2019

Community-Based Occupational Therapy Practice Among Older Adults: A Delphi Study

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June 5, 2019

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Acknowledgments

First and foremost, I would like to thank God for giving me the strength, knowledge, ability and opportunity to undertake this journey of perusing my doctoral degree. It is with God's grace and mercy that I have persevered. Without his blessings, this achievement would not have been possible.

In my journey towards this degree, I have found a teacher, a mentor, and a role model who so graciously supported and guided me, Dr. Lawrence Faulkner. I am so grateful for his heartfelt support and guidance throughout this journey. Dr. Faulkner left me with his invaluable guidance, inspiration, and knowledge. Thank you, Dr. Faulkner, for providing me the freedom to pursue my research, while non-obtrusively ensuring that I stay on course and not deviate from the core of my research.

To my caring, loving, and supportive husband, Mark, who held my hand and encouraged me throughout this entire process. Thank you for always praying for me and providing me with words of encouragement when times were good and when times were rough. I love you with all my heart.

I want to thank my family and friends for their kind co-operation and encouragement. To my biggest cheerleader, my mom, thank you for always being the most compassionate, and selfless person I know. You have always been by my side with words of encouragement and of course chocolate. To my sister Connie, you were always there to listen to me and pray with me. The tassel was worth it!

My completion of this degree would not have been accomplished without the support of the community partners who assisted me during my residency hours and the ongoing support from my residency supervisor Gina Ord.

Abstract

This capstone project explores the socio-political environment of current and potential community-based occupational therapy (OT) services among community-dwelling older adults, including the current state of community-based OT practice and the current awareness of OT's potential impact on health and wellness among community-dwelling older adults. The goal is to identify how to increase the presence of OT in community settings to decrease the occupational injustice among the older adult population.

The research method used is the Delphi Method, an anonymous structured communication between experts in the field of community-based OT practice and the older adult population. Experts, provided real-world knowledge and guidance to: 1. identify indicators that inhibit the presence of OT in community-based practice for the older adult, 2. identify if OT is a potential service within the community to improve health, wellness, and quality of life (QOL) for the prevention of disease among older adults, and 3. forecast how an increased presence of OT in community settings can decrease occupational injustice among the older adult population.

Community-based OT practice was identified as a valuable service among older adults. Recommendations were established on how to increase community-based OT practice among older adults. Limitations were identified as to why OT is rare in community practice. A body of evidence, including this research, supports the need to address the OT profession's theoretical, philosophical and practical perspective on community-based OT practice among older adults.

Key Words: community-based OT practice, older adult population, occupational injustice

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Chapter 1 Capstone Project Introduction

Project Description

As healthcare costs continue to rise, changes in healthcare policy emphasize health and wellness. Community-based practice offers a broad range of services to meet the needs of community-dwelling older adults. Without community-based occupational therapy (OT) practice, older adults are being deprived of the opportunity to improve occupational engagement. The increased presence of OT in the community provides older adults with access to interventions that aid in the prevention of disease and dysfunction by focusing on improving overall health, wellness, and quality of life (QOL).

Through the Delphi Method, experts within the field of OT will provide real-world knowledge and guidance as to why there is a limited presence of occupational therapy practitioners (OTPs) within community practice among older adults. These experts will also offer quality indicators that support OT as an effective intervention for improving QOL among community-dwelling older adults. OT expert knowledge will provide suggestions for future practice that focuses on how to increase the presence of community-based OT among community-dwelling older adults.

Definition of Terms

Community. According to Chavis and Lee (2015), a community is developed when people who dwell in the same environment, share common characteristics or commonalities. Communities support and facilitate interactions between individuals who work together to meet the needs of their members (Chavis & Lee, 2015).

Community-Dwelling Older Adults. Older adults living independently within the community that are 60 years of age or older (Wagenfeld, 2016). Community-dwelling older adults may or may not have health concerns impacting their participation in daily life activities.

Emerging Practice. According to Holmes and Scaffa (2009a) "multifaceted concept [that] encompasses diverse professional roles, a variety of contexts for the provision of services, as well as the development of innovative business models" (p. 81). Emerging practices are programs that are developed from traditional practice areas carried out in the community. These programs are innovative and designed to meet the needs of the community in which they are developed. Community-based OT practice is considered an emerging practice area (Wagenfeld, 2016).

Productive Aging. The term productive aging is used to describe the societal contributions of older adults, including paid employment, volunteer activities, caring for others, and daily activities (Wagenfeld, 2016).

Subject Matter Experts (SMEs). Individuals who have a deep understanding of their profession and subject matter of topic (Hohmann et al., 2018). For this capstone project, occupational therapists and occupational therapy assistants with greater than five years of experience in the field of community-based OT practice and aging is referred to as the SMEs or experts.

Wellness. The term "wellness' refers to "taking control of one's choices to increase satisfaction in life and improvement in overall health (Wagenfeld, 2016).

Background and Rationale

Healthcare in America has been evolving for centuries. Changes in healthcare services and delivery have been influenced by sociocultural values, religious beliefs, economic factors,

political views, and the enhancement of scientific knowledge (Anderson & Reed, 2017). During the Agricultural Revolution between 10,000 BC and 2,000 BC, there was increased production of the food supply. This increase in food supply led to the development of communities, allowing the people to labor the lands together. As people began to live close together in communities, they began investing in caring for each other's well-being (Early Concepts of Disease, 2015). As years passed, individuals living in communities were continually striving to improve their QOL and prevention of disease. Historical events would later mold and refine the way communities cared for citizens, as well as, impact the development and delivery of healthcare within the United States (US).

During the 18th century, the Moral Treatment Era and the Progressive Movement strived to improve the well-being of all individuals by promoting social justice (Anderson & Reed, 2017). The objectives in these early movements were to provide improved medical care for all individuals within their living environments. Before the development of the medical model in the 19th century, health care services were predominantly delivered within the community, in the patients' homes, and through public health services (Myers, 2010, pp. 3-4). The beginning of aging services, where community members supported the needs of the older adult, began in England in 1601 (Achenbaum & Carr, 2018). This custom of caring and supporting the older adults within their community continued during the colonization of America.

Throughout the 20th and 21st century, advances in medicine and technology influenced the mortality and longevity of individuals around the world. As these advances began health services shifted to the medical model of service delivery, which included the provision of healthcare services predominately within institutional settings. According to Shah and Mountain (2007), the medical model is "a scientific process involving observation, description, and

differentiation, which moves from recognizing and treating symptoms to identifying the disease and developing specific treatments" (p. 375). The medical model impacted healthcare services on various levels; an increase in health care costs, a decrease in the quality of medical care, and inequitable access to healthcare across all populations (Zinner & Loughlin, 2009). In 1965, the initiation of Medicare provided comprehensive services for individuals 65 and older, while Medicaid offered long-term care for individuals with a disability or of lower income (Longest, 2016).

In the early 21st century, healthcare delivery began to shift to integrated care and to emphasize the prevention of disease. Integrated care introduced a collaborative approach for an individual's healthcare services; for example, behavioral health became integrated with a person's primary care needs (Integrated Care, 2017). In 2010, President Obama signed the Affordable Care Act (ACA) providing equal opportunity for all individuals to have access to health coverage. The ACA promotes a return to medical services in communities to decrease economic burdens, to increase the quality of life among community-dwelling individuals, and to emphasize the promotion of health and wellness for prevention of disease (Longest, 2016).

Historical Overview of Occupational Therapy in Community Practice

The OT profession was established in 1917, with the humanistic view promoting wellness through the engagement of occupation (Reitz, 1992; Anderson & Reed, 2017). During this time community-based models originated as part of the professions scope of practice by providing services to patients with mental illness (Anderson & Reed, 2017). In 1942 the Rehabilitation Movement marked a shift in OT service delivery. As healthcare reimbursement was for biomechanical and more reductionist approaches, OTPs followed the trends in healthcare. OT leaders recognized the shift in healthcare and emphasized the importance of

remaining true to the profession's philosophical roots, emphasizing a holistic approach. In Wilma West's Eleanor Clarke Slagle lecture, she reminded OTPs to recognize and respond to the changes in healthcare that will impact the future of the OT profession (West, 1968). If the OT profession follows the words of its leaders and follows current trends and policies in healthcare, delivery to the community is inevitable.

Community-based OT practice is not a new concept for the OT profession. In the early 1900s, the profession's founders, George Barton, and Eleanor Clarke Slagle started the development of community-based OT practice (Anderson & Reed, 2017; Scaffa & Reitz, 2014). George Barton established the Consolation House in New York in 1914. This community program for convalescents, focused on engagement in occupations to enable productive living (Scaffa & Reitz, 2014). In 1915, Eleanor Clarke Slagle was hired to develop work programs for individuals with mental or physical disabilities at Hull House in Chicago. Those who participated, developed work skills to support independent living within the Hull House community (Anderson & Reid, 2017).

During a roundtable discussion at the American Occupational Therapy Association (AOTA) annual conference in 1940, the critical role of OT in community health was acknowledged. In the 1960s, OTP's, such as Mary Reilly, Wilma West, and Anne Mosey, understood the vision of AOTA and became advocates of change to the OT profession. They began describing the benefits of occupational engagement and its connection to improving health, wellness, and QOL of individuals living within their geographic communities. Through their continued research, Mary Reilly, Wilma West, and Anne Mosey cautioned OTPs to avoid only building its roots in the traditional medical model. Wilma West believed the OT profession could profoundly serve the needs of the community through the reintegration of social functions

(Scaffa & Reitz, 2014). In the early 1960s, Mary Reilly reasoned that individuals hold an intrinsic desire to master their environment. She determined, that individuals acquire the skills needed to succeed in life roles, through the interactions in their environments throughout their lifespan (Walker & Ludwig, 2004). Anne Mosey's (1985) Eleanor Slagle Lecture, addressed the OT profession by arguing they must begin to adopt a pluralistic perspective. She emphasized how the pluralistic perspective provides the OT profession the opportunity to grow and progress outside of traditional models of practice (Mosey, 1985).

As the OT profession began to advocate for their role in community-based OT practice, they found barriers that were limiting their ability to create a strong community presence. These barriers included practical constraints, historical factors, and gaps in knowledge and theory, which began to inhibit the continued growth and development of community-based OT practice (Scaffa & Reitz, 2014). Recently, these barriers have served as a conduit to enlighten the profession's focus on community-based OT practice. The Accreditation Council for Occupational Therapy Education (ACOTE) included an emphasis on health promotion and population-based services to the accreditation standards for academic programs, while AOTA released their 2017 Centennial vision that included growing community OT practice (AOTA, 2006). The OT profession continues to emphasize the need to develop the profession in community practice. In AOTA's *Vision 2025*, awareness of community-based OT practice remains an ongoing goal (AOTA, 2017). In summary, the concept of OT practice within the community has been alive from the conception of the profession to current times, but the presence of OT within community practice is seemingly scarce.

Aging in the Community

Community health and social services to assist the needs of the aging population in the USA dates back to 1642 with the Pilgrims at Plymouth Colony (Achenbaum & Carr, 2018). During this time, community members worked together to provide deprived elders with food and basic needs to support aging in place. In 1967 the first almshouse was built to collect supplies needed to support the aging population within the communities. Until the 20th century, it was expected that families would support their older relatives within their living environments while community assistance was considered on a case by case scenario (Achenbaum & Carr, 2018). After the Great Depression, it was apparent that as individuals age, working was not always going to be an option. It was thought that older adults would likely need assistance to live productive lives. The development of the Social Security Act in 1935, identified a need to support those who are no longer employed, such as the older population or those with a disability, by providing monetary assistance. The US Government mandated that all employers and employees contribute to Social Security, so individuals age 65 and older or those with a disability are provided with monetary support to assist with health and social needs for independent living (Achenbaum & Carr, 2018; Longest, 2016). The Older Americans Act (OAA) in 1965 provided older adults in the community with community-based services such as meals-on-wheels, transportation, legal services, elder abuse prevention, and caregiver support. More importantly in 1965 President Lyndon Johnson signed the Healthcare Reform enacting Medicare and Medicaid services, which are federal and state-funded health insurance programs for individuals 65 and older, individuals with a disability, and individuals with low income (Achenbaum & Carr; 2018, Longest, 2016).

