect (Cole & Tufano, 2008, Chapter 10). A holistic view of the person is made up of intrinsic factors such as physiological, cognitive, psychological, spiritual, and neurobehavioral factors (Boyt Schell, Gillen, & Scaffa, 2014 Chapter 38; Cole & Tufano, 2008, Chapter 10). The environment are the

extrinsic factors in which occupation occurs. The environment can be built, natural, cultural, societal, social, and economic systems (Cole & Tufano, 2008, Chapter 10). Occupation is defined as activities that are goal-directed pursuits of the person that are meaningful and have distinct purpose (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 38; Cole & Tufano, 2008, Chapter 10). Occupational performance is the outcome of the interaction between the person, environment, and occupation. The result of the interaction is the participation in doing occupations (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 38; Cole & Tufano, 2008, Chapter 10). The older adult population (the person) is interacting with low-income housing and the surrounding community (the environment) through activities that they perform (the occupation), resulting in the occupational performance. This theory is relevant to this proposal because it focuses on areas of interest for the older adults (the occupation), an analysis of how the older adults are participating in the chosen occupations (performance), and if there are any intrinsic or extrinsic barriers to performing the chosen occupations (Cole & Tufano, 2008, Chapter 10). Increasing occupational engagement in the community can decrease social isolation and increase access to the community (Mulry, Papetti, De Martinis, & Ravinsky, 2017). With the proper fit between all these elements, the older adult can function better within their environment to increase occupational participation (Lien, Steggell, & Iwarsson, 2015). Mastery of the person-environment fit can increase occupational participation and promote self-efficacy and confidence, which leads to overall wellbeing and quality of life (Mulry & Piersol, 2014).

The Model of Human Occupation (MOHO) is a holistic approach that stresses the importance of a connection between motivation and occupation. MOHO addresses the concepts of volition, habituation, and performance capacity (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 39). Volition refers to the motivation behind choosing activities. Volition is influenced by factors

such as personal causation, values, and interests. Personal causation are the thoughts of how effective and capable one feels in their abilities to do activities. Values are the beliefs and commitments about what is important to the person, which includes what activities are important. Interests are developed through participation in activities that bring about pleasure and satisfaction (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 39). Habituation refers to the patterns and routines in which people organize actions. Habituations are developed through habits and roles. Habits are learned ways of performing activities automatically (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 39). Roles are a source of identity which provides inherent expectations of how to act in particular situations and obligations associated with that identity (Cole & Tufano, 2008, Chapter 7). Performance capacity refers to one's underlying abilities and how those abilities influence occupational performance. Abilities include mental, physical, and bodily systems (Boyt Schell, Gillen, & Scaffa, 2014, Chapter 39). Using MOHO can give an understanding into motivating factors for participation or lack of participation in occupations can help identify areas of decreased occupational performance. An understanding of motivation and roles the older adult population identifies can inform past and current occupational performance.

Significance of Proposed Project

According to Healthy People 2020, some of the goals and objectives set in place are to: “attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages” (Center for Disease Control and Prevention [CDC], 2014). Following these guidelines, productive aging promotes the health of the older adult population by enabling this population through support via the environment to

increase occupational engagement in desired occupations. Productive aging takes into account areas of physical, cognitive, social, cultural, and spiritual (Barney & Perkinson, 2016). Research has demonstrated that there is a need to focus more on a holistic view, rather than just focusing on the physical, and a particular focus on occupation-based and client-centered interventions are particularly more effective (Mulry, Papetti, De Martinis, & Ravinsky, 2017; Wilkins, Jung, Wishart, Edwards, & Shelley, 2003). Because there is an estimate of 83.7 million older adults by 2050, it is vital that the environment support productive aging (Mulry, Papetti, De Martinis, & Ravinsky, 2017). There has been research in providing occupational therapy services for older adults in productive aging, but there is a gap in evidence focused on seniors with low-income and limited resources (Mulry, Papetti, De Martinis, & Ravinsky, 2017). A community-based focus will also enhance program development to focus on the needs of the older adult population in a specific community (Cassidy, Richards, & Eakman, 2017). This capstone seeks to increase occupational therapy's role in productive aging for low-income older adults to support older adults through the aging process.

Interfaith provides many opportunities for the older population to live a more fulfilling life by providing programs for seniors of low-income. Occupational therapy can provide further opportunities for the residents to participate in meaningful occupations. Limited monetary resources can decrease participation in multiple areas of instrumental activities of daily living (IADLs), such as community mobility, nutrition, leisure, social participation, and more (Berger, Escher, Mengle, & Sullivan, 2018; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Schmelzer & Leto, 2018). The goal of this capstone project is to understand and assess limitations and strengths in occupational performance of the low-income older adult population participating in Interfaith Community Service's community programs to participate in meaningful occupations,

increase participation in the community, and build resources and relationships within the community.

Preliminary Project Objectives

- Establish an understanding of productive aging needs and desires of the older population associated with Interfaith's low-income communities and programs
- Perform interviews to enhance an in-depth understanding of participants, staff members, and volunteers to analyze occupational participation strengths and limitations within this population
- Assess current resource availability to the local community
- Develop a program incorporating recommendations to enhance occupational participation

Definition of Terms

Community mobility is defined as the “planning or moving around the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding buses, taxi cabs, or other transportation systems” (AOTA, 2014, p. S19).

The environment refers to the physical and social conditions in which the individual participates in occupations or activities (AOTA, 2014). The environment includes the built or physical, natural, cultural, societal, social and economic systems, institutional, situational, and social interaction (Cole & Tufano, 2008, Chapter 10; Eckel, 2012).

Low income is indicative of earnings at 80 percent of the average income for San Diego county (“What is Affordable Housing,” n.d.).

Occupation refers to the activities or tasks in one's life that are meaningful to the individual, whether it is something that is required or something more enjoyable (Cole & Tufano, 2008, Chapter 10). Occupational performance is an interaction between the person, the environment,

and the occupation, leading to the resulting participation in the occupation or activity (Cole & Tufano, 2008, Chapter 10).

Older adults are defined as adults ages 65 years and older.

Productive aging supports the health and wellbeing of older adults through residing in their preferred living space while maintaining and increasing occupational participation within the home and community (Mulry & Piersol, 2014). Productive aging is a “process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (Johansson & Björklund, 2016, p. 207).

Social participation is defined as the engagement of activities that involve the community, family, peers, and friends. Social participation may also involve technologies, such as the telephone, virtual, and computer interactions (AOTA, 2014).

Assumptions and Limitations

One assumption about the residents of Interfaith older adult low-income community is that they have limited occupational participation. This may be due to physical, emotional, cognitive, or monetary limitations (Hunter & Kearney, 2018). If occupational participation is not a limitation for this community, a preventive approach can be taken. Another assumption about the seniors living in Interfaith’s low-income older adult participants is that there is a lack of use and knowledge of community resources; therefore, there is a need for support and access to resources available. Another assumption is that the older adults have limited access to private transportation, such as a motor vehicle due to limited monetary resources. Another assumption is that the older adults have decreased participation in IADLs such as community mobility, social participation, meal preparation, nutrition, and leisure (Hunter & Kearney, 2018; Mulry & Piersol 2014).

Limiting factors that may influence the results of the project include comorbidities, chronic illnesses, or disabilities that may limit occupational participation. Disabilities can result in an impaired quality of life, which could be due to an impairment in participation in IADLs (Hunter & Kearney, 2018). Another limitation is the time frame of capstone project, potential sample size, and geographical location. Due to the length of the capstone experiential component of the doctoral program, it limits the amount of time spent learning, applying, and implementing the project. Another limiting factor refers to the sample size due to potential participants' interest in participating in the project. Due to the geographical location and resources available in Northern San Diego County, the resources provided to the participants are limited to this community and would not be generalizable to the older adult population. However, areas of decreased occupational performance of low-income older adult can incorporate occupational therapy community interventions and ideas that can make it generalizable. The last limiting factor is that specialized occupational therapy interventions may not be delivered because there is not a supervising occupational therapist to oversee any interventions that may be delivered, therefore, interventions need to be general versus individually-based.

This proposal seeks to find opportunities for further occupational performance through an understanding of intrinsic and extrinsic personal factors, environmental fit, and motivation.