In 1979, the U.S. Department of Health and Human Services published a public document, Healthy People. According to Cohen (2013), the goal of Healthy People is to provide national health goals and objectives that include interdisciplinary collaboration, to eliminate health disparities and propose initiatives in the prevention of disease and promotion of health across the US. Since its first publication, Healthy People has been updated several times, with its current release entitled Healthy People 2020. Healthy People 2020 seeks to achieve the promotion of QOL, improved health behaviors, the creation of social and physical environments that facilitate good health, achieve health equity, prevent chronic disease and disability, and decrease health disparities among those living within the US (Cohen, 2013). National health goals and objectives, such as those developed for Healthy People 2020, impacts healthcare policy and reimbursement. These national health goals and objectives support the need for optimal health and well-being of all community-dwelling older adults.

Healthcare reform and policies throughout the years have been developed to support the aging population within budgetary constraints. Between 1996 and 2013, healthcare costs in the US increased by $933.5 billion due to increased prices in healthcare service, increased population growth, increased aging population, and increased disease prevalence and incidence (Dieleman, Squires, Bui, et al., 2017). Healthcare expenditure is expected to continue to grow 5.5% annually between 2017 and 2026 (Cuclker et al., 2018). Providing health and social services within communities is a crucial component in helping community-dwelling older adults who want to age in their living environment. According to Horowitz et al. (2014), “in 2011, the youngest “Boomers” turned age 65; each subsequent year is adding to the number of older Americans” (p. 137). By 2040, it is estimated that the American population will include 14.1 million individuals 85 years old (Horowitz, Tagliarino, & Look, 2014). It is projected that by

2050, 20% of the US population will be age 65 and older (US Census Bureau, 2016). As the older population percentage increases, more demands on social services and healthcare services will be needed to adequately meet the medical needs of the aging population.

While elder health is an increasing concern, an assumption cannot be made that as individuals age, they will all require assistance due to illness or disability. According to Hwang (2010), "We are currently witnessing a paradigm shift in the nation's health care focus from treatment of disease to prevention of disease, as well as the promotion of healthy lifestyles" (p. 786). The fact remains that with advanced aged comes increased risk for chronic disease, disability, and the need for expanded various healthcare services (Horowitz et al., 2014).

Not all older adults want or will need services based in institutions such as Assisted Living Facilities (ALF) or Skilled Nursing Facilities (SNF). Aging in place and aging in the community are more desirable options for the aging population, as both promote health and wellness for the prevention of disease to increase independent living. Wagenfeld (2016) defined aging in place as "[l]iving in the same environment, typically one's home, as one ages" (p.502). Aging in place focuses on the living environment and accessibility to the older adult as they age. Aging in the community encompasses a broader perspective. Thomas (2016) defined aging in the community as, neighborhoods and networks that provide support to facilitate well-being and QOL for older adults to successfully age in their community. For older adults to lead productive and independent lives in the community, community programs are imperative to assist in keeping them healthy, active, and safe (Scaffa & Reitz, 2014). Community-dwelling older adults would significantly benefit from effective community-based services to support their physical, cognitive, and psychosocial needs (Dabelko-Schoeny & King, 2010).

Occupational Justice Theory

The occupational justice theory evolved from social justice theory, which emphasizes the importance of equal rights for individuals, groups, and populations, so that their basic needs are met (Nilsson & Townsend, 2014). Social justice accentuates the importance of equal opportunity across race, gender, class, income, ability, or disability to abolish inexcusable inequalities. Occupational justice and occupational rights "like social justice and human rights, in general, are concerned with ethical, moral, and civic issues such as equity and fairness for both individuals and collectives but specific to engagement in diverse and meaningful occupation" (Wilcock & Townsend, 2014, p. 542-543).

The beliefs and assumptions of occupational justice are founded under the connections between health, occupation, and equality. According to Durocher, Gibson, and Rappolt (2014) "all individuals are occupational beings, and value is placed on occupations based on an individual's cultural and socio-political determinants" (p.420). Occupations are meaningful and purposeful tasks or activities that individuals choose to, need to, and can participate in that improves overall QOL. Occupational choice supports occupational engagement by allowing individuals to identify the meaningful activities in which they wish to participate. Therefore, occupational participation is a determinant of health, wellness, and QOL (Nilsson & Townsend, 2014).

An injustice occurs when external restrictions in occupational participation occur. Without access to equitable health-related services in the community to support the older adult's occupational, health, and social needs as they age, an occupational injustice is occurring. According to Horwitz et al., (2014) there is an increased demand on society to provide adequate support for the healthcare and social needs of the aging population as they choose to remain

living within the community. Older adults have the right to remain independent in daily life activities while aging in the community. Without adequate support for occupational engagement, older adults are at increased risk of disease and disability, decline in functional abilities, social isolation, and poor health, wellness, and QOL.

Statement of the Problem

Community-based OT practice is an emerging area of practice that is easily implemented in the practice areas of disability and participation, mental health, health and wellness, children and youth, productive aging, work and industry, management, and education. OTPs have the skills and knowledge to address the occupational needs of community-dwelling older adults, which can help in resolving social and health inequities while improving QOL (Pizzi & Richards, 2017). Although OTPs recognize community-based OT practice as an effective way to address the older adult's occupational needs outside of the traditional, i.e., institutional practice settings, very few OT community programs for the older adult exist. According to AOTA (2015), only 2% of OTPs are working in community settings. As healthcare delivery shifts towards the promotion of health and wellness with a focus on prevention of disease, OTPs have the opportunity to re-emerge and to re-define their role in community practice among community-dwelling older adults.

The current problem addressed by this project is that while the trends in healthcare delivery are shifting towards community-based practice, with only 2% of the OT workforce engaged in community practice, there are not enough OTP's working in this practice area to fill the need. Community-based OT can provide a valuable service to the older adult population, focusing on improving health, wellness, and QOL for the prevention of disease. With healthcare costs rising and changes in healthcare policy emphasizing health and well-being, community-

based OT practice offers a broad range of services to meet the needs of community-dwelling older adults. Without enough OTP's working in community-based OT practice, community-dwelling older adults will not have their occupational needs met leading to an occupational injustice.

Purpose of the Study

The purpose of this capstone project is to explore the socio-political environment of current and potential community-based OT services among community-dwelling older adults and to explore the current state of community-based OT practice, as well as the current awareness of OT's potential impact on health and wellness. Through the utilization of the Delphi Method, structured communication between subject matter experts (SMEs) in the field of OT practice, will aim to:

1. Explore indicators that inhibit the presence of OT in community-based practice for the older adult.
2. Identify OT as a potential service within the community to improve health, wellness, and QOL for the prevention of disease among older adults.
3. Forecast how increased presence of OT in community settings can decrease occupational injustice among the older adult population.

Survey Methods

Qualitative surveys are a research methodology used to understand a population's in-depth thought and reasoning about a research topic and hypothesis. When using qualitative methods, such as a survey, the researcher seeks to understand the human perspective of an issue (Pathak, Jena, & Kalra, 2013). Qualitative methods strengthen research by increasing the involvement of the research participants by allowing them to provide their thoughts, beliefs, and

opinions to research topics. Some advantages of survey methods include 1. open-ended process, 2. ease of design, 3. data can be generalized, 4. direction of the research can be revised quickly, and 5. flexible structure (Rahman, 2016). Along with advantages comes disadvantages of using survey methods, which includes, 1. software for developing quality survey questions are not always easy to navigate, 2. low response rates, 3. not interviewing participants can impact the clarity of responses, 4. quantity of data can be time-consuming, and 5. personal bias of the researcher could affect data (Safdar, Abbo, Knobloch, & Seo, 2016)

This capstone project will use a specialized survey method to gather OTPs thoughts and opinions on community-based OT among the older population. The Delphi method facilitates communication through surveys to anonymously seek experts' opinions on topics to formulate a consensus or forecast predictors for future practice (Hasson, Keeney, & Mckenna, 2011). According to Hsu and Sanford (2007), various objectives can be achieved in research when utilizing the Delphi method:

1. To determine or develop a range of possible program alternatives;
2. To explore or expose underlying assumptions or information leading to different judgments;
3. To seek out information which may generate a consensus on the part of the respondent group;
4. To correlate informed views on a topic spanning a wide range of disciplines, and;
5. To educate the respondent group as to the diverse and interrelated aspects of the issue (p. 1).

As part of the Delphi Method process, multiple rounds of questions are used to accumulate responses that are then summarized and given back to the experts until a final consensus is achieved. According to Keeney, Hasson, and McKenna (2011) the development of open-ended questions should target the research objectives should not be ambiguous and should relate to the panelist's area of expertise. Reliable questions are those that are short in length, use simple vocabulary, and are not leading or considered to be hypothetical (Keeney et al., 2011).

For this capstone project, the first round of questions is qualitative to generate ideas and facilitate expert's freedom to express their opinions, thoughts, and beliefs regarding community-based OT practice among the older adult population (Hsu & Sanford 2007; Hasson et al., 2011). Responses to round one questions will be used to formulate questions for round two. Second and subsequent rounds of questions provide possible statements for agreeance and Likert scales with a comment box so that each expert has the opportunity to revise or add to their previous responses. Controlled feedback by the researcher is supplied to the experts after data analysis of each round of questions. The number of rounds will vary depending on the depth of the issue or topic being researched. Three rounds of data are the norm when processing data to formulate a consensus (Hsu & Sanford 2007, Skulmoski, Hartman, & Krahn, 2007; Hasson et al., 2011).

Characteristics of the Delphi Method

According to Linestrone and Turoff (1975), the evolution of the Delphi Method began in the early 1950s with the conception of Project Delphi by Norman Dalkey of the RAND Corporation. This project was conceived between the United States (US) Military and the RAND Corporation to obtain expert opinion on the future of technology in warfare. Through a series of questionnaires, the researchers of Project Delphi gathered expert opinion with controlled feedback to provide consensus on future technological capabilities within the US

Military (Linestrone & Turoff, 1975). The Delphi Method was initially developed to increase accuracy in forecasting future scenarios or developments.

The Delphi method has matured as both a quantitative and qualitative research method that supports consensus building through the following characteristics: 1. The anonymity of participants, 2. Collection and structure of initial data, 3. Cyclical feedback until a consensus is obtained, and 4. Statistical analysis techniques (Dalkey, 1967; Woudenberg, 1991; Skulmoski et al., 2007; Hsu & Stanford, 2007).

In uncertain situations, human judgment is heavily relied upon to reach a consensus (Hohmann, Brand, Rossi, & Lubowitz, 2018). The Delphi Method is a practical research method to achieve agreement among a group of experts on an issue where no agreement previously existed. SMEs with advanced knowledge and practice in their fields of expertise utilize their judgment to develop a common consensus among professional colleagues. When conducting research using the Delphi Method, the researcher guides communication among multiple SMEs by using questionnaires and feedback. Most studies employ three rounds of data collection on a known topic with the second round allowing the SMEs to provide feedback to their answers and the other SME's answers. Final consensus provides forecasting to improve practice or identify areas for further research (Iqbal & Pipon-Young, 2009).

Selection and anonymity of participants

When selecting the SMEs/panelists, clear inclusion criteria is a priority. The inclusion criteria include documented evidence that the SMEs are experts within the research focus. When choosing the expert panel, the researcher takes into consideration the research topic, how much time is allowed for completion of the research, and the available resources. The recommended number of panelists is between 10 and 100 experts (Iqbal & Pipon-Young, 2009; Keeney et al.,

2011). Identification of the expert panelists is the first and most crucial step to the Delphi Method. The researcher is unable to complete research without first identifying proper SMEs that fit the research purpose.

Response rate and attrition of the participants is a factor to consider when using the Delphi Method. According to Keeney et al., (2011), although there are no specific guidelines for response rate and attrition, the literature identifies an 8% to 100% response rate from panelists during rounds of questioning. Since this rate varies, the goal is to have a 70% response rate from the panelists throughout each round of questioning (Keeney et al., 2011). Due to the Delphi Method having cyclical feedback, it is common to lose experts. It is essential for the researcher to limit attrition by providing the panelists with enough time to answer questions, as well as ensuring that all question are clear and concise (Keeney et al., 2011; Hsu & Sanford 2007; Skulmoski, Hartman, & Krahn, 2007; Hasson et al., 2000).

If experts come together face-to-face, a common drawback often occurs when one expert tends to dominate the conversation, causing ideas to be lost. The Delphi Method preserves the anonymity of participants to allow SMEs the freedom to express their thoughts and opinions (Brady, 2015, Hohmann et al., 2018). Confidentiality of the SME's views is maintained by participant geographical location and through the means of electronic communication (Hsu & Sandford, 2007).

Collection and structure of initial data. A structured process is utilized to collect research data centered around gathering expert knowledge through rounds of questioning. The initiation of data collection begins in round one. During round one, the researcher develops a questionnaire utilizing open-ended questions to invite the panelists opportunities for brainstorming their opinions on salient issues (Iqbal & Pipon-Young, 2009). Generally, the

panelists are asked to spend about 30 minutes answering the initial questionnaire. The first round of questions initiates the cyclical feedback. Iteration of data provides the SMEs opportunity to refine their views and thoughts through multiple rounds of questioning (Skulmoski et al., 2007).

Cyclical feedback. The researcher controls the interaction between panelists. Controlled feedback is provided to all the participants after the researcher has filtered out irrelevant information (Skulmoski et al., 2007; Iqbal & Pipon-Young, 2009). At least three rounds of communication between the SMEs are recommended to develop an accurate consensus. Content analysis including coding, categorizing, and conceptualizing the responses of round one questions will assist with the generation of round two questions (Keeney et al., 2011; Hsu & Sanford 2007; Skulmoski et al., 2007; Hasson et al., 2000). It may take longer to develop round two questions as the researcher has to analyze the reactions from round one typically utilizing qualitative methods. Round two questions provide an opportunity for the panelists to give feedback to the responses from round one (Brady, 2015). The questions in round two are typically in a ranked or rated format with a comment component to allow the experts to share any changes, missing or new thoughts to an issue where there is no agreement. The third round of questions is developed through an analysis of the answers to questions in round two. During round three, the researcher is analyzing responses to establish a final consensus on the salient issue. If there is no consensus, then additional rounds of questions should continue to collect further data (Brady, 2015).

Data analysis. According to Brady (2015), when using the Delphi Method for research, data analysis is conducted iteratively as the research questionnaires are completed and collected. The Delphi method yields both qualitative and quantitative data to improve the reliability of the

research results. Continuous verification of data is achieved through ranking and rating panelists responses and qualitative coding (Skulmoski et al., 2007; Holmes & Scaffa, 2009). During round two and three, the questions are more focused and can be presented using quantitative format. The panelists may be asked to rank themes utilizing a weighted value to provide standard deviations, mediums, and means. At the end of round three, both qualitative and quantitative data allows for the generalization of consensus (Skulmoski et al., 2007; Holmes & Scaffa, 2009; Brady, 2015).

After round three the results of the research can be presented in various ways. The researcher can decide how much of the data to report, therefore reported data can include only items that have reached a consensus or itemizing topics from the highest level of agreement to the lowest level of agreement (Iqbal & Pipon-Young, 2009). Dissemination of the findings can be reported in a consensus report, journal article, or presentation.

According to Safdar et al., (2016) surveys are often used to initiate randomized controlled trials. Surveys are a vital step in collecting data on human perception to guide the development of future applicable interventions or studies. For this capstone project, the Delphi Method will assist in gathering expert OTPs thoughts, beliefs, and perceptions to forecast future implications for increasing the presence of OTPs in community practice among older adults.

Chapter 2 Literature Review

As individuals living in the community age, they are eager to learn how to improve their health and wellness to prevent disease and improve QOL. Older adults value their independence and prefer to live in their homes versus institutions (Stepler, 2016). An extensive literature search was completed using the following search terms; community health, health policy, and reimbursement for community practice, community-based occupational therapy, aging in place, aging in the community, occupational therapy and the aging population, Delphi Method, and Occupational Justice theory. The literature search was completed using *CINAHL* and *EBSCO* databases to search peer-reviewed academic research journal articles. Since the planned impact of this research is on the US OT populations, foreign literature was excluded.

The following literature review consists of an analysis of current research supporting OT in community practice as well as examining concerns relevant to community-based OT practice, which includes: current community health practices, healthcare policy and reimbursement, and the current shortage of community-based OT practitioners. Current literature supports the provision of community-based OT across multiple populations and areas of practice. The occupational justice theory anchors the identification of strategies to increase the ability of OT's to practice with older adults in the community. The older adult population has the same right as any other person to improve their QOL through access to OT services; however, due to the current healthcare environment, many of their needs are not being met. The literature review concludes with a summation of evidence-based articles to support the use of the Delphi Method as a valid research tool.

Community Health Overview

Public health is described as the science of preventing disease and optimizing the health status of communities and populations. Mayes and Oliver (2012) defined the impact public health has on community health by examining structural disadvantages faced by those who advocate for public health policies. The researchers have reported that over the last century public health initiatives have increased adult and child life expectancy, decreased child mortality, changed public sanitation, improved nutrition, and developed effective vaccinations and antibiotics. While these recent public initiatives have improved community health, challenges continue to emerge relating to chronic diseases such as cardiovascular disease, cancer, diabetes, asthma, and depression (Mayes & Oliver, 2012). Current public health initiatives continue to implement preventive and health promotion measures at the community level to improve overall health and wellness and reduce chronic disease among community-dwelling individuals. Due to the ever-changing nature of public health, community health has emerged as a field that reflects the diversity and values of communities in their efforts to attain an improved QOL (Goodman, Bunnell, & Posner, 2014).

Public health initiatives have an impact on community health interventions, while also serving to guide intervention strategies for improving the overall health and well-being of community dwelling older adults. According to Scaffa and Reitz (2014), community health interventions combine social, environmental, and educational efforts to facilitate changes in the health and health behaviors of individuals. Community health interventions strive to reduce chronic disease and increase health promotion among older adults residing in the community. To accomplish this goal, community health interventions focus on providing equal access to healthcare services to promote healthy living, prevention of disease, and decrease health gaps

between race, ethnicity, location, social status, and income (CDC, 2015). Community health initiatives seek to improve the health and well-being of communities so that persons living in the community may experience improved QOL that allows them to participate in daily life activities.

When working with and within a community health care practitioners must outline and understand the local economic, social, and political circumstances in order to address health, social, and racial inequities. Wiggens (2011) used a systematic review of peer-reviewed literature to explored how to decrease health inequities and increase health knowledge and empowerment within communities. The researcher identified the most effective way to promote health and well-being within communities, is to create economic, social, and political circumstances that support healthcare practitioners in addressing the community's health and social injustices (Wiggins, 2011). Community empowerment is created when healthcare practitioners provide communities with equal healthcare opportunities that enhance health, wellness, and QOL. According to Vatcharavongvan, Hepworth, and Marley (2013), community empowerment improves overall community health. Utilizing a parallel track model, the researchers reviewed literature which concluded that despite the advances in technology and the overall improvements in the healthcare services, health inequities continue to occur within communities (Vatcharavongvan et al., 2013).

This review of the community health literature emphasizes common themes that impact the overall efforts of improving community health. Health inequities are intrinsically linked to the need for community health promotion. Long-term community empowerment is an effective way to reduce health inequity for community health promotion (Wiggins, 2011; Vatcharavongvan et al., 2013). OTPs can establish and implement community-based OT programs that promote engagement in occupation, which will improve the health and wellness of

older adults living in the community. There is a significant role for OT within community practice, to provide intervention that can assist in decreasing health disparities and social inequities. However, for OTPs to increase their presence in community-based practice, they must understand how policy and funding impacts community health, public health initiatives, and funding for services.

Healthcare Policy and Reimbursement for Community Practice

It is essential for OTPs to understand their roles and contributions to healthcare policy and reimbursement, as both are in a continual state of change (Lemorie & Paul, 2001). To meet the national health initiatives of decreasing health inequities, the Affordable Care Act (ACA) was implemented. The ACA increased access to affordable health insurance and provided those who already have health insurance with an affordable payment. During the implementation of the ACA, the delivery of healthcare services also shifted from the treatment of illness to emphasizing healthcare policies addressing the prevention of disease and promotion of health. By focusing on health promotion and prevention of disease, the ACA could provide greater equality to all populations related to healthcare cost, access, quality, and efficiency (Fisher & Friesema, 2013).

The ACA has impacted Medicaid funding by expanding Medicaid programs in the hopes of decreasing economic burdens and increasing primary care and preventive services. Changes to reimbursement and policy significantly influence the resources that allow for quality community practices to improve health initiatives in communities and for the aging population (Longest, 2016). Preventive care is an essential component of community practice with older adults. As individuals age, aging in the community is supported through the provision of education on prevention of disease.

As healthcare policy impacts healthcare reimbursement, healthcare professionals must begin changing their perspectives on how they deliver healthcare services to the older adult population. Community health interventions will not take away from the importance of individualized or emergency care. However, individualized and emergency care are not the only models of healthcare delivery that can improve the health and well-being of community-dwelling older adults (Gofin, Gofin, & Stimpson, 2015). According to Leppin et al. (2018), primary health care and community-based health programs are two separate systems that must find ways to support each other's approaches to improve healthcare delivery. With these two systems leading healthcare initiatives, healthcare policy, and healthcare reimbursement, OTPs have the skill set and opportunity to develop community programs that facilitate health promotion for the prevention of disease and disability for older adults living in the community (AOTA, 2014).

Understanding reimbursement for medical services is an essential skill for the OTP when developing community programs, an emerging practice area. Payment for medical services is currently dependent upon medical necessity and client outcomes. The ACA and other medical reimbursement policies focus on client measures to mandate care in post-acute settings (Mroz, Pitonyak, Fogelberg, & Leland, 2015). To impact reimbursement in community settings, OTPs must advocate for reimbursement policies that enhance outcomes of the older adult population within the community (Stover, 2016). OT services utilize cost-effective interventions to increase an individual's skills, so that they may live an abundant, healthy life. With policy and reimbursement, and support from ACA and Healthy People 2020, there is an opportunity for OTPs to build client-centered community-based OT programs for community-dwelling older adults with outcomes that improve, enhance, and promote occupational engagement (Arbesman, Lieberman, & Metzler, 2014). OTPs can provide older adults within the community with

interventions that focus on increasing independence in daily life, improved mental health, improved life satisfaction, and improved social functions, all leading to healthcare savings (Clark et al., 2012)

Community-based Occupational Therapy

Given the trend towards increased community health practice, OTP's should consider a shift from current traditional practice settings into community-based OT practice. OT community programs provide primary and preventive care as part of the continuum of care for older adults discharged from an inpatient setting into the community. Community-based OT practice facilitates OT interventions that are holistic and comprehensive as compared to inpatient acute or rehabilitative settings where the medical model and simulation of occupation is often practiced (Devereaux, 1991). An exploratory, descriptive study conducted by Ramsey (2011), found OTPs in community practice assume multiple professional roles including clinician, case manager, consultant, and educator. Through a survey and focus group methods, the researcher was able to analyze the experience of community OTPs and conclude that there is a need for increased educational and professional support for OTPs to expand their presence and service delivery in the community setting (Ramsey, 2011). OTP's require the development of advanced skills when entering into community-based practice to align with current healthcare trends.