Literature Review

As people age, multiple factors can limit participation in instrumental activities of daily living (IADLs). IADLs have been associated with independence, and a decrease in participation in IADLs can increase dependence on others (Spillman, 2004). Areas of interest that can decrease life satisfaction include community mobility and social participation.

Community Mobility

Community mobility is defined as the ability to move around the community, outside of the home (Mulry, Papetti, De Martinis, & Ravinsky, 2017). In order to move about the community, it involves “planning and moving around the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding the buses, taxi cabs, or other transportation systems” (AOTA, 2014, p. S19). The ability to move about the community allows for participation in meaningful activities and roles (Mulry & Piersol, 2014). As older adults age, life expectancy can exceed driving ability. Without knowledge of community resources available for community mobility, it can decrease community-based occupations and increase social isolation (Mulry, Papetti, De Martinis, & Ravinsky, 2017; Mulry & Piersol, 2014). Community mobility allows individuals to engage in their community as they desire, which is the right of every individual (Polgar, 2011).

A limiting factor to community mobility involves falls and environmental barriers. Falls are recognized as a public health issue for older adults, as it is a precipitator to emergency room visits (Chippendale & Bear-Lehman, 2011). When an individual falls, it could be due to intrinsic factors, but when analyzing the reasoning for falls, examining the extrinsic factors such as the physical environment can create opportunities that allow the older adult population to continue participation in community mobility. Occupational therapy can provide adaptations to the built environment to help maximize function and independence for the older adult (Chippendale & Bear-Lehman, 2011).

A walkable community is defined as a community in which residential density, street connectivity, and mixes of land contribute to a community’s ability to walk to desired locations (Muller-Riemenschneider et al., 2013). Environmental barriers to a walkable community include uneven surfaces, such as poor pavement quality, potholes, and high curbs; and the presence of

obstacles, such as trash bins and advertisements (Chippendale & Bear-Lehman, 2011). In order for this to be feasible for the older adult, the walkable community is dependent on its connectivity and density. Influences on walkability of a community include the population density (too populated or too rural), the slope of the environment, and the proximity to businesses and community members (Stav, 2014). A walkable community not only provides means of community mobility by providing access to shops and ability to run errands, but it also provides a means of physical activity (Chippendale & Bear-Lehman, 2011; Stav, 2014). The ability to move about the community also provides a social-emotional impact, such as natural scenery in a neighborhood, which can divert an individual's attention away from problems in their lives and can facilitate social participation through social interaction and networking within the community (Chippendale & Bear-Lehman, 2011).

Programs have been developed that aim to promote health and wellness of the older adult through productive and meaningful activities in a preventive measure to help older adults maintain independence. Lifestyle Redesign® is a multimodal occupational therapy community-based program that encourages participation in occupation and the relationship to health in older adults (Clark et al., 1997, 2012; Hay et al., 2002; Mulry & Piersol, 2014). Through this 9-month program, the goal was to help participants understand the importance of participation in meaningful occupations to achieve healthy and satisfying lifestyle through individual and group sessions (Clark et al., 1997). Results from the Lifestyle Redesign® program demonstrated benefits of health promotion by fostering a lifestyle that encouraged occupational participation, delayed age-related decline in function, and reduction in health care costs (Cassidy, Richards, & Eakman, 2017; Clark et al., 1997, 2012). Lifestyle Redesign® was effective at improving physical and role functions related to IADLs (Orellano, Colón, & Arbesman, 2012). Within the

Lifestyle Redesign® program, transportation utilization was addressed to help the older adults with ethnic group representation in community mobility, providing opportunities to explore and master public transportation, especially linked to limited income and resources (Clark et al., 1997, 2012).

Although Lifestyle Redesign® demonstrated effectiveness in reducing health care costs, the adoption of the program has not been widely established. Other programs, such as Aging Well by Design and Let's Go program have been designed to focus on feasibility within local community-dwelling older adults via shorter programs, and do not cover all the topics from Lifestyle Redesign® (Cassidy, Richards, & Eakman, 2017; Clark et al., 1997; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Mulry & Piersol, 2014). Aging Well by Design presented the topics from Lifestyle Redesign® except for multicultural awareness and took place at a primary care clinic versus a community setting. This program demonstrated the feasibility of a Lifestyle Redesign-inspired program is feasible in a large health care system (Cassidy, Richards, & Eakman, 2017). One of the themes that emerged from the study was that participants found it beneficial to learn about community resources. Participants participated by sharing resources with each other, which were added to the class notes for future programs (Cassidy, Richards, & Eakman, 2017). The Let's Go program is a 4-week interdisciplinary program developed with a focus for older adults who expressed concern about community mobility due to a lack of personal transportation as they have aged. Results demonstrated increased confidence in community mobility (Mulry & Piersol, 2014). Based on the feasibility study of the Let's Go program, it was then provided in a community-based setting, in which participants identified supports and barriers, whether physical, social, or socioeconomic factors to participation in community-based occupations. Results demonstrated increased participation in community-

based occupations, increased frequency in the number of outings, and increased confidence in community mobility skills (Mulry, Papetti, De Martinis, & Ravinsky, 2017). A Scandinavian adaptation of Lifestyle Redesign® provided client-centered themes based on the occupational needs of the group, provided over 4 months. The program consisted of multiple topics, one of which was occupation and mobility. From this study, it was noted that the results showed the participants felt safer and more secure about their surroundings because of the program (Johansson & Björklund, 2016). One participant stated, “About taking the bus...I used to be afraid...I was very afraid... the drivers don’t wait until you’ve sat down...but I was told to tell them to wait...so now I dare to take the bus again” (Johansson & Björklund, 2016, p. 215). An educational program in Australia helped older adults become more knowledgeable about community mobility transportation choices based on pretest and posttest scores about available community mobility options in the community, with most of the participants still maintaining a valid driver’s license (Di Stephano, Lovell, Stone, Oh, & Cockfield, 2009).

According to AOTA (2016), further research is needed in community mobility programs, such as education about community mobility options and resources and in living in walkable neighborhoods, providing older adults with opportunities to move about the community via walking. Providing community mobility resources can enable the older adult to participate in meaningful occupations in the community, promote the development of these resources, and meet the older adults’ community mobility needs (Stav, 2008, 2014). This capstone will seek to provide community resources to enhance community mobility among the older adults living at Interfaith.

Social Participation

As defined by AOTA, social participation is the engagement in activities that involve a social interaction with others, such as family, peers and friends, and community members (AOTA, 2014; Boyt Schell, Gillen, & Scaffa, 2014). Through the aging process, it has been found that social participation decreases with age (Dahan-Oliel, Gélinas, & Mazer, 2008). A lack of social participation increases loneliness among older adults (Ollonqvist et al., 2008). Although social participation is a critical area in occupational therapy interventions, this can become secondary to the primary issues of referral, such as independence and safety within the home (Turcotte, Carrier, Roy, & Levasseur, 2018). As a population, older adults are more likely to experience social isolation because they are more likely to live alone due to a loss of a spouse, experience chronic illnesses, have limited income, and experience transportation difficulties (Smallfield & Lucas Molitor, 2018). Social participation can impact overall quality of life, health, and wellbeing, with higher risks of mortality comparable to obesity and tobacco smoking (Turcotte, Carrier, Roy, & Levasseur, 2018).