Over the years, healthcare reform and policy has provided both challenges and opportunities for the OT profession. As healthcare changes, the OT profession has examined its philosophy of service to comply with current and future healthcare policy and reimbursement modifications. The American Occupational Therapy Association's centennial vision identified emerging practice areas as a growing area of practice to meet the needs of communities and individuals (AOTA, 2006). In a pilot study conducted by Holmes & Scaffa (2009a), 174 OTPs

were surveyed to collect data relating to their perspective on the profession's impact on community practice. The researchers concluded that community OT offers an opportunity to provide services that are holistic, occupation-based, and consistent with the philosophical roots and values of the profession (Holmes & Scaffa, 2009a). The OT profession and current practicing OTP's emphasize the potential for OT to develop community programs that maximize occupational performance among community-dwelling older adults.

According to the Occupational Therapy Practice Framework 3rd edition (OTPF), "Achieving health, well-being, and participation in life through engagement in occupation is the overarching statement that describes the domain and process of occupational therapy in its fullest sense" (AOTA, 2014, p. S4). The implementation and design of health promotion and prevention of disease is openly supported by the philosophical foundations of the OT profession. The OTPF describes occupational therapy approaches to intervention, which include creating occupation-centered intervention with outcomes for promoting health as well as the prevention of disease and disability. With healthcare reform and initiatives such as Healthy People 2020 and the ACA challenging the nation to increase community practice, the OTPs have the philosophical and practical experience to build and support OT within communities.

OTPs practicing in the community possess distinctive competencies to successfully implement and maintain community-based OT programs. Through a systematic review of the literature, Winstead (2016) identified specific unique competencies that 130 community-based OTPs possessed leading to success in community practices. Among these competencies were specialized knowledge of health promotion, business and leadership skills, ability to write grants, understanding of program development, and various forms of clinical reasoning (Winstead, 2016). OTPs working within community settings possess specific competencies that assist them

in developing and sustaining active community OT programs. These competencies are not always present when an OTP enters into practice. Due to the lack of these competencies, OTPs are less likely to seek employment within community-based OT practice. In an exploratory study utilizing the Delphi method, Holmes & Scaffa (2009) identified 104 essential competencies for OTPs to succeed in community-based settings. Through questioning of expert panelists, the researchers concluded there is a need for further research that identifies adequate educational preparation and professional development to improve the OTPs competencies for success in community-based OT practice (Holmes & Scaffa, 2009). In conclusion, with ongoing changes in healthcare and the unique skills OTPs hold, there is potential to increase the presence of community-based OT services. However, additional education or practice beyond entry-level may be needed.

OTP's Working in Community Practice

Community-based OT practice includes health promoting and health-related services that are provided within the community. These community settings include but are not limited to schools, adult day centers, homeless shelters, community centers, habilitation centers, home health services, and outpatient clinics. According to Scaffa and Reitz (2014), OTPs who utilize vision and creativity have the potential to develop community-based OT programs. These programs can impact the promotion of health and wellness, acute and chronic medical care, habilitation services, and rehabilitation services through direct and indirect intervention.

Despite possessing unique, specialized skills, most OTPs who provide direct client interventions do not identify themselves as community practicing OTPs. AOTA's (2015) workforce survey reported 15.8% of OTPs are working in community-based settings. Within that 15.8%, only 2% were identified as working in community settings that were considered

emerging areas of practice (AOTA, 2015). Emerging practice areas are defined as, "multifaceted concept [that] encompasses diverse professional roles, a variety of contexts for the provision of services, as well as the development of innovative business models" (Holmes & Scaffa, p. 81, 2009a). Community-based OT practice includes innovative programs that either build off traditional practice settings or are provided in non-traditional practice settings where an OTP may not be employed. Examples of emerging practice areas include aging in place, driver assessment, community health and wellness, needs of children and youth, ergonomics consulting, assistive-device development, and consulting (Wagenfeld, 2016).

The concept of community-based OT practice continues to be an essential part of OT scope of practice. However, research evidence does not address why the presence of OT is lacking in the community. Practice patterns are not silent, and the literature supports the need for increased scholarly evidence that will increase community-based OT opportunities. OTP's across various practice areas have developed innovative ideas and explored the effectiveness of their views in practice. These ideas include, but are not limited to, community programs to increase psychosocial well-being of individuals with mental health diagnosis, community reintegration for both individuals with physical disabilities and mental health diagnosis, improving environmental accessibility for those with disability, community driving programs, increasing participation in occupation and social participation among older adults, and educational programs for increased awareness of health, and wellness and prevention of disease among older adults (Wagenfeld, 2016).

OTPs have been providing services for individuals with mental health conditions since the profession's commencement. These services are delivered in either an inpatient setting or community-based setting. OT intervention for individuals with mental illness includes

community reintegration, activities of daily living (ADL) training, social participation training, work education, and instrumental activities of daily living (IADL) training. Evidence-based programs and OT interventions have identified the effectiveness of community-based OT practice within the mental health practice area.

A quantitative analysis of OT interventions was completed by Lipskaya-Velikovsky, Bar, and Bart (2014) that compared the influence of context on OT interventions among individuals with mental health conditions. The researchers utilized the Documentation of Occupational Therapy Session during Intervention (DOTSI) to collect data from 18 OTPs who practiced in a mental health setting. The primary objective of this study was to quantify the characteristics of OT intervention and how context impacts intervention. Analysis of data revealed OT intervention in the community emphasized real-life context, education, and work when compared to interventions in inpatient settings that emphasized leisure activities. Therefore, OT interventions in the community setting for individuals with mental illness support community reintegration and the rebuilding of meaningful lives (Lipskaya-Velikovsky et al., 2014). Community-based OT practice provides an environment that is empowering to individuals living in the community with a mental health condition through therapeutic strategies that emphasize real-life context, education, work, and social participation.

Community reintegration is an essential intervention technique utilized by OTPs working within traditional mental health practice settings. Community-based OT programs can provide community reintegration interventions that can also support the rebuilding of meaningful lives among community-dwelling individuals. OTP's working in community settings can provide opportunities for individuals with mental health conditions to engage in social participation while practicing newly learned skills that promote occupational engagement. According to Hultqvist,

Eklund, and Leufstadius (2015), community day centers play a vital role in offering meaningful daily activities, opportunities for social interactions, and inclusion while creating a structured environment for individuals with mental health conditions. A cross-sectional study of 123 Swedish day centers investigated the perception of empowerment among attendees with mental illness (Hultqvist et al., 2015). This longitudinal study was completed between 2009 and 2012. During this time, participants in the study completed an empowerment questionnaire to understand the day centers' attendees perceived level of empowerment, occupational engagement, and client satisfaction. The participant's health-related and socio-demographic factors were considered during data collection. Data analysis revealed a significant correlation between occupational engagement and client satisfaction when there was an emphasis on occupational engagement. Researchers concluded, individuals with mental illness who attend a community day center have the potential to become active members of their community through empowerment and occupational engagement (Hultqvist et al., 2015).

Community-based OT practice provides individuals with mental illness the opportunity to become productive citizens within the community through empowerment and community re-integration. Community-based OT programs that emphasize the promotion of health and wellness will support the reduced stigma among individuals living in the community with mental health conditions. By increasing self-empowerment among individuals with mental illness, there is hope that social injustice and health inequities can be diminished.

According to the ADA National Network (2018), a person who has a physical or mental impairment that limits one or more of major life activities is considered to have a disability. The role of OTPs when working with individuals in the community who are impacted by disease, injury, or disability is to promote independence in daily activities within their living

environment. Community OT programs focus on interventions that explore the effectiveness of community-based OT practice within rehabilitation and disability practice areas.

Community-based rehabilitation (CBR) improves the physical and mental abilities of an individual with a disability. According to Pollard and Sakellariou, (2008), individuals with disabilities who encounter improvement in their physical and mental abilities will more willingly contribute and participate within their community. The success of CBR is dependent upon the combined efforts of the individual with a disability, the families, organizations, communities, and governmental and non-governmental health, education, and vocational services (Pollard & Sakellariou, 2008). CBR is complicated, but if utilized correctly, it can enhance community participation for individuals with disabilities and decrease health disparities.

Individuals living in the community with disabilities and chronic disease can improve their quality of life and participation in daily activities through interventions that promote self-efficacy and self-management of disease symptoms. Garvey, Connolly, Boland, and Smith (2015) conducted a randomized control trial to examine the feasibility of a six-week occupation-based self-management program called OPTIMAL for individuals with chronic diseases. The researchers of this study identified the substantial impact that community OT programs have on improving quality of life, self-efficacy, and occupational performance among individuals with health-related disabilities residing in the community (Garvey et al., 2015). Although only a six-week program, the OPTIMAL program emphasized the impact community-based OT can have on improving quality of life among individuals living in the community with chronic disease. Community-based OT practice provides individuals with chronic conditions the opportunity to learn about disease management as well as receive education on healthcare access.

At some point, individuals with physical disabilities or diagnosed with chronic disease who first receive OT within traditional practice settings will undergo discharge planning to the community. Many individuals who have an impairment or chronic illness want to continue being productive contributors within their community. The current literature illustrates the need for community-based OT interventions among individuals living in the community with a mental illness, disability, or chronic disease to provide improvements in health, wellness, and quality of life.

Community-based OT and Productive Aging.

OTPs providing interventions to older adults strive to provide interventions that focus on independence and safety in ADLs. Intervention strategies include the promotion of health and wellness, therapeutic techniques to improve performance skills, and compensatory techniques to provide adaptations within the everyday environment (AOTA, 2014). Community-based OT intervention with older adults reduces falls, increases the QOL, increases social participation, and increases improvement in participation in ADLs and IADLs (Scaffa & Reitz, 2014). In the following section, several evidence-based programs and OT interventions explore the effectiveness of community-based OT practice in productive aging.

Evidence identifies the need for more community-based OT programs that support the health, wellness, and QOL among older adults who are aging in the community. As one ages physical, cognitive, and psychosocial well-being will gradually decline. These expected anatomical and physiological changes should not dictate where and how older adults embrace aging. De Coninck, Bekkering, Bouckaert, Declercq, Graff, and Aertgeerts, (2017) completed a systematic review and meta-analysis randomized controlled trials to identify the effectiveness of OT intervention for the frail elder population who reside in the community. It was concluded

that community OT interventions improved quality of life, participation in ADLs, and increased empowerment among older adults living in the community (De Coninck et al., 2017). The establishment of OT services in the community provide psychosocial, cognitive, and physical interventions that improve QOL while engaging in daily occupations. Community-based OT practice has an essential role in supporting healthy and productive aging.

Healthy aging remains a significant factor for older adults with the goal of staying productive within their communities. According to Papageorgiou, Marquis, Dare, and Batten (2015), participation in community-based OT services may prevent or reduce social isolation in community-dwelling older adults. The researchers conducted a literature review of 14 studies that included one randomized controlled trial, one pre-post measure, three cross-sectional, one ethnographic study, four qualitative exploratory studies, and four mixed methods studies. The researchers analyzed the data and concluded that community-based OT programs are an essential component in supporting healthy aging by promoting occupational engagement and decreasing social isolation (Papageorgiou et al., 2015). By reducing social isolation older adults are given the opportunity to improve their quality of life through participation in occupation.

OTP's can assist in healthy aging by providing older adults who live in the community with practical tools to support aging in the community. Community-based OT practice promotes healthy aging, which in return will reduce healthcare costs and decrease the chances of older adults living within institutions (Hart & Parsons, 2018). Lifestyle intervention is a cost-effective OT intervention that focuses on improving the well-being of community-dwelling older adults. According to Clark et al., (2012) community-dwelling older adults who participated in OT lifestyle intervention were more likely to reduce their decline in health by promoting healthy well-being. The researchers completed a randomized controlled trial for six months. Treatment

reflected the Well Elderly study to increase healthy lifestyle and personal meaning in everyday activities. Compared to the untreated cohorts, participants in the treatment group demonstrated changes in bodily pain, vitality, social functioning, mental health, life satisfaction and symptoms of depression (Clark et al., 2012). The study concluded that older adults who participated in Lifestyle intervention demonstrate increased physical and mental well-being. It is evident that community-based OT practice is a cost-effective approach for the prevention of disease and promotion of health and wellness.

As individuals with disabilities age in the community, their healthcare needs will likely increase. OTPs can provide these individuals with interventions that support their healthcare needs. OT is effective in improving an individual's functional capacities by eliminating environmental barriers through home modifications. Stark, Keglovits, Arbesman, and Lieberman (2017) performed a systematic review of 36 research articles that emphasized the importance of OT home modifications for community-living adults and older adults with disabilities. Home modifications improved the function of older adults with varying health conditions, decreased their risk of falls, and increased ease of caregiving for individuals with dementia. Home modification interventions included the occupational therapist assessing the person's abilities, home environment, occupational goals, development of an intervention plan to remediate barriers, and training for caregivers. The researchers concluded OTPs are trained to effectively deliver and implement home modifications that improve accessibility when compared to other healthcare professionals (Stark et al., 2017). Individuals living in the community with a disability deserve the same accessibility to community resources as those who do not have a disability.

There will be an increase in the need for OT services to meet the increasing aging population's health care needs. Factors such as biological changes, environmental changes, and available resources can impact the independence of older adults. Engagement in meaningful occupations promotes health and wellness, satisfaction in life, and longevity among the aging population (Wagenfeld, 2016). As socio-political changes occur that impact available resources for older adults, OTPs have the opportunity to develop community-based OT programs to support the needs of the aging population. The lack of community resources providing access to healthcare services that promote health, wellness, and prevention of disease in the community for older adults creates a social and occupational injustice.

Occupational Justice Theory

It is unfortunate that OTPs witness occupational injustice throughout all areas of OT practice but even more so in community-based OT practice among older adults. An occupational injustice occurs when the occupational rights of individuals, groups, or populations are limited or taken away (Nilsson & Townsend, 2014). As the older adult population increases, there are not enough community programs to promote health and wellness for productive daily living. The older adult population is being deprived of adequate healthcare and social services to meet their everyday needs so that they can remain healthy and independent in their living environment. Without proper services, older adults will be forced to move into living environments that are not conducive to their personal desires or occupational needs.

An injustice is occurring as a result of the limited amount of community-based OT programs available to meet the occupational needs of community-dwelling older adults. Due to this occupational injustice older adults living in the community who require OT services and are not receiving them are experiencing an occupational imbalance, alienation, marginalization, and

deprivation (Durocher, Gibson, & Rappolt, 2014). Through community-based OT practice, OTPs can empower older adults to engage in occupations to alleviate the sense of feeling powerless and increase their overall health, wellness, and QOL. Individual's life circumstances and occupational needs are all different and should be honored. It is important for OTPs to encourage and enable older adults to participate in meaningful occupations that contribute to their well-being and the well-being of their communities (Nilsson & Townsend, 2014).

Older adults have the right to equal healthcare opportunities that provide them with services to increase their overall health and wellness. Community-based OT practice is a healthcare service that facilitates independence in daily life activities. Although research supports the positive effects of community-based OT practice on improving health, wellness, and QOL, there are still limited programs and few OTP's practicing in the community with older adults. Without community-based OT practice, older adults within the community are being deprived of the opportunity to improve occupational engagement and participate in OT interventions that will enhance their overall health, wellness, and QOL. The literature review revealed few studies related to occupational justice theory and older adults, indicating a gap in research.

The Delphi Method

The Delphi Method facilitates structured communication between SME's to gather knowledge for formulating a consensus on a topic that does not have a conclusion (Holmes & Scaffa, 2009). A separate literature review was completed on the Delphi Method using peer-reviewed journal articles in *CINAHL* and *EBSCO* databases. Search terms that were used included, the Delphi Method, the Delphi Method, and qualitative research, and OT and the

Delphi Method. The purpose of the literature review of the Delphi Method was to document its reliability in qualitative research.

History of The Delphi Method

The Delphi Method has been used for forecasting and estimating unknown parameters, policy development, and decision making (Woudenbert, 1991; Skulmoski, Hartman, & Krahn, 2007; Hsu & Stanford, 2007).

During its initial development, the Delphi Method was mainly quantitative, and researchers used the Delphi Method in the 1950s-1960s for forecasting dates and estimating unknown parameters (Woudenbert, 1991). By the 1970s, the Delphi Method had been called a "communication device" due to researchers reporting qualitative results from the group communication process of their participants (Woudenbert, 1991, p. 132).

Literature Review of Research Conducted Using The Delphi Method

According to Hsu and Stanford (2007), various professions across many contexts have utilized the Delphi Method to develop a better understanding of problems, opportunities, or solutions on crucial decisions and topics. The researchers noted that multiple fields of study had used the Delphi method for program study, needs assessment, policy determination, and resource utilization. According to Brady (2015), the use of the Delphi Method in public policy has provided a better understanding of policy design and implementation. To better understand educational systems in California, the Delphi Method was used by researchers to identify trends that impact educational access and the quality of public education (Brady, 2015). Fletcher and Childon (2014) completed a participatory research study using the Delphi Method to identify consensus on the future implication for promoting community participation in the development of healthcare delivery. Brady (2015) noted in the field of Information Technology (IT), the

Delphi Method has provided increased efficiency and effectiveness within infrastructure and communication. Studies conducted in the areas of management and organizational development used the Delphi Method to gather expert knowledge on improving working relationships and making group decisions (Brady 2015; Skulmonski et al., 2007). The researchers support the use of the Delphi Method when researching incomplete knowledge about a salient issue across various professions.

In OT research, the Delphi Method has forecasted implications for clinical intervention and educational standards. Timmer, Unsworth, and Taylor (2015) used the Delphi Method to determine the level of consensus regarding OT service delivery and interventions for older adults in inpatient rehabilitation. Three rounds of data were analyzed among expert OT clinicians to forecast the best practice for OT service delivery within an inpatient rehabilitation setting (Timmer et al., 2015). The Delphi Method provided a consensus of opinions to assist with understanding best practice in OT intervention.

Using the Delphi method, Holmes and Scaffa (2009) identified 104 essential competencies for OTPs to succeed in community-based settings. Through analysis of OT expert opinion, the researchers concluded there is a need to increase research that identifies adequate educational preparation and professional development to enhance the current and future roles of OTPs in community-based settings and practices (Holmes & Scaffa, 2009). In conclusion, the literature supports the use of the Delphi Method as a scientific method to resolve salient issues by achieving consensus among experts within various professions and within the profession of OT.

C**hapter 3 Capstone Method**

This chapter will describe the type of study and procedures for this capstone project. The Delphi Method, the primary research method, will be described. Finally, data analysis methods and format for presenting results are described.

Research Questions

As established in the background, the literature evidence is lacking to support the fundamental role of community-based OT among community-dwelling older adults. OTPs are adequately serving the adult and mental health populations by offering community-based OT programs. Community-dwelling older adults are not receiving equal opportunities to participate in community-based OT programs as compared to adult and mental health populations, which is an occupational injustice. The literature review has revealed that although community-based OT practice can provide necessary interventions for improving health, wellness, and QOL, the presence of OTPs and OT programs for older adults are limited.

For this capstone project, the questions guiding the investigation are:

1. How do experts in the field of OT define the impact of OT services on older adult's health, wellness, prevention of disease, and QOL?
2. How can the OT profession create and more effectively support the role of OTPs within community-based OT practice among older adults?
3. What is inhibiting OTPs from providing OT services to older adults in a community practice setting?

The Rationale for the Capstone Project

Regardless of age or health status, older adults have the right to equitable services that support and promote QOL. Currently, an occupational injustice exists among older adults

having access to community OT services that facilitate improved health and wellness for the prevention of disease. Without access to community-based OT services, older adults are at risk for decreased independence in occupation, decreased QOL, and social isolation (Clark et al., 2012; Papageorgiou et al., 2015).

Design

The Delphi Method facilitated structured communication between SMEs through three rounds of questionnaires. The panel of experts anonymously provided their knowledge and views on community-based OT practice and the impact OT has on improving QOL among older adults living within the community. As the questions were analyzed and synthesized, additional rounds of questions were sent to the SMEs until the synthesis of data revealed a consensus (Hsu & Sandford, 2007).

The purpose of using the Delphi Method was to narrow the SME's responses to reach a final expert consensus. The advantages of utilizing the Delphi Method include (Rooney & McKeena, 2018; Hasson et al., 2011; Hsu & Sanford, 2007; Skulmoski et al., 2007):

1. Participants can be geographically dispersed
2. Allows for participants to discuss complex problems anonymously
3. "Translation of scientific knowledge and professional experience into informed judgment to support effective decision making" (Rooney & McKeena, 2018, p. 291)

As recommended in the literature on the Delphi Method, multiple rounds of questions are used as the primary method for collecting data. For this capstone project, four rounds of questioning were completed to reach consensus among eight SMEs through Survey Monkey. The questions used in round one were qualitative, while those used in round two and three were primarily quantitative. In round two and three, SMEs were provided with the opportunity to

revise their opinions and thoughts from previously submitted questions. A forth questionnaire was used as a consensus report to inform the SMEs on the statements that had reached consensus, to confirm their agreeance on the final statements, and to provide them with a final opportunity to add their thoughts and opinions on the outcomes as well as future directions.

The questions used in round one were developed to support and guide the SMEs into formulating and expressing their expert opinions about community-based OT practice among older adults (see Appendix E). Based on the SMEs responses to the round one questions, nine questions were developed to send out in the round two questionnaires (see Appendix F). The questions in round two were formulated as rated questions to elicit quantitative data using a Likert Scale. By using questions with a Likert Scale, the researcher sought consensus through the level of agreement among the questions provided to each SME (Bishop & Herron, 2015; Boone & Boone, 2012). Each question had a comment box so that the SMEs had the opportunity to provide an open-ended response to the questions. Similar to the round two questions, round three questions were formulated in a rated format using the Likert scale to seek agreeance among the SMEs to validate consensus about the importance of community-based OT practice among the older adult population (Hasson et al., 2011; Hsu & Sanford, 2007; Skulmoski et al., 2007).

Rating scales, such as the Likert Scale, are used to measure attitudes, values, or opinions (Bishop & Herron, 2015; Boone & Boone, 2012). According to Joshi et al. (2015), “Likert scales were devised in order to measure attitude in a scientifically accepted and validated manner in 1932” (p.397). Likert Scales are considered ordinal scales that measure from agreement to disagreement of a specific topic or area of content. The purpose of using a Likert scale is to measure the intensity of agreement on a linear scale, such as strongly agree to strongly disagree (Bishop & Herron, 2015; Joshi et al., 2015; Boone & Boone, 2012). The Delphi Method’s

purpose is to gather SME's opinions through an anonymous survey and then to narrow the responses to develop a consensus (Roney & McKenna, 2018). By providing the SMEs with a Likert scale for each statement in round two and three, the researcher was able to determine the level of agreeance based on the SME's rating. A threshold of agreeance while utilizing the Delphi Method is met when 70% of the participants agree or strongly agree with a statement (Nicola-Richmond, Pepin, & Larkin, 2016; Hasson et al., 2011).

Participants

The researcher identified 15 potential SMEs to participate with an expected acceptance rate between 40-50%. It was determined by the researcher that 15 participants would be the maximum, five participants would be the minimum, and eight participants would be the ideal number of participants. Out of the 15 SMEs, a total of eight SMEs agreed to participate. A list of the eight SMEs is provided in Appendix B. According to Keeney et al., (2011), an 8% to 100% response rate from SMEs during rounds of questioning is the goal. This percentage rate is based on the total number of participants. The literature supported a range of participants who ae recognized SMEs. Since this rate varies, the goal for this capstone project was to have a 40-70% response rate from the SMEs throughout all rounds of questioning (Keeney et al., 2011). All eight participants who signed the consent form received all four Survey Monkey links to all three rounds of questioning and the final survey to disseminate and confirm the statements that reached at least 70% agreeance.

Inclusion Criterion

The inclusion criterion to identify SMEs to participate in the research was as follows; must be OTPs currently working in clinical practice, academia, or retired and at least one of the following: demonstrate experience working in community-based OT practice for a minimum of 5

years or experience working with the older adult populations for a minimum of 5 years. Ideal candidates will meet all three criteria (see Table 1).