Research in social participation for occupational therapy has not been the sole focus of the research. Evidence has consisted of community occupational therapists focused on home modifications and social participation; community mobility and social participation; safety and independence and social participation; and health education and social participation (Turcotte, Carrier, Roy, & Levasseur, 2018). Within Lifestyle Redesign®, occupational therapy intervention group, the social control intervention was highly individualized, giving participants the opportunity to apply the intervention in their own experiences (Clark et al., 1997, 2012). Through the wellness and health promotion program, Aging Well by Design, they demonstrated an increase in social connectedness and in social relationships (Cassidy, Richards, & Eakman, 2017). One participant stated, “I have enjoyed the class tremendously. And the one really

positive, positive thing that came out of it, we are all meeting each other after the class” (Cassidy, Richards, & Eakman, 2017, p. 71041900504). Within the Aging Well by Design study, participants mentioned that reasons they joined the program was for the social relationships they could build (Cassidy, Richards, & Eakman, 2017). The community mobility Let’s Go program was developed to increase community mobility among older adults, yet a theme that emerged from the program was about peer and community support. The participants would practice using resources together, making it easier to try new community mobility methods and increase social participation. One participant stated, “It was scary to go out alone. The five of us going on the train together wasn’t scary; it was fun” (Mulry, Papetti, De Martinis, & Ravinsky, 2017, p. 71041900305). Another wellness program developed client-centered themes that included social participation. Participants concluded that these meetings provided important social meanings. It created a positive space where members could contribute to the community and share experiences and solutions. It allowed the participants to gain perspectives from their peers, and helped maintain friendships and this new social network (Johansson & Björklund, 2016). A program developed based on the Well Elderly study demonstrated increased social and community participation among middle- to upper-class seniors living in an apartment complex (Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003). Although there is limited support for solely social participation interventions, when combined in a wellness program, it can increase physical activity, increase quality of life, and decrease cognitive decline (Smallfield & Lucas Molitor, 2018; Stav, Hallenen, Lane, & Arbesman, 2012). The results from these studies align with previous work supporting the importance of social interaction and its connection to mortality risk (Vrkljan, Leuty, & Law, 2011).

Evidence in social participation has targeted intrinsic and extrinsic factors to increase social participation among older adults. Enabling factors to social participation include occupational therapy creativity, working with the older adult population, and involving their community (Turcotte, Carrier, Roy, & Levasseur, 2018). Limiting factors to social participation include proximity to resources, availability of resources, and community mobility (Levasseur et al., 2015). Other limiting factors include organizational and systemic obstacles, such as policies and reimbursement (Turcotte, Carrier, Roy, & Levasseur, 2018). Research has demonstrated group and individual interventions to increase social participation, but most have been associated with group interventions, however, there is limited research working with marginalized older adults (Turcotte, Carrier, Roy, & Levasseur, 2018).

Social participation is considered an important aspect that can increase overall health, wellness, and quality of life. Because it has a large impact on an individual's quality of life, it remains vital that occupational therapy be involved. Evidence has shown that social participation decreases cognitive and physical decline and has positive implications for engagement in leisure activities (Smallfield & Lucas Molitor, 2018; Stav, Hallenen, Lane, & Arbesman, 2012). Due to more pressing issues, occupational therapists are faced with increasing independence and safety within the home before addressing issues related to social participation (Turcotte, Carrier, Roy, & Levasseur, 2018). This capstone seeks to address the social participation needs of the older adult population at Interfaith to increase social participation by providing a means of social interaction.

In conclusion, research has demonstrated that the impact that community mobility and social participation can have on an older adult's wellness and quality of life. With limited resources, the older adults of Interfaith may be limited in their participation in IADLs such as

community mobility and social participation. Occupational therapy has demonstrated the positive impact in which it can have on older adults' participation and can ultimately increase life satisfaction. Working with the seniors of Interfaith can demonstrate how marginalized communities can also benefit from similar programs.

Proposed Methods

Productive aging supports the health and well-being of older adults by helping them reside in their desired housing and maintaining occupational performance within the home and community (Mulry & Piersol, 2014). This capstone proposal seeks to understand the low-income older adults using Interfaith Community Services' programs by understanding the needs, desires, strengths, and limitations of the low-income senior community. The process will consist of performing interviews with older adults and staff of Interfaith Community Services to complete a needs assessment; observations of current programming; assessment of current resource availability in North County San Diego for older adults; and development of a program to enhance occupational participation in desired occupations to further enhance Interfaith Community Services' senior programs.

Participants will be recruited from the older adults participating in Interfaith Community Services' senior programs and the staff working within these programs with at least one year of experience through convenient sampling. By having one year of experience, the staff will have more meaningful experiences with the participating seniors and may have more insight into their satisfaction with the current programs. The older adult population includes adults ages 65 years and older. The population of interest are older adults living in low-income housing independently, without any caregivers. Recruitment will occur through participation in Interfaith Community Services' senior service programs that include Project CARE, social services, and

the North County Senior Connections lunches for older adult participants. Staff and volunteer recruitment will occur at town meetings and through interactions within the senior programs established at Interfaith Community Services.

Assessments that will be modified for interviews with the older adult population include the Canadian Occupational Performance Measure (COPM) and the Occupational Performance History Interview-II (OPHI-II) (Kielhofner et al., 2004; Law et al., 2014). The COPM provides insight into an individual's performance and satisfaction with performance, which can provide further meaning into occupational performance. According to Tuntland and colleagues (2016), the COPM has content validity, construct validity, and is feasible for the older adult population. Topics from the OPHI-II as it relates to the older adult will focus on daily routines, leisure, and critical life events. Psychometrics for the OPHI-II stated the rater reliability, content validity, and construct validity were applicable across cultures (Kielhofner, Mallinson, Forsyth, & Lai, 2001). Specific questions from the Let's Go Participant Survey semi-structured interview questions may include satisfaction with the participant's abilities to go into the community, activities the participant participated in when they were in the community, how often the participant is able to go out into the community in the last month, and if the participant is able to perform all activities that are important to him or her (Mulry, Papetti, De Martinis, & Ravinsky, 2017). Specific topics that will be addressed are community mobility, social participation, and leisure participation (see Appendix A).

Open-ended questions will be used to provide further exploration into staff and volunteer opinions of current programs, the extent of participation seen in the older adult population, and any areas the staff feel needs further exploration, such as cohesion among all programs provided at Interfaith Community Services. Examples of questions for staff and volunteers include how do

current programs support the low-income older adult population, do the older adults participate in the programs or do they show up to receive services, are there areas that staff see that are still lacking in program development, and can you think of improvements to current programming to support older adults (see Appendix B).

A qualitative design will provide an understanding into the participants' meaning of behind their occupational performance (Creswell, 2014, Chapter 9). An ethnographic qualitative analysis will provide an insight and meaning to the lived experience of Interfaith Community Services' low-income older adults as a group (Creswell, 2014, Chapter 9; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Portney & Watkins, 2015, Chapter 14). Qualitative interviews and observations of Interfaith Community Services' programs will identify areas participants are satisfied in and areas where they identify needed improvements. Many studies used mixed methods approaches to gain an understanding into different perspectives for further explanation of satisfaction with program implementation (Johansson & Björklund, 2016; Lien, Steggell, & Iwarsson, 2015; Mulry, Papetti, De Martinis, & Ravinsky, 2017). Studies in the area of older adult population occupational performance used qualitative data to gain a deeper understanding of the quantitative results (Johansson & Björklund, 2016; Lien, Steggell, & Iwarsson, 2015; Mulry, Papetti, De Martinis, & Ravinsky, 2017). The needs assessment will provide a qualitative approach that can help to determine areas of interest and areas the participants would like more access and participation in.

The first week of the Capstone Experience will include observations and participation in the programs for seniors at Interfaith Community Services. Observations will be documented in a notebook of how programs are run, who runs them, how the programs are structured, how the seniors benefit from the programs, cohesion among the programs, areas for improvement, and

how the program seems to be received by participants. Observations will also take place in a shadowing format with case managers associated with Interfaith Community Services. These observations can also document informal conversations with potential participants about areas of decreased occupational participation. After observing the current programs, the recruitment process will begin by approaching the older adults individually or in groups about participating in an interview process to gain understanding into areas they feel they are successful and areas they feel they lack participation or more programs they would like incorporated at Interfaith Community Services. The interview process will be conducted in a semi-structured format, which includes topics from the Canadian Occupational Performance Measure (COPM) and the Occupational Performance History Interview-II (OPHI-II) as it relates to older adults and aging. If possible, obtaining the satisfaction, performance, and importance scoring of the COPM will be included. Consent forms will be provided to record interviews. Interviews will be conducted on an individual basis and recorded for transcribing and thematic coding in Interfaith Community Services' Escondido office, unless participants request to have the interviews at a different location, such as their homes. Recorded interviews will then be transcribed for thematic coding. If participants request no recordings, the interview can be given and the conversation can be documented through observation notes. Completion of the interviews, transcription process, and analysis for thematic coding will be concluded by the tenth week. Analysis of community resources will be conducted through Internet searches and resources through Interfaith Community Services by the twelfth week.

A presentation of the needs assessment and collected data will be presented to Interfaith Community Services prior to the end of the Capstone Experience for further implementation. Program development will occur until the end of the project. The goal is to develop a program to

be administered and run by Interfaith Community Services staff. Program topics can be administered based on the completion and development of each topic.

Proposed Planned Analysis

The planned analysis of the capstone project consists of the transcription of interviews for thematic coding. Observations and conversations will also be included in thematic coding. Based on thematic coding, identified areas of decreased occupational participation will be presented to Interfaith Community Services via a PowerPoint presentation for further program development. Based on the themes from observations and interviews, the capstone will consist of developing a program to be run by current staffing at Interfaith Community Services. Depending on time, program development will occur until the end of the project, but may not be complete in its entirety. The goal is to develop a program that can be included in Interfaith Community Services senior programming to increase occupational participation in IADLs, as documented in thematic coding as well as research.

Actual Methods and Timeline

During the experiential component, timelines and methods changed in response to the needs of the population and factors related to the site. Originally, the timeline was to conduct observations of the current programs for one week, but it was extended to two weeks of observations due to the extensive amount of information to learn about current programs. After the first two weeks, recruitment of participants through convenient sampling started with the older adults participating in the Senior Connections lunches. Recruitment at the Senior Connections lunches occurred through verbal consent to participate in the interview process. The Senior Connections lunches occur at different senior mobile home parks across North County. They occurred for one hour and include an affordable meal and provide social participation

opportunities and resources through speakers. The written consent form was not used due to the informal and public environment in which interviews occurred and because data was not going to be distributed, the interview was not recorded, nor were names documented. Due to the environment where interviews took place, recording interviews was not conducted because of the noise level, the lack of privacy, and the identification of themes did not require that level of response. The interview process occurred in individual and group formats, as stated in the proposed methods, but after conducting a few group interviews consisting of two participants at a time, it was discovered that this was not the best method to receive in-depth responses. This could be due to many factors: the amount of privacy of their responses, feelings of being compared to other participants, or not wanting to open up about any limitations they may be experiencing. Due to this discovery, interviews were conducted one-on-one, but still in a public environment, due to the fact that they occurred at the Senior Connections lunches. Based on responses from the older adults participating in the Senior Connections lunches, and through a discussion with the Doctoral Coordinator and Capstone Mentor, interview questions were revised to gain more in-depth responses about decreased participation from participants during the fifth week of the capstone experience (see Appendix E). Based on responses at that time, it was decided to include older adults participating in all senior programs connected with Interfaith to gain an understanding of differences and similarities between the two groups of older adults—those that live and participate in a senior mobile home community and case management clients who are more isolated and live alone. Interview notes were recorded in a field notebook. With the inclusion of case management clients, interviews occurred in the home and in the office after case management had addressed their needs.

Interfaith staff members were limited due to the number of staff working within senior services. The team consisted of four staff members, each performing different tasks. Because the team was small, there were no restrictions on inclusion and exclusion criteria. Recruitment of staff did not occur in town meetings, because they did not have any meetings for all staff, but through observation and participation in senior programs. One case manager had one month of experience when the capstone experience started, but her position involved a majority of the issues related to the capstone project, and therefore, it was concluded that all staff members should be included. Formal interviews did not occur for Interfaith staff members because they were not familiar with program development, as the original interview questions had been constructed. All data was gathered through observations and informal conversations about their clients and participants. Volunteers with Interfaith included older adults, but any conversations were informal because the volunteers are working through the Senior Connections lunches.

Themes were identified starting in the sixth week of the capstone experience. Identifying themes was conducted earlier than the proposed methods to discover if interview questions were obtaining in-depth responses to develop themes. The assessment of current resources for North County San Diego started the first week of the capstone experience because it provided an understanding of resources Interfaith provided. Analysis of the interviews to develop themes was completed by the tenth week. Program development was conducted until the end of the experience and presented to Interfaith during the final week. A separate program was not developed because of funding with senior services, therefore, resources were given to include in current programming.

Results and Analysis

Twenty-two senior participants participated in the interview process. An additional 11 participants were included after observations with case management because of their identified areas of decreased participation. By including observations, the total number of participants in the capstone experience added up to 33 participants, 12 male and 21 female. Originally, case management clients were not included in the interview process, and after a discussion with the Doctoral Coordinator about including more participants to gain more insight from the needs assessment, observations of case management clients were included. There were also participants identified by case management as not being a good fit for the interview process, therefore, they were not included. After conducting the needs assessment of older adults participating in Interfaith senior service programs, a few themes developed.

Table 1. Qualitative Themes and Examples

Occupational Category	Number of Participants Identifying Decreased Participation	Examples
Community Mobility	9	<p>Decreased driving due to decreased vision (examples of adaptations some participants made were to cease night driving, cease freeway driving, only local streets)</p> <p>Decreased community mobility as a result of driving cessation (examples of continued community mobility were use of public transportation; and relying on friends, family, and neighbors)</p>
Home Establishment and Management	9	<p>Decreased participation due to back pain</p> <p>Decrease participation due to arthritis</p> <p>Decreased participation due to decreased energy levels</p>
Leisure Participation	9	<p>Decreased leisure participation due to financial and socioeconomic status</p> <p>Decreased leisure participation due to decreased vision, speed, energy, increased pain, and arthritis</p>

Social Participation	7	<p>Decreased social participation due to lack of energy to participate</p> <p>Decreased social participation due to decreased community mobility, caregiving responsibilities, and isolation</p>
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Among the participants, there were differences in socioeconomic level and where they lived. The Senior Connections lunches occurred in different senior mobile home parks that provided activities within these communities for the residents. It allowed them to have social events and develop a sense of belonging among the residents. Case management participants were usually more isolated, living alone, with lower socioeconomic status, and experienced more difficulties with community mobility and social and leisure participation.

Community Mobility. Reasons for decreased participation were categorized between older adults who were driving and those who used alternative community mobility options other than driving. For participants who continued to drive, four participants mentioned reasons for decreased participation included driving at night, on freeways, and lack of familiarity with surroundings. One participant stated that she would only drive locally to the grocery store and relied on other forms of transportation for other events, such as church and Bible study. Another participant stated he had vision issues, which limited his confidence in his abilities to drive at night. Participants who used other options for community mobility reported difficulty using public transportation, difficulty walking to the bus stops, and difficulty with ride share options. One participant described that she used public buses for transportation to doctor's appointments, but because of distance, it could take up to 5 hours to travel and attend her doctor's appointments. Staff provided feedback about previous clients indicating that the older adult

clients are afraid of using ride share options such as Uber, Lyft, and taxis because of fear of being taken advantage of.

Home Establishment and Management. This area describes the person's ability to obtain and maintain the home environment and possessions in the home, including how to seek help and who to contact for assistance (AOTA, 2014). Many participants identified home management as an area of decreased occupational performance. Many of Interfaith's clients requested assistance for home management activities due to pain and decreased energy levels to perform such activities. One participant described having decreased participation because of back pain. She would try and push through the pain to complete home management activities, which she reported she could not function for the next three days after cleaning. Another participant reported she can handle the smaller tasks of home management, such as dusting, sweeping, and cleaning the toilet bowl, but needed assistance to clean the entire home. Another participant reported his son comes over to help with home management activities.

Leisure Participation. This was an area of decreased participation for participants from the Senior Connections lunches as well as case management clients. The reasons mentioned for decreased leisure participation included decreased vision, fine motor skills, energy, mobility, increased pain, arthritis issues, and finances. Six participants had identified decreased community mobility as a reason for decreased or lack of participation in leisure activities. Four participants identified fine motor skills, mobility, and speed as issues for decreased leisure participation. Finances was an issue that most participants identified, whether it was because of living on a fixed budget or one participant describing not having the finances to go buy a cup of coffee at Panera Bread with his friend once or twice a month.