Table 1

Participants' Expertise

Participant	Community-Based Practice	Older Adult Population
Participant 1	X	X
Participant 2		X
Participant 3	X	X
Participant 4		X
Participant 5	X	X
Participant 6	X	X
Participant 7		X
Participant 8	X	X

Exclusion Criterion

OTPs who have no experience in community-based OT practice and working with the older adult population were excluded. Specifically, OTPs working with the pediatric, mental health, and physical disability population as their primary focus were excluded from this study.

Recruitment and Consent of the Participants

Occupational therapy practitioners with expertise practicing with the older adult population and within community practice were identified through searching the American Occupational Therapy Association (AOTA) and the Florida Occupational Therapy Association (FOTA). These occupational therapy associations have special interest's chairs for the older adult and community practice settings. The special interest chairs were contacted to participate and asked if they would help in finding occupational therapists with expertise in these two areas of practice. In addition, an email was sent out to Program Directors and esteemed faculty members working within OT and OTA academic programs requesting their participation.

Various occupational therapy experts have written books and research articles on occupational therapy, the older adult population, and community-based occupation therapy practice. These books and articles are used within the literature review, and the authors were contacted via email. The authors that were invited to participate have provided their email information on their published books and research articles.

Each of the experts chosen to participate received via email a letter of invitation to confirm availability to participate (see Appendix C). The chosen SME's vary in professional backgrounds and education. To verify their expertise, the researcher received the participant's Curricula Vitae (CV) documenting a minimum of five years of clinical practice within community settings and/or five-years' experience working with the older adult population. The eight OTPs who committed to participation are currently working in academia or clinical settings. Their expertise is described in Table 1.

After each participant agreed to participate, a letter of consent (see Appendix D) was sent via email, signed, and collected before beginning the research project. This letter of consent included Nova Southeastern University's IRB approved information regarding the nature of the Delphi Method, the capstone purpose, the obligations of participation, the length of time to spend on answering questions, and the time-frame for their participation.

Procedure

To begin the Delphi procedures, the SMEs received a letter of invitation for participation through email. The letter explained the Delphi Method and the purpose of the study, emphasizing the commitment of time needed. Three days after the letters were sent to each participant, a follow-up email was sent to those who did not respond to confirm participation. With a commitment of eight participants, the consent forms were emailed, signed, and returned

to the researcher before sending a Survey Monkey link to the round one questionnaire. To allow for continuity, SMEs were not replaced after the first round of questions had been analyzed.

The round one questionnaire consisted of six open-ended questions to facilitate brainstorming and to encourage a wide variety of responses on the topic of community-based OT for the older adult population. At the end of the questionnaire, the experts were asked to rate their level of confidence in answering the questions by choosing, extremely confident, very confident, somewhat confident, not so confident, or not at all confident (see Appendix E). The SMEs were allotted two weeks and asked to spend a minimum of 30 minutes completing the questionnaire. Three days after the round one questionnaire had been disseminated, the researcher contacted each SME to verify receipt of the Survey Monkey link and to answer any questions. After each SME submitted their answers, responses underwent qualitative analysis. The statements for round two were developed through color coding, categorizing, and conceptualizing themes from round one responses.

Data analysis took place over the course of one week, after which the round two questionnaire was developed (see Appendix F). This questionnaire consisted of nine Likert Scale questions and one comment box at the end of the questionnaire. Each participant received the Survey Monkey link to the second questionnaire through email. The participants were given one week to complete the second questionnaire. Again, the researcher contacted each participant three days after sending the questionnaire to verify its receipt, as well as answer any questions SMEs may have had at that time. The participants were asked to spend a minimum of 15-30 minutes completing the questionnaire, which was formatted as a rating scale using a Likert scale. Furthermore, the participants were given the opportunity to add any comments to clarify or amend previous responses, which enhanced the opportunity for consensus. For each question,

the participants were asked to rate their level of agreeance using a five-point Likert Scale (strongly agree, agree, no opinion, disagree, strongly disagree). After one week, round two data underwent quantitative analysis to determine the number of statements that had reached consensus. The responses to round two guided the researcher in narrowing down themes and concepts to possibly conclude final consensus during round three.

After round two data analysis, each participant received a Survey Monkey link to the third questionnaire through email (see Appendix G). The participants had one week to complete the third questionnaire and were contacted three days after sending the questionnaire to verify receipt of the questionnaire and to answer any questions. The participants were asked to spend a minimum of 15-30 minutes answering two questions that were formatted as a rated question using the same five-point Likert scale used in round two. For each question, the participants were allowed to add any comments to clarify or amend previous responses to enhance the opportunity for consensus. The final consensus was met after round three with over 70% agreeance to nine statements. Statements that reached the predetermined threshold of agreeance were disseminated through email using a Survey Monkey link asking for final comments. In attempt to balance the participants' anonymity and a desire to acknowledge participants publicly, a final survey was developed and sent asking permission to utilize the SMEs names and credentials in future publications (see Appendix H and I). Figure 1 outlines the Delphi Process for this capstone project.

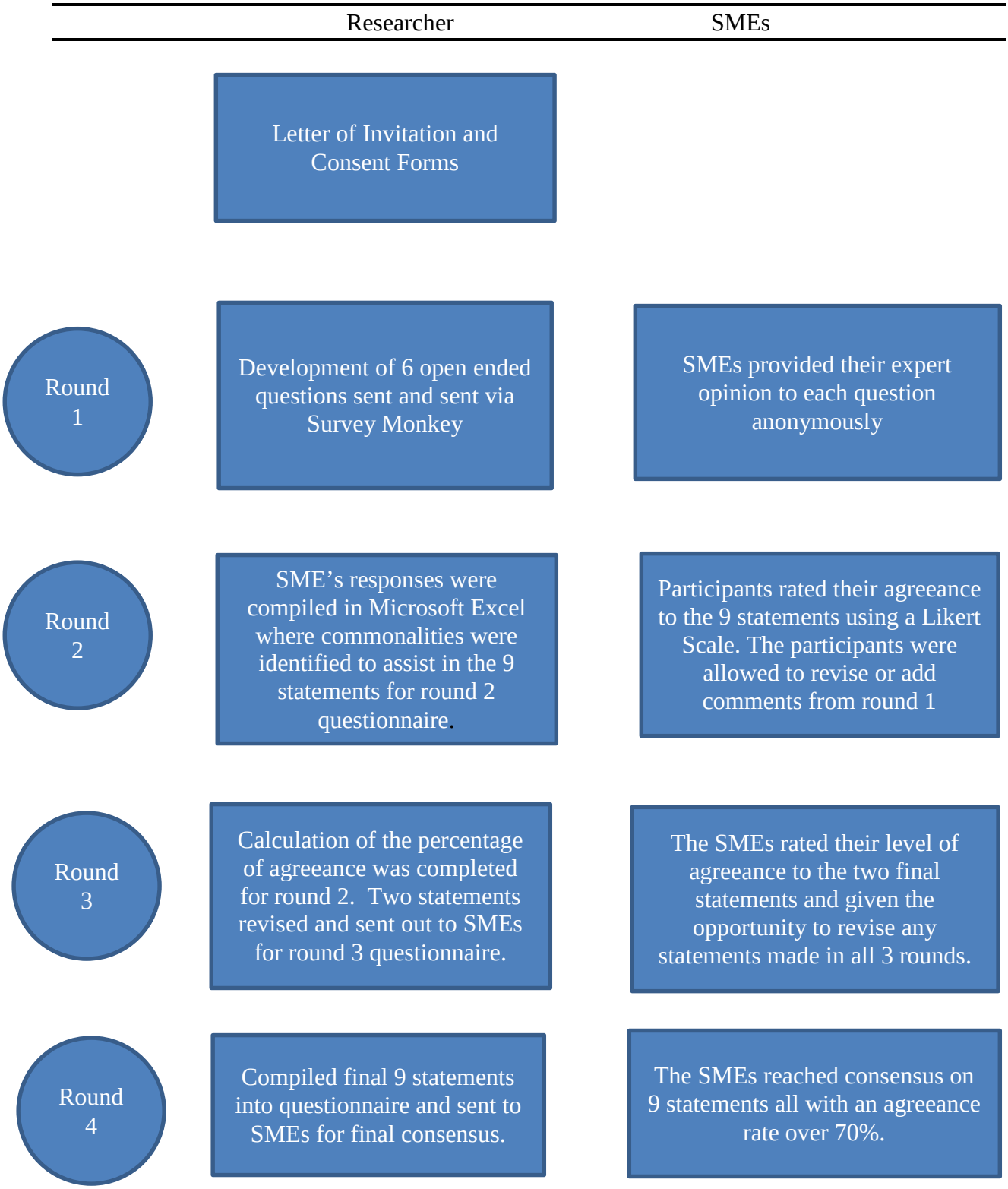

Figure1. Steps taken by the researcher to achieve consensus using the Delphi Method

Data Analysis

The research project employed a four round survey design to gather data from SME's in the field of OT specializing in community-based OT among older adults. Survey research, through individuals' responses to questions, is used to gather an individual's knowledge and explore human behavior on a specific subject matter (Ponto, 2015). When using a survey, both qualitative and quantitative methods are used to collect data. For this capstone project, qualitative strategies, the use of open-ended questions, and quantitative strategies, Likert scale questions, were used to collect data.

The first round of questions were open-ended in nature, and the method of analysis used a qualitative approach, content analysis. In order to weigh the SMEs statements, the researcher asked the SMEs to rate their overall level of confidence in answering each of the round one questions (Keeney et al., 2011). Narrative analysis was completed by extracting word for word statements from the responses of the participants and categorized or grouped on Microsoft Excel spreadsheets. Round two and three questions were ordinally quantitative to determine if a 70% agreeance rate was reached for consensus. Data from all three rounds were analyzed and documented on Microsoft Excel spreadsheets.

Using a series of statements formulated from the previous round's information, the researcher created the round two and three questions and assigned a Likert scale to each question. A five-point Likert scale was used starting from strongly agree and ending with strongly disagree (McDavid, Huse, & Hawthorn, 2013). Agreeance was determined when 70% or more of the participants indicated strongly agreed or agreed with the given statements. When agreeance was reached, a statement was accepted as reaching consensus ending further debate among the SMEs.

A fourth survey was sent to all the participating SMEs providing them with the nine statements that had reached agreeance. In this round four questionnaire, the SMEs were offered the opportunity to read the nine final statements and to provide feedback. The SMEs were also asked to provide their opinions on future directions for community-based OT practice among older adults. While not part of the Delphi Method or research process, a fifth and final survey was sent out to all the SMEs requesting permission to use their names and credentials in future publications. In this survey, the SMEs were also asked to identify if they would like to receive the final analysis of data and results by email.

Chapter 4 Results

This chapter includes data analysis from the eight participants who engaged in the Delphi process. The Delphi Method was used to extract SMEs opinions and perceptions on community-based OT practice among older adults. Qualitative data guided the development of round two and three statements as well as identified essential themes. Quantitative analysis determined agreeance on relevant statements derived from the SMEs responses to multiple rounds of questions. A final consensus was reached in round three with data analysis revealing three underlining themes:

1. Community-based OT practice is a valuable service among older adults
2. Suggestions as to why OT is limited in community practice
3. Recommendations to increase community-based OT practice among older adults.

The Delphi Method Round One

In round one, 100% of the SMEs responded to the questionnaire. The data received from the six open-ended questions (see Table 2) was organized into strengths and weaknesses that impacted the presence of community-based OT practice among older adults (see Table 3).

Table 2

Delphi Method Round 1 Questions

1. In your opinion, how can community-based OT impact the overall health, wellness, and quality of life of older adults living in the community?
2. List and describe current or emerging community-based OT practice areas for the older adult, where OT's are or should be considered essential?
3. Based on the answer in question #3, Why do you think OT's are essential for these interventions?
4. Why do less than 2% of the OT practitioners provide OT services in non-institutional home health or community-based practice?
5. How can the OT profession best develop new roles for OT practitioners within community-based OT practice among older adults? [Consider various options including, academic programs, OT associations, and accrediting bodies.]
6. How confident do you feel about the answers provided to the above questions?