Social Participation. This was an area of decreased participation based on 7 participants. All of these participants were case management clients, which may be due to the fact that older adults attend the Senior Connections lunches for the social participation aspect, as one participant pointed out. Thirteen participants reported that they were satisfied with their social participation, from attending the Senior Connections lunches and participating in community events, such as the 4th of July party, and were satisfied with their social participation. These 13 participants were all living in mobile home communities. Reasons for decreased social participation were related to finances. One participant stated that he did not have the finances to go for a cup of coffee with a friend. Often, participants associated social participation with eating or buying a cup of coffee. Participants associated social participation with leisure activities, which may be a reason that lack of energy was a reason for decreased social participation. One participant stated she had decreased social participation was because of her caregiving role. She reported she was tired from taking care of her spouse, or she felt that she could not leave him for long periods of time to go have lunch with her friends.

The assessment of local resources available started with a review of their current materials that Interfaith had on site. The assessment continued by searching for San Diego county options for more resources available. Interfaith utilized many resources for community mobility options in North County San Diego, but what was indicated from the assessment was that they did not include resources for older adults that are still driving (see Appendix G). Other local resources included connecting older adults with opportunities for social and leisure participation and providing autonomy to decide what events would be more beneficial for the client. Home management was addressed through recommendations to adapt the task or environment to increase occupational performance (see Appendix F & Appendix G). Leisure

opportunities were focused on providing a social participation aspect to the activity versus exploring quiet leisure opportunities, but solitary leisure options are available on the Modified Interest Checklist, which was given to Interfaith as a resource for leisure exploration to develop goals for their clients.

Discussion

The purpose of the capstone experience was to understand the occupational performance issues of low-income older adults and how to address such issues while taking socioeconomic status into consideration. The objectives were to perform a needs assessment with the older adults participating in Interfaith Community Services' senior programs, create themes of areas of decreased occupational participation, assess resources available to North County San Diego, and to develop a program based on the results of the needs assessment. Findings from the needs assessment confirmed areas of decreased occupational performance in areas also identified in the literature such as community mobility and social participation and leisure (AOTA, 2016; Dahan-Oliel, Gélinas, & Mazer, 2008; Di Stephano, Lovell, Stone, Oh, & Cockfield, 2009; Johansson & Björklund, 2016; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Mulry & Piersol, 2014; Smallfield & Lucas Molitor, 2018). Program development was presented as resources to Interfaith senior service staff to include enhancements in current programming (see Appendix H). A formal presentation of the findings and resources were provided to the Interfaith staff. The presentation was also audio recorded and given to Interfaith senior services manager on a flash drive to use for future hires. Resources were presented to Interfaith staff to provide to their clients to enhance occupational performance. The information provided was well received by staff with immediate incorporation of material into current programs.

Results from the needs assessment indicated community mobility as an area of decreased participation due to factors that have been established in literature. Community mobility occupational therapy programs have provided community resources for alternative transportation options via multimodal design (Clark et al., 1997, 2012; Mulry, Papetti, De Martinis, & Ravinsky, 2017; Mulry & Piersol, 2014). It is important to address community mobility issues through client-centered education, direct experience, and exploration of alternative transportation options to increase community mobility among older adults to increase occupational performance (Mulry & Piersol, 2014). Occupational therapy provides opportunities to develop client-centered interventions for driving and community mobility to increase occupational performance and increase other areas of occupation, such as social participation (Mulry & Piersol, 2014). Advocacy for occupational therapy to provide opportunities for direct experience was also provided as a resource to increase community mobility. Interfaith provided resources for community mobility options for older adults after driving cessation, but were limited in resources for older adults still driving. Resources provided were given in written and online format with information regarding resources for drivers such as CarFit, Driving Rehab Specialists, AAA, and AARP; and other modes of transportation for older adults no longer participating in driving, such as RideFACT, NCTA, taxi voucher options, and senior center pick-up options (see Appendix I).

In previous research, it was identified that occupational therapy could improve IADL performance, such as shopping, health management (specifically medication management), communication management, and financial management (Hunter & Kearney, 2018). Questions asked from the interview did not specifically ask about all IADLs, and may be a reason that these IADLs were not reflected in the needs assessment. Although multiple IADLs were mentioned as

areas of decreased participation (such as caring for others; employment seeking, interests, and acquisition; health management; meal preparation; and volunteer participation), they were not mentioned enough to develop a theme (only 1-2 participants mentioned as areas of decreased participation in each occupation). Based on findings from the needs assessment, the identified decreased IADL performance was home establishment and management. As research suggests, activity-specific interventions can improve IADL performance among older adults (Orellano, Colón, & Arbesman, 2012). Further exploration into limitations to perform home establishment and management occupations should be considered in occupational therapy, especially low-income older adults, which can help with financial management as well. To address home establishment and management needs, Interfaith was provided with details of adapting the environment and the occupation to address decreased occupational performance. Resources provided included proper body mechanics, energy conservation strategies, examples of adaptations and modifications to the environment and occupation (see Appendix F & Appendix G). Advocacy and referrals for occupational therapy was recommended to further create interventions addressing intrinsic factors such as addressing physiological, cognitive, spiritual, neurobehavioral and psychological factors (Boyt Schell, Gillen, & Scaffa, 2014). These recommendations were not provided to the staff due to their limited training and ability to incorporate this specialized knowledge.

Leisure and social participation were identified as areas of decreased participation as indicated in literature (Smallfield & Lucas Molitor, 2018). Previous literature addressed social participation with other areas of decreased occupational performance, such as through wellness programs, community mobility programs, safety and independence, home modifications, and health education (Turcotte, Carrier, Roy, & Levasseur, 2018). To address social participation, the

case management training was associated with leisure and social participation. Research also suggests using leisure education to increase leisure participation (Smallfield & Lucas Molitor, 2018). To help Interfaith address areas of leisure and social participation, they were provided with resources to help explore leisure participation options to increase social and leisure participation while considering financial management. A resource they were provided was the Modified Interest Checklist to identify areas of leisure to enhance participation to address areas of health and wellness for their clients. Staff were encouraged to provide resources of the local senior centers with opportunities to participate in leisure exploration and participation in social leisure activities by sharing the monthly activities calendar. Some of the case management participants had diagnoses of depression, and the staff were educated on best ways to address a client with depression when helping to develop goals of social and leisure participation in the presentation.

Although this capstone originally sought out to identify if social participation was an area of decreased occupational performance among low-income older adults, it was noted that social and leisure participation were both areas of decreased participation more for the case management clients who were the older adults that do not live in senior communities. The older adults participating in the Senior Connections lunches identified attending the lunches for the social participation aspect. These participants also attended events and activities hosted at the clubhouses and were part of the social committees for their mobile home parks. To better understand if social participation was an area of decreased participation among senior communities, more older adults, such as those who do not attend the Senior Connections lunches, needed to be interviewed to gain a better understanding of a senior community and benefits of living in senior communities.

Limitations

There were multiple factors that could have limited the results of this project. Limitations that occurred within the capstone project included researcher bias based on development of the interview questions, a small sample size, limited number of participants interviewed from case management, the environment in which interviews occurred, the limited student relationship with participants prior to interviewing, language barrier with case management clients, limited resources to evaluate all contexts and environments in which older adults participate, limited reliability in creating themes, and limited intrinsic interventions for the older adults.

The focus areas of the interview questions were developed based on literature, which focused on decreased participation in community mobility and social participation among older adults. This could have created bias because some questions were framed to specifically ask about limitations in these areas, whereas other IADLs may have been overlooked. The interview included questions about self-care, productivity, and leisure, but more questions were directed towards community mobility and social participation. For future interviews, questions could include more specific questions on areas such as medication management, shopping, and financial management.

The sample size was limited to the older adults attending the Senior Connections lunches and case management clients. Case management spent a majority of their time contacting clients over the phone, limiting the number of interviews that could occur. Results were also limited due to the environment interviews occurred at the Senior Connections lunches. The lunches occurred at the mobile home clubhouse. The environment was noisy, interviews were conducted prior to them receiving their food, and if food arrived, the interview was rushed so that they could enjoy their food and social participation. Most participants were asked to participate in the interview

with no prior relationship made between the participant and the interviewer. If a previous bond or relationship had been made, responses may have reflected more occupational performance issues. Another reason the interview may not have reflected in-depth responses is that participants are not seeking out services, and therefore, may not view any decreased occupational performance issues as problems or just a normal part of aging. Five participants reported no occupational performance issues, which may have been due to factors such as not wanting to discuss occupational performance issues for fear of being judged, not wanting to share issues that may be having, or agreeing to participate even though they had no concerns just to be polite.

When including more participants from case management, many of the new referrals to case management were Spanish-speaking only, and because of this, they were excluded from participating in the needs assessment because the student did not speak Spanish. Interfaith and Neighborhood Healthcare were in collaboration on a research project for seniors with depression. Case management relied on the Neighborhood Healthcare collaboration for translation, but Interfaith was told that they needed to find their own translator. Case management did not have anyone to translate so they relied on having the clients read papers or have family members be the translators, but there were times when the case managers met with clients and did not have a translator. When case management had family that would translate, the conversations were not all translated to the client limiting the amount of input from the client.

Due to the timeframe of the capstone experience, there was not sufficient time to evaluate all contexts and environments in which older adults participate, such as evaluating social, physical, cultural, temporal, and virtual. An example of further exploration could include life after the loss of a spouse. One participant had lost his spouse three years prior, and found it very difficult to discuss his daily life because he compared his life now to when his wife was alive.

The development of themes was not confirmed by a peer reviewer. Because interviews were documented in a field notebook, it was not feasible to have the Capstone Mentor confirm themes, nor were peers available to review the interviews.

Finally, recommendations were not made to address intrinsic limiting factors such as physiological, cognitive, spiritual, neurobehavioral, and psychological interventions because of the limited training and ability of staff to implement recommendations. The case managers were not formally trained in social work, one with no background in social work, and therefore, intrinsic factors were not addressed because it did not seem feasible for case management to address such issues without further in-depth training. A suggestion was for clients to advocate for a referral to occupational therapy to improve intrinsic factors and for individualized adaptations for extrinsic factors.

Implications for Occupational Therapy

The needs assessment performed confirmed areas of decreased participation associated with previous research such as community mobility, social participation, and leisure participation (Hunter & Kearney, 2018; Johansson & Björklund, 2016; Smallfield & Lucas Molitor, 2018). Based on the results, further advocacy of occupational therapy in community-based settings, such as non-profit community agencies, should be explored to address the needs of older adults to help address occupational performance. Being part of a team in community agencies can help reach older adults that may not qualify for occupational therapy without a physiological need. As people age, their client factors and performance skills decline (AOTA, 2008), but addressing the contexts and environments can increase occupational performance in IADLs (Eckel, 2012). Advocacy for the inclusion of IADLs such as leisure and social participation should be explored

for future inclusion in occupational therapy reimbursement and treatment to address older adults holistically and increase overall occupational performance.

Further implications for occupational therapy include occupational therapy in primary care. Having an occupational therapy consultant available in primary care can help alleviate some occupational performance issues older adults face by enhancing and connecting older adults to resources.

Lastly, in academia, curriculum should include education on delivering resources in leisure and social participation to low-income communities with chronic conditions via leisure exploration and participation in leisure groups for further development of problem solving and critical thinking skills.

Future Research and Projects

Some areas were underexplored through the experience with Interfaith such as the experiences of rural clients. Future research should examine differences between decreased occupational performance among low-income older adults living in rural communities versus urban communities to better understand access to resources for continued occupational participation in community mobility, social participation, and leisure participation.

A future project at Interfaith could explore the areas of financial management and leisure participation to identify ways for occupational therapy to support participation and skills in these area for low-income older adults. Interfaith creates a budget list for their clients, but further exploration into incorporating leisure participation into financial management could help the seniors participate in occupations that may have been lost.

Research has also indicated that peer exchange is an important part of community mobility programs, but due to Healthcare Insurance Portability Accountability Act (HIPAA) and

Interfaith's financial limitations, Interfaith was not able to match clients with one another to discuss and perform direct experience nor create a separate program to use multimodal forms of education, exploration, and direct experience (Mulry & Piersol, 2014). A future project could include program development that includes community mobility, social participation, and leisure participation through multimodal group experiences.

Further exploration into the culture of aging, such as a comparison between older adults living alone versus moving in with family, can provide information into how older adults are able to continue occupational performance in IADLs and areas where they have limitations in performance. A comparison of occupational performance between moving in with family and living alone can increase knowledge of how to best help older adults as they age to continue to perform occupations such as IADLs.

Future research could entail comparing senior communities versus living outside a senior community and addressing the differences between resources, social participation, and community mobility. This project could examine the difference between quality of life between the two environments. There are older adults that are isolated in these senior communities and examining the difference between the isolated in senior communities and the isolated living outside a senior community could indicate the next steps to providing resources for those in outside senior communities.

Lastly, future research should evaluate all contexts and environments in which low-income older adults participate in to gain understanding into all limiting factors. Limiting factors that were mentioned by most participants were related to the physical environment. Further exploration into other contexts such as cultural, personal, temporal, and virtual could help

identify other factors that can influence occupational performance and reasons behind limiting factors.

Conclusion

The findings from this capstone project and experience supported previous literature that areas of decreased occupational participation include community mobility, social participation, and leisure participation among older adults is similar for marginalized older adults. Based on the results, it is also notable to include home establishment and management when addressing IADLs in occupational therapy interventions. Through educating case management on ways to provide assistance through adaptation and modification and providing resources, this can help older adults to continue to participate in IADLs for a longer period of time and help delay the need to pay for assistance, especially for those who are financially limited and not currently receiving occupational therapy services. Further advocacy for occupational therapy to provide services in non-profit community agencies can help address decreased IADL participation among community-based marginalized older adults to promote health and wellness.

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APPENDIX A

Proposed Older Adult Population Interview

Appendix A: Proposed Older Adult Population Interview

1. Describe a typical day during the week for you.
2. Do you do anything different on the weekends?
3. What are the most important things in your routine?
 - a. Does your routine allow you to get the most important things done?
 - b. What important things are you not able to do?
4. Was your daily routine ever different? OR How was your routine different when you were between your 40s and 60s?
5. Do you have any ongoing hobbies/projects that are part of your ongoing routine?
6. Do you have any hobbies/projects that were part of your routine in the past?
7. Self-Care: In this category, self-care is considered personal care, your ability to get around, and how you move about the community.
 - a. Can you think of some activities you do for personal care? How happy are you with your abilities to perform your personal care? On a scale from 1 to 10, how important is personal care to you?
 - b. How do you get around your house? How about in the community? How satisfied are you with your movements around the home? On a scale from 1 to 10, how important is the ability to get from place to place?
 - c. Are you participating in the community outside your home? What are some activities you did within the last month that was outside your home and in your community? How important is participating in these activities on a scale from 1 to 10?
 - i. How did you get to this activity (i.e., driving, public transportation, walking, friend/relative dropped you off)?
 - ii. What activities did you do when you were in the community?
 - iii. Are there activities that you used to do in the community that you no longer do? If so, what are they?
 - iv. Are you able to do all activities in the community that you want to do?
8. Productivity is considered activities such as paid or unpaid work, household management, and school/play.
 - a. Are you participating in any paid/unpaid work? Are you satisfied with your participation in these activities? On a scale from 1 to 10, how important is this work?
 - b. What household management activities do you do? Do you receive any help? Are you satisfied with how your household skills are? On a scale from 1 to 10, how important is it to perform household management activities?
9. Leisure includes activities that you do that are not related to being productive. These can be considered quiet recreation or active recreation.
 - a. What are the main things you do to recreate or relax?
 - b. Can you think of activities that you do currently? How would you rate your satisfaction in your participation? Is this important to you?
 - c. Who do you relax and recreate with most?
 - d. How about socializing? Who do you socialize with? How do you socialize? How would you rate your satisfaction in socializing? On a scale from 1 to 10, how important is socializing?

10. Critical Life Events

- a. What were some events or experiences that most shaped or changed your life?
- b. When did things really change for you?
- c. If you think about your life, what do you consider the time when you were doing best? What made this period so good?
- d. What do you consider your biggest success in life?
- e. What do you consider the worse period in your life?
- f. If you could make your future turn out as you wanted, what would you be doing?