Table 3

Delphi Method Round 1 Themes

Strengths of Community-Based Practice Among Older Adults	Weaknesses of Community-Based Practice Among Older Adults
1. Community-based OT improves QOL Health, wellness, and prevention of Disease	1. Limited Reimbursement
2. OTPs are experts in occupation offering engagement in meaningful activities	2. OT's role is not well defined in community-based practice
3. OT offers a Holistic approach	3. OTPs lack the skills to articulate the value of OT in community practice
4. OT supports aging in place	4. Academic settings are not adequately preparing entry-level OTPs for community-based practice.
5. OT can help decrease the burden of care when older adults reside in the community versus long-term institutions	5.OTPs lack the business, marketing, and leadership skills to develop community-based programs

Round one produced common themes, which led to the production of nine statements seeking expert opinion and consensus for round two. The comments received in round one emphasized how community-based OT practice improves QOL, health, wellness, and engagement in

occupation for the prevention of disease among community-dwelling older adults. Data analysis began with first identifying what the SMEs considered to be strengths and weaknesses related to the perceptions of the OT profession and the community regarding community-based OT practice among older adults. These strengths and weaknesses were further analyzed through color coding each SMEs opinions which contained similar concepts. According to Belotto (2018), the coding process allows for large sections of data to be interpreted and then connected into themes. In round one, the SME's comments were categorized to identify commonalities in the expert's opinions:

1. Importance of community-based OT practice among older adults (coded orange)
2. Limitations of community-based OT practice among older adults (coded red)
3. Recommendations for improving community-based OT practice among older adults (coded blue).

At the end of the round one questionnaire, the SMEs were asked to rate their level of confidence in answering the questions. All but one SME expressed some level of confidence in answering the proposed questions (see Table 4). One SME skipped this question, leaving their level of confidence inconclusive. All statements were considered valid for analysis.

Table 4

SMEs Level of Confidence

Answer Choices	Percentage	Number of Response
Extremely Confident	42.86%	3
Very Confident	28.57%	2
Somewhat Confident	28.57%	2
Not So Confident	0	0
Not at all Confident	0	0
No Response	12.5%	1

Two comments are shared here to illustrate the SME's opinions relating to the importance of community-based OT practice among older adults:

> "Community-based OT provides older adults with an opportunity to engage in meaningful occupations they would otherwise be limited. They have an opportunity to perform social participation, leisure, or meal preparation, which is vital towards overall health and wellbeing."
>
> "In my opinion, the impact of OT in the community can be a major factor for the aging population. OT looks at the individual as a whole when other professions overlook some of the most important factors for an individual. The overall areas of health, wellness and quality of life in older adults can be looked at from a 30,00-foot view and as close up as 300 ft. view. The possibilities are very broad and vastly overwhelming, depending on location, demographics, disparities, and economic factors. Within the OTPF Framework of occupations, we have so many untapped areas to develop in the community for the aging population outside of the traditional four walls of hospitals, nursing homes, and traditional clinics. There are opportunities related to Inclusion [*sic*] for an aging population, health promotions, and program development (social, sexual, driving, retirement preparation and adjustment, leisure exploration/participation, and family support)."

While the SMEs emphasized the importance of community-based OT practice, they also expressed concern with the level of knowledge OTPs have with understanding how to articulate the role of OT within community practice. Comments presented reimbursement, lack of education, and role identity as barriers to developing and engaging in community-based OT practice.

The following three comments illustrate the SME's opinions relating to the weaknesses that are limiting factors for community-based OT practice among older adults:

> "The lack of awareness and understanding of "OT." OT's lack the skills to successfully articulate the value and benefits of OT. The lack of business skills and knowledge to expand the profession outside of traditional settings. The lack of leadership in areas of brand development and marketing. OTs lack the ability to remove the fear of selling. Their driving force is "helping and making a difference" when more assertiveness needs to be implemented as other professions have done so successfully to grab the attention of other healthcare professionals and the community."
>
> "Many of these centers do not know what OT is and how it can benefit the population. Funding is also an issue, as many of these facilities require limited government funds to operate. Not many of these facilities have OT, and students do not have an opportunity to perform Level 2 training in them. Also, these settings are not able to provide competitive salaries to OT."
>
> "I feel the development of new roles for OT practitioners within community-based OT practice would start in academic programs. Perhaps, future OT students could develop projects, etc. and create/investigate research supporting new ideas on how OT practice can expand."

The Delphi Method Round Two

For round two, 75% of the SMEs responded to the questionnaire. Of the eight SMEs who participated in round one, only six completed and returned the round two questionnaire. In round two, the SMEs had to select their level of agreeance to nine statements developed from the comments provided in the round one questionnaire (see Table 5). The statements were measured

using a five-point Likert Scale (strongly agree, agree, no opinion, disagree, strongly disagree). For each round two statement, a comment box was provided for the SMEs to add any revisions to their round one opinions and comment.

Table 5

Delphi Method Round Two Statements

1. Community-Based OT Practice improves overall safety, quality of life, well-being, and health of older adults through engagement in meaningful occupations, including preparation for aging, social participation, and leisure.
2. Occupational therapists have the skills to practice in community centers, senior centers, adult daycare, and wellness programs for community-dwelling elders and should be considered essential practitioners in these settings.
3. Occupational Therapists are essential to community-based health since they provide skilled (evidence-based, reasoned, therapeutic) services to individuals or groups that consider and impact the whole person (physical, mental, social) and their "family," their environment (personal and community) and occupations.
4. There is a need to accurately define the roles and paths to practice occupational therapy in non-traditional community-based practice.
5. The development of new roles for occupational therapy practitioners within community-based OT practice should start within academic programs as part of emerging practice education and student involvement program development and community projects leading to dissemination. (Note: This assumes CBOT practice is occurring at an emerging practice level and has the potential to grow, not just occurring as an innovative community practice).
6. Occupational Therapists' lack the skills to successfully articulate and market the value, benefits and "brand" of occupational therapy services outside the traditional practice settings.
7. Within the community setting, occupational therapists lack the knowledge, business skills, and leadership skills, to market themselves and expand the profession outside of traditional settings.
8. Limited reimbursement of occupational therapy services in community settings has negatively impacted the number of occupational therapists working and developing programs in community practice. Greater education of community-based wellness and leisure locations and funders is needed to improve awareness of the impact occupational therapy can make outside of the "four walls" of traditionally reimbursed health care settings. This can be done directly or through public speaking, lobbying by individual practitioners or state associations, or participation on community-related boards which impact health initiative funding.
9. Occupational therapy is an essential service and should be easily available to all older adults in the community to decrease rising healthcare costs and hospital readmissions by optimizing quality of life, health and wellness (including periodic assessment and intervention for minor changes in status), increasing their safety, restoring their prior level of function with daily occupational tasks/routines (ADLs/IADLs), and to help decrease the burden of care overall when discharged to their place of long-term residence.

The number of responses and the percentage of agreeance was calculated for each statement (see Table 6). A statement was considered to have reached consensus if at least 70% of participants indicated agree or strongly agree with a statement. Of the nine statements presented

in round two, seven of them reached consensus with an agreeance rate over 70%. Two questions did not reach consensus and were therefore revised using the SMEs comments, and presented again in round three.

Table 6

Delphi Method Round 2 Number of Responses and Percentage of Agreeance

	# of Responses	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	% of Agreeance
question 1	6	5	0	0	0	1	83%
question 2	6	6	0	0	0	0	100%
question 3	6	6	0	0	0	0	100%
question 4	6	4	2	0	0	0	100%
question 5	5	2	2	0	0	1	80%
question 6	6	1	0	0	3	2	16%
question 7	6	1	3	0	2	0	67%
question 8	6	6	0	0	0	0	100%
question 9	5	5	0	0	0	0	100%

In round two, it was evident that the SMEs opinions on community-based OT practice among older adults had formed. There was a 100% agreeance rate for questions two, three, four, eight, and nine, an 83% agreeance rate for question one, and an 80% agreeance rate for question five. In this round, question nine again asked the SMEs to offer further insight or comments to the proposed statements and provided revisions to their round one comments. There were two participants who elaborated on their expert opinion of the nine round two statements. The following statements are the SMEs comments provided in round two:

> "I agree that OT practitioners are well suited for community-based practiced. The focus needs to be developing programs that can be brought to the community as well as business skills to market and educate the community about OT and the impact it can make in their elder population. I also think that education about grant research can be a

valuable asset to collaborate with community partners. Learning more about communities and infrastructures will also be equally important, and that may not be a strong focus in school (learning how to think and view things in a broader sense). I think community-based can be a catalyst to provide better outcomes because all environments are considered. Patients probably showed better outcomes when home assessments were standard before discharge because it raised more confidence in the patient by relearning how to be in their "real environment," the family was also able to learn and understand the impact of "unsafe" areas and items in the home and the patient probably returned to a level of independence with the support of the family because everyone was involved in the "natural environment." The OT also gained more awareness before D/C to facilitate additional training and learning for the patient. So, bringing OT to the community can make a huge impact to make recommendations and treatments to meet the needs of the community in a more holistic way."

"I believe that OT practitioners should embed themselves in all areas of occupation and community should be a Primary Area of Practice."

Five out of six SMEs disagreed with statement six, which says, Occupational Therapists' lack the skills to successfully articulate and market the value, benefits and "brand" of OT services outside the traditional practice settings. Although four of six SMEs indicated agreeance with statement seven, it did not reach the established consensus criteria of 70%. Statement six was consequently revised to say "have the skills" rather than "lack the skills," in order to facilitate agreeance. Statement seven was also revised based on SME comments; it was redeveloped to say "entry- level OTPs" rather than "OTPs" lack the knowledge, business skills, and leadership skills, to market themselves in community-based practice. By analyzing round

two comments and separating common themes and ideas, such as entry-level OTP's, business skills, and OT knowledge, the two questions that did not reach consensus were reformatted and sent back to the SMEs through email utilizing Survey Monkey (see Table 7).

Table 7

Delphi Method Round Three Statements

1. Occupational therapists have the skills to successfully articulate the value and benefits of occupational therapy services within community-based practice among older adults.
2. Within the community setting, most entry-level occupational therapists lack the knowledge, business skills, and leadership skills, to market themselves beyond established practice roles and locations.

The Delphi Method Round Three

In round three, 100% of the SMEs participated, and final consensus was met on the last two statements. Round three consisted of two statements with Likert rating scales and comment boxes. During this round, both statements reached consensus criteria, with question one having an 88% agreeance and question two having a 100% agreeance (see Table 8).

Table 8

Delphi Method Round 3 Number of Responses and Percentage of Agreeance

	# of Responses	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	% of Agreeance
question 1	8	4	3	0	1	0	88%
question 2	6	2	6	0	0	0	100%

In round two, the percentage of dis-agreeance for statement six was 16%. All but one participant agreed that OTPs could not articulate the value of OT outside of traditional settings. When the question was revised for round three to state that OTPs have the skills to articulate the value of OT in community-based OT practice among older adults, seven out of the eight agreed.

It is evident that one participant disagrees with the level of knowledge OTPs have to clearly articulate the value of OT in community-based OT practice among older adults.

Consensus

Final consensus was reached on nine statements, seven from round two and two from round three (see Appendix H). By color coding the SME's responses in round one, the researcher was able to develop nine statements for round two, which after minor modification would lead to a final consensus in round three. Through color coding of the expert's opinions, the researcher was able to complete a thematic analysis. This analysis revealed three overarching themes:

1. Community-based OT practice is a valuable service for older adults
2. Suggestions as to why OT is limited in community practice
3. Recommendations to increase community-based OT practice among older adults.

Theme 1: Community-based OT Practice is a Valuable Service for Older Adults

SMEs were in unanimous agreement that community-based OT practice is an essential service to increase the QOL, health, and wellness for the prevention of disease among older adults. The SMEs expressed how OT is unique in its approach to interventions, which are centralized around occupational performance. When discussing the impact and importance OT has on older adults living in the community, three SME's stated:

> "The "community," "family," and individuals will need access to out of the box resources and programs to assist especially with rising healthcare cost. The impact OT can bring to a community outside of the four walls of traditional healthcare practice is vast."