APPENDIX B

Proposed Staff Interview Questions

Appendix B: Proposed Staff Interview Questions

1. What is your current role?
2. How long have you been working at Interfaith Community Services?
3. Can you tell me about the program you are currently working in?
4. How was the program developed?
5. How does the current programming support seniors?
6. Do you feel like the seniors appreciate the programming provided? How can you tell?
7. Are the seniors actively participating or do they show up to receive services?
8. Are the seniors able to participate in programs they want to? How are they participating?
9. After working with the seniors do you feel there are other programs the seniors would benefit from?
10. Do you see any areas or opportunities where more programming for seniors would benefit them?
11. How are the programs offered through Interfaith cohesive (supporting one another)?

APPENDIX C

Proposed Consent Form to Participate with Recording

Appendix C: Proposed Consent Form to Participate with Recording

You are invited to participate in an interview on Promoting Productive Aging among Low-Income Older Adults. This interview is part of a doctoral project being conducted by Sarah Matsuoka, an occupational therapy doctoral candidate at University of St. Augustine Health Sciences. It should take approximately 60 minutes to complete.

Funding Source

None

Benefits

You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about activities that you have difficulty participating in.

Risks

There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participants have the right to drop from participation in the study at anytime.

Costs and Payments to the Participant:

You are not responsible for any costs or payments related to this participation.

Confidentiality

Your answers will be recorded and where data will be stored in a password protected electronic format. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study.

Contact

If you have questions at any time about the study or the procedures, you may contact the doctoral student, Sarah Matsuoka, by E-mail at s.matsuoka@usa.edu.

Voluntary Consent by Participant

Participation in this research project is totally voluntary, and your consent is required before you can participate. See signature statement below. You may refuse to take part in project at any time without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason.

Participant's claim

I have read this consent form (or it has been read to me) and I fully understand the contents of this document and voluntarily consent to participate. All of my questions concerning this research have been answered. If I have any questions in the future about this study, the occupational therapy doctoral candidate listed above will answer them. This form can be printed for your records.

Participant's Signature

Date

Participant's Printed Name

APPENDIX D

Proposed Consent Form to Participate without Recording

Appendix D: Proposed Consent Form to Participate without Recording

You are invited to participate in an interview on Promoting Productive Aging among Low-Income Older Adults. This interview is part of a doctoral project being conducted by Sarah Matsuoka, an occupational therapy doctoral candidate at University of St. Augustine Health Sciences. It should take approximately 60 minutes to complete.

Funding Source

None

Benefits

You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about activities that you have difficulty participating in.

Risks

There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participants have the right to drop from participation in the study at anytime.

Costs and Payments to the Participant:

You are not responsible for any costs or payments related to this participation.

Confidentiality

Your answers will be kept in written notes in summary format. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study.

Contact

If you have questions at any time about the study or the procedures, you may contact the doctoral student, Sarah Matsuoka, by E-mail at s.matsuoka@usa.edu.

Voluntary Consent by Participant

Participation in this research project is totally voluntary, and your consent is required before you can participate. See signature statement below. You may refuse to take part in the project anytime without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason.

Participant's claim

I have read this consent form (or it has been read to me) and I fully understand the contents of this document and voluntarily consent to participate. All of my questions concerning this research have been answered. If I have any questions in the future about this study, the occupational therapy doctoral student listed above will answer them. This form can be printed for your records.

Participant's Signature

Date

Participant's Printed Name

APPENDIX E

Revised Older Adult Population Interview

Appendix E: Revised Older Adult Population Interview

1. How long have you been living in the mobile home community?
2. Tell me how you came to make the decision to move to this community.
 - a. What do you like about living here?
 - b. What is different about living here compared to other situations where you have lived?
3. What does a typical day look like for you?
4. When you think about your daily routine, what are the most important things you do?
5. Has your routine changed recently?
6. Do you have any ongoing hobbies/projects that are a part of your current routine, such as you do weekly?
7. Any ongoing hobbies/projects different in the past?

Self-Care

8. Think about your morning/night routine. Can you think of some activities you do for your personal care?
 - a. Has your self-care routine changed at all?
 - b. Can you think of reasons why your daily routine has changed?
9. How do you move around your home?
10. How do you go into the community?
11. What activities do you do when you are in the community?
12. Are there any activities that you used to do in the community that you no longer do?
13. Are there any activities that you want to do that you are not doing at this time?
 - a. Why has participation in community changed?

Productivity

14. Are you currently participating in any paid/unpaid work?
 - a. Do you find any aspect of the paid/unpaid work more difficult?
15. What household management activities do you do?
 - a. Do you receive any help?

Leisure

16. Who do you socialize with?
17. Who do you relax or recreate with most? How do you socialize?
 - a. What do you do when you're together?
 - b. Has your social life changed from before moving to this community to now living in the community?
 - c. Is there anything in your social life that you would like to change?

APPENDIX F

Home Management

Household Management

Reasons for Decreased Participation

- Does not have the energy
- Causes pain
- Increases pain

Standards of Body Mechanics

- Maintain a straight back; minimize hunching forward
- Bend from the hip
- Avoid twisting
- Maintain good posture
- Carry loads close to the body
- Lift with the legs
- Lift with a wide base of support
- Lift slowly

Use Energy Conservation Techniques (4 P's): See Energy Conservation Flyer

Techniques to Cope with Pain

- Progressive Muscle Relaxation Techniques
 - Relax your muscles
 - Starting with your feet
 - Then to your calves
 - Thighs
 - Abdomen
 - Shoulders
 - Head
 - And neck
- Meditation
 - Repetition of a word, sound, phrase, prayer, image, or physical activity in the context of passive disregard for ongoing thoughts
 - You can use a word, such as “one,” “peace,” “The Lord is my Shepherd,” “Hail Mary, full of grace,” or “shalom”
 - Sit quietly and in a comfortable position
 - Close your eyes
 - Use progressive muscle relaxation techniques
 - Breathe slowly and naturally, and continue to say your word or phrase silently to yourself as you exhale

- Assume a passive attitude, meaning don't worry about how well you are doing, if other thoughts start coming, simply say "Oh well" and gently return to the repetition
 - Continue for 10-20 minutes
 - Do not stand immediately after, give yourself a minute or two to let the thoughts return, then open your eyes, and sit for another minute
 - Practice this technique once or twice a day. Good times to do this are before breakfast and before dinner
- Deep breathing
 - Breathing in through your stomach
 - Stomach should move in and out, not chest
- Yoga
 - Chair yoga
 - <https://www.youtube.com/watch?v=-Ts01MC2mIo>
 - Standing yoga
 - <https://www.youtube.com/watch?v=kFhG-ZzLNN4>
- Relaxation
- Visualization
- Imagery

Adapting the Environment or the Task

- Use long-handled equipment, such as long-handled brushes to clean the tub, long-handled dust pans, long-handled duster
- After washing dishes, allow them to air dry
- Clean one room at a time, instead of going back and forth between rooms to do each job
- Keep trash can in every room to avoid too much walking
- Gather all supplies before starting cleaning activity
- Divide activities throughout the week instead of one day of cleaning everything
- Take breaks
- If object is heavy, slide it across surface instead of lifting

- If doing laundry, roll it instead of carry it

If you want further evaluation and personalized adaptations, seek an occupational therapist. Occupational therapists are trained to help individuals participate in activities by adapting the environment to meet the individual's needs and abilities

APPENDIX G

Energy Conservation

4 P's of Energy Conservation

What is Energy Conservation?

Prioritize

- What are the most important activities that you need to get done?
- What can be done at a later time?

Plan

- Plan your activities before you start to avoid extra trips, such as gather all your supplies and equipment (for example, gather all gardening tools you will need before you plant flowers)
- Plan to alternate between heavy and light tasks
- Plan your activities through the week so that you do not do too many activities in one day
- What time of the day do you have the most energy? Plan to do your activities at that time

Pace

- Maintain a slow and steady pace, don't rush
- Take breaks, rest before you feel tired
- Avoid holding your breath (slow and steady breathing)
- Use pursed lip breathing techniques (breathing in through your nose for a count of 2 and out from your mouth for a count of 4; like blowing out a candle)

Position

- Too much bending and reaching can cause fatigue
- Maintain a nice, upright posture when sitting and standing (helps get more oxygen to your lungs and around your body)
- Sit when you can (sitting reduces energy use of 25%)
- Carry objects close to your body, do not hold arms out while carrying, lifting, or bending

Learning how to conserve your energy is all about finding a good balance between rest, leisure, and work to decrease the amount of energy demand on your body

APPENDIX H

Interfaith Presentation

Interfaith Presentation

Sarah Matsuoka

Interfaith Seniors Needs Assessment Results

Needs Assessment Findings

- Home Assessment
- Household Management
- Transportation
- Leisure and Social Participation

Occupational Therapy: What is it?

- Client-centered
- Therapeutic use of daily and meaningful activities across the lifespan
- Activity analysis

Home Assessment

Bathroom

- The bathroom is the most dangerous room in the home
- Safety around tub
- Safety around toilet (Tomita, 2017)

Kitchen

- Place commonly used items on the counter or areas that do not require a lot of reaching or bending
- Add lighting
- Use sturdy step stool to reach into upper cabinets (Tomita, 2017)

Living Room

- Throw rugs
- Cords
- Clutter
- Accessibility of light switches
- Accessibility of walkways (Tomita, 2017)

Bedroom

- Throw rugs
- Cords
- Clutter
- Accessible pathways
- Height of the bed
- Lack of nightlight (Tomita, 2017)

Home Management

Reasons for Decreased Participation

- Decreased energy
- Causes pain
- Increased pain

Standard Body Mechanics

- Maintain a straight back; minimize hunching forward
- Bend from the hip
- Avoid twisting
- Maintain good posture
- Carry loads close to body
- Lift with the legs
- Lift with a wide base of support
- Lift slowly (Radomski & Trombly Latham, 2014)

Energy Conservation Techniques

- Prioritize
- Plan
- Pace
- Position

Techniques to Cope with Pain

- Progressive muscle relaxation techniques
- Meditation
- Deep breathing
- Relaxation
- Visualization
- Imagery
- Yoga (Radomski & Trombly Latham, 2014)

Adapting the Environment or Activity

Adapting the Environment

- Keep a trash can in every room
- Store all supplies together
- Use long-handled equipment to avoid bad posture
- Reacher

Use long-handled equipment to maintain proper posture

Adapting the Activity

- After washing dishes, allow them to air dry
- Clean one room at a time
- Gather all supplies before you start cleaning
- Divide cleaning activities throughout the week
- Take breaks
- If object is heavy, slide instead of lift
- When carrying laundry, roll instead of carry

Transportation

Resources for the Senior Driver

- CarFit
- AAA
- AARP
- The National Safety Council
- NHTSA Driving Safely while Aging Gracefully

Resources for the Senior not Driving

- Ride FACT
- ADA Ride
- Senior Service Council of Escondido
- City of San Marcos
- Vista Community Clinic
- 2-1-1 San Diego Senior Transportation

Social and Leisure Activities

Reasons for Decreased Leisure Activities

- Pain
- Decreased vision
- Decreased speed
- Decreased dexterity
- Decreased energy
- Finances

Leisure Activities

- Balance of work and leisure is crucial to mental and physical health (Fox et al., 2017)
- Different types of leisure
 - Quiet leisure
 - Active leisure
- Leisure has been shown to increase quality of life and wellness and decrease stress (Radomski & Trombly Latham, 2014)

Leisure Activities

- ✓ Interest Checklist
- 🎯 Establish goals that can be easily mastered and progress to more challenging goals (Erickson, 2013)
- 📍 Provide schedule of events at local senior center to peak interest in leisure activities

Reasons for Decreased Social Participation

- Finances
- Relationship status
- Transportation
- Caregiving for a spouse

Social Participation

- Social and leisure participation can decrease cognitive and physical decline
- Socialization can increase quality of life (Smallfield & Lucas Molitor, 2018)
- Leisure activities that involve social participation

References

- [illegible]

APPENDIX I

Community Mobility Flyer

Transportation

Programs that provide evaluations, driving simulators, and on-the-road training

Driver Rehab Specialists, Inc.

<https://drivesafesandiego.com/>

TREDS (Training, Research & Education for Driving Safety)

<https://www.scripps.org/services/physical-rehabilitation/driving-program>

Shar Memorial Hospital

<https://www.sharp.com/services/rehab/adapted-driving.cfm>

Resources for Senior Drivers

Car Fit

- <https://www.car-fit.org/carfit/RegisterCarFit/CA>
- Car Fit is a community-based educational program that promotes continued safe driving and mobility among older drivers focusing on safety, comfort, and fit
- Creating a proper fit between the driver and the car can increase the driver's safety along with the safety of others

- Brochure: https://www.car-fit.org/downloads/CarFit_Brochure_2017.pdf

Search AAA

- <http://www.aaa.com/stop/>
- Enter zip code
- Click on "Safety and News"
- <https://www.calif.aaa.com/automotive/driver-education/senior-programs.html>
- <https://seniordriving.aaa.com/>
- Online Resources
 - Drivesharp
 - Roadwise Driver online course
 - Self-Rating Driving Assessment Tool
- Adult Skills Audit
- Link to CarFit

Search AARP

- <https://www.aarp.org/auto/driver-safety/info-2019/how-to-drive-with-health-issues.html>
- Click on “Take the AARP Smart Driver Course online or find a course near you”
- Classes are not free

Search The National Safety Council

- <https://www.nsc.org/safety-training/defensive-driving/courses>
- Defensive Driving courses

NHTSA Driving Safely while Aging Gracefully

- <https://one.nhtsa.gov/people/injury/olddrive/Driving%20Safely%20Aging%20Web/index.html>

Resources for the Seniors not Driving Anymore

Ride FACT

- <https://factsd.org/>

ADA Ride

- Individualized and Group Mobility and Travel Training
 - Call Trese Gmyr at (760) 966-6509
 - Training will meet you at your residence
 - Walk to the nearest bus stop
 - Board the bus
 - Demonstrate paying fare options
 - Identify designated seating for those who are seniors or have a disability
 - Will provide specific instruction for those using a mobility device, including wheelchair
 - Landmark identification and pulling the cord for alerting the driver
 - Transferring of buses (if necessary) or Sprinter
 - Return trip
 - Willing to provide repeated training if the customer needs additional assistance
- LIFT Paratransit Eligibility
 - www.adaride.com
 - Call (877) 232-7433
- Applying for Senior/Disabled/Medicare Reduced Fair ID Card
 - Call NCTD (760) 966-6500

Senior Service Council of Escondido

- <https://www.escondido-senior-services.org/>
- Taxi vouchers for Yellow Cab company for medical appointments
- \$10 taxi vouchers for medical appointments in Escondido
- Requirements: Need to apply in person (728 N Broadway. Escondido 92025 in DEBB Building), show proof of income (Social Security) of less than \$22,600 per year, and a bill with name and address to show proof of residence

- Only for people who have no other means of transportation
- Usually 3 per month
- The vouchers will be mailed

City of San Marcos Taxi Voucher Program

- Free taxi vouchers for San Marcos residents 60+ with income less than \$50,000 per year and have no other means of transportation
- 2 Booklets of \$20 each are allowed per doctor visit with a maximum of 2 visits per month for a total of \$80
- Call San Marcos Senior Center to apply (760) 744-5535 ext. 3605
- **Contact Name:** Jerry LaFave – Transportation Coord.
- **Contact Email:** jlafave@san-marcos.net
- san-marcos.net

Vista Community Clinic Transportation

- Transportation provided to and from clinic location or specialty appointments at other locations
- Clinic locations at
 - 1000 Vale Terrace, Vista CA 92084
 - 161 Thunder, Suite 212, Vista CA 92083
 - 818 Pier View Way, Oceanside CA 92054
 - 517 N. Horne Street, Oceanside CA 92054
 - 846 Williamston, Vista CA 92084
 - 4700 North River Road, Oceanside CA 92057
- vistacommunityclinic.org
 - Contact Name: Joaquin Quiroz, ext. 159 – Manager Transportation Service
 - Contact Phone: 760-407-1220
 - Contact Email: jquiroz@vistacommunityclinic.org

2-1-1 San Diego Senior Transportation

- <https://211sandiego.org/resources/basic-needs/senior-transportation/>
- <https://211sandiego.communityos.org/zf/taxonomy/detail/id/568550>
 - Senior transportation services offered in San Diego County
 - Ranges from senior centers to home care

North County Transportation Association (NCTA)

- <https://www.gonctd.com/>