> "Occupational therapists who use occupation as a restorative and curative force have a goal to enhance clients' occupational performance while developing meaningful occupations and restoring underlying capacities of each client."
>
> "Community-based OT allows people to age in place."

Theme 2: Suggestions As To Why OT is Limited in Community Practice

The SMEs shared common opinions on identifying why a limited number of OTPs are working in community-based practice. They emphasized the limited reimbursement for OT services at the community level, which steers OTPs to practice in institutional based settings. The SMEs suggested that OTPs and the OT profession lacks the skill to adequately articulate OTs role in community-based OT practice among older adults. Additionally, the SMEs revealed that many community partners, organizations, and community centers do not fully understand the roles of OT and the benefits that OT provides for the older adults. Funding or reimbursement was also a factor. Three SMEs stated;

> "OT's lack the skills to successfully articulate the value and benefits of OT. The lack of business skills and knowledge to expand the profession outside of traditional settings."
>
> "Many community centers do not know what OT is and the benefits OT offer [*sic*] to individuals."
>
> "I believe, reimbursement for the OT services in a community-based setting is extremely low."

Theme 3: Recommendations to Increase Community-based OT Practice Among Older Adults

When the SMEs were asked how the profession could assist in increasing the presence of OTPs in community-based practice, they emphasized the necessity for academia to educate

newer OT graduates on community practice, leadership, and business skills. Additionally, the SMEs reported the need for OTPs to increase their involvement in community partnerships, advocacy, and to improve their business skills. Three SME's stated:

> "I feel the development of new roles for OT practitioners within community-based OT practice would start in academic programs."
>
> "Sit on community boards, participate in more health initiatives, public speaking, more student involvement in projects."
>
> "Be open to creative and innovative approaches, learn business acumen to start an effective practice, advocate for OT reimbursement in other ways."

The SMEs disagreed on two questions in round two that stated OTPs lack the knowledge to articulate the benefits of OT and lack the knowledge of business skills and leadership skills to build community-based practice successfully. Based on the two comments made in round two, these two questions were revised for round three. The comments in round three from the SMEs emphasized that OTPs can clearly articulate the value of OT. However, entry-level practitioners lack the competencies to enter community-based practice with adequate business and leadership skills. When discussing if OTPs can clearly articulate the benefits of OT, one SME wrote:

> "We are experts at providing therapy in all areas of occupation with community falling under the umbrella of our scope of practice."

When discussing entry-level OTP's competencies, another SME noted that:

> "MOST curriculum is NOT business oriented; therefore, it is up to students to understand business concepts."

After round three, the SME's comments demonstrated their level of agreeance concerning thoughts and opinions on the impact of community-based OT practice among older adults and

the need to increase the presence of OT within community practice. The outcomes forecasted ways to improve the presence of OT within community practice to address the occupational injustice that is currently occurring among the older adult population. Qualitative data elicited themes, and quantitative data determined agreeance over 70% for final consensus among statements provided to the SMEs responses.

Round Four and Five: Dissemination of Data

A final survey was sent out to all the SMEs thanking them for their dedication and participation in this research study. The SMEs contributions reached a final consensus that identified the importance of community-based OT practice among older adults as an essential service to improve health, wellness, and QOL for the prevention of disease. In the round four questionnaire, the SMEs were provided with the established consensus outcomes and were asked to provide final comments on the statements and the future direction of OT within community practice. Final consensus was explained to the SMEs as follows: a statement is considered to have reached agreeance if 70% of participating SMEs indicate that they agree or strongly agree with the given statement. The final nine statements exceeded the 70% agreeance threshold (Nicola-Richmond, Pepin, and Larkin, 2016; Hasson et al., 2011). The response rate for this survey was 25%. Of the eight SMEs who participated in the study, two completed and returned the round four survey by the initial deadline. These two SME's did not provide additional comments regarding future direction; however, both indicated agreement with the nine final statements.

A fifth questionnaire was sent out to all the SMEs requesting permission to use their names and credentials in future publications. Of the eight SME's who received this final survey, four of them responded. This survey was sent out a second time in the efforts to increase the

response rate. However, only 50% of the SME's agreed that their names and credentials could be used in future publications, while the other 50% did not respond.

In conclusion, color coding of data revealed common ideas and themes among all the SMEs. After grouping the SMEs statements under each color, data analysis identified three overarching themes among the nine statements that had reached a final consensus. Each SME agreed that OT is a vital service to improve QOL, health, and wellness among older adults living in the community. Reimbursement and lack of knowledge of OT roles in the community were factors that were identified as limiting the presence of OT within community-based OT practice among older adults. Finally, the SMEs all emphasized the need for academic settings to establish strong curriculums that emphasize OTPs roles and competencies for building community-based OT practice.

Chapter 5 Discussion

Occupational therapists expertly design and implement interventions to enable participation in occupation. Through engagement in occupation, community-dwelling older adults can increase their overall health, wellness, and QOL. The literature review reveals an occupational injustice is likely occurring among community-dwelling older adults. The access to community-based OT practice among older adults is limited, and in return, the occupational needs of community-dwelling older adults are not adequately being met. The main purpose of this capstone project was to:

1. Explore indicators that inhibit the presence of OT in community-based practice for the older adult
2. Identify OT as a potential service within the community to improve health, wellness, and QOL for the prevention of disease among older adults, and
3. Forecast how increased presence of OT in community settings can decrease occupational injustice among the older adult population.

SMEs participated in four rounds of questioning utilizing the Delphi Method, to explore expert opinion on strengths, challenges, and barriers to community-based OT practice among older adults (see Appendix B). Throughout each round of questioning, the SMEs responses were analyzed, color coded, and linked back to the original research question. This analysis revealed three overarching themes:

1. Community-based OT practice is a valuable service among older adults
2. Suggestions as to why OT is limited in community practice
3. Recommendations to increase community-based OT practice among older adults.

To further support the research data obtained by the SMEs, a literature review was performed to include new evidence that was published after this project's initial literature review. Four electronic databases were utilized, *PubMed*, *CINAHL*, *MEDLINE*, and *PsycINFO*. The search parameters were limited to articles published between 2018 and 2019, contained community-based OT practice, and the sample population of community-dwelling older adults. The initial search terms were community-based OT practice, which identified 35 articles. Out of these 35 articles, four pertained to the older adult population. The evidence-based articles identified are threaded throughout the discussion chapter to support the value of community-based OT practice and future recommendations to increase the presence of OT within community practice among older adults. The new evidence in literature supports this research project by validating the value of OT among community-dwelling older adults as an essential service to support QOL, health, and wellness. New evidence also recognizes the need to increase research and evidence to support OT roles in community-based OT practice.

A final OT international search was completed utilizing The World Federation of Occupational Therapy (WFOT) website. This search resulted in one position paper and one article that brought new information to the community practice area, which was not available prior to this investigator's research and literature review for this capstone project. In 2018, a new practice framework was developed, called Community-Centered Practice Framework. Occupational therapy researchers in Australia developed a framework to support the growth and guide OTPs within the community settings. This new conceptual framework supported OTPs working with communities versus working within communities, as identified in community-based OT practice (Hyett, Kenny, & Dickson-Swift, 2018).

In 2019, WFOT showed support for this new framework by publishing a position paper entitled, “Occupational Therapy and Community-Centered Practice.” This position paper identified the fundamental principles and significance of OT within communities and the use of community-centered practice as a guideline to intervention (WFOT, 2019). OTPs are experts in understanding how occupational engagement within community practice can improve the health, wellbeing, and survival of community members. WFOT (2019) stated that two challenges with community-centered practice included (a) the limited number of OTPs working in community practice and (b) lack of academic curriculums to include more in-depth knowledge of community-centered practice.

The identification of this new framework was further compared to the literature used for this capstone project supporting community-based OT practice. Literature in the US uses “community practice” and “community-based” OT practice interchangeably. Community-based OT practice was identified as OTPs who work within communities, whereas community-centered practice was defined as OTPs working with communities (Hyett et al., 2018). This new framework offers one theoretical guide to practice, eliminating confusion or misinterpretation by identifying community practice as an emerging area in the OT profession. Unfortunately, this new evidence was identified after the SMEs completed all rounds of questioning and had come to a final consensus. If the new framework had been available prior to the beginning of this research, the researcher would have incorporated it within the questioning. The findings of this project supported previous literature by Winstead (2016) and Homes and Scaffa (2009a) and more recent literature by WFOT (2019). Similarities and new information are provided in the following sections.

The Value of Community-based OT Practice

The SMEs agreed that community-based OT practice is a valuable service among older adults. OTPs provide evidence-based practice to older adults across many settings to enable participation in occupation, so that they may continue to live within the community (Juckett & Robinson, 2018). Throughout each round of questioning, the SMEs emphasized and highlighted engagement in occupation as the essence of OT that sets it apart from all other medical professions. According to one SME, "Community-based OT provides older adults an opportunity to engage in meaningful occupations; they would otherwise be limited."

When left alone in the community without appropriate resources, the older adult population is at high risk for social isolation, decline in physical and cognitive capabilities, and falls (Juckett & Robinson, 2018; Smallfield & Molitor, 2018). By engaging in community-based OT practice, older adults can increase their engagement in ADLs, IADLs, social participation, and leisure activities, which all lead to increased QOL, health, and wellness. When referencing the value of OT among older adults, one SME stated, "They [the older adults] have an opportunity to perform social participation, leisure, or meal preparation, which is vital towards overall health and wellbeing."

As the population of older adults living with disabling conditions increases, health care costs and spending increases within the US (Agency for Healthcare Research and Quality, 2010). With the community-dwelling older adult population growing, increased resources will be needed to sustain QOL, health, and wellness. According to Berger, Escher, Mengie, and Sullivan (2018), older adults living with one chronic condition make up 90% of the older adult population, while 75% of this population lives with multiple chronic conditions. OT services can provide the community-dwelling older adult population, with or without chronic conditions,

tools and essential skills to support living within their desired communities. These skills include education on prevention of disease, environmental modifications and adaptations, education on community transportation and mobility, and health promotion, maintenance, and management (Berger et al., 2018; Juckett & Robinson, 2018; Smallfield & Molitor, 2018).

> One SME compared and contrasted community OT practice to inpatient rehabilitation; "Community-based OT can impact the overall health, wellness, and quality of life of older adults living in the community in a variety of ways. I will dive into the benefit of skilled OT services in skilled nursing facilities (SNFs), in which many older adults live with chronic illness and are cared for by staffed health care professionals who offer skilled expertise and services related to cardiac, respiratory, neurological, musculoskeletal, and orthopedic diagnoses. Occupational therapy services within this setting aim to achieve health, well-being, and participation in life through the engagement in occupation. The focus on self-care and health by OTs contributes to enhanced quality of life for the older adult population within skilled nursing facilities, where OTs, caregivers, and clients collaborate and develop goals to address barriers to performance in all occupations. Occupational therapists are skilled in developing programs, promoting health and participation, addressing impacts of disability, remediating deficits, and addressing occupational performance barriers. Rehabilitation interventions provided with SNFs by occupational therapists have the potential to facilitate disabled older adults' opportunity to regain independence in daily activities to return home. Occupational therapy interventions can include the use of preparatory methods and tasks, advocacy, occupations and activities, group interventions, and education and training. Occupational therapists who use occupation as a restorative and curative force have a goal to enhance

clients' occupational performance, while developing meaningful occupations and restoring underlying capacities of each client. When meaningful occupations are incorporated into the intervention process, clients value the intervention methods and actively engage."

Of the nine statements that met final consensus, five of them supported theme one, OT as a valuable service to community-dwelling older adults:

1. Community-Based Occupational Therapy Practice improves overall safety, quality of life, well-being, and health of older adults through engagement in meaningful occupations including preparation for aging, social participation, and leisure. (83% agreeance rate, n=6)
2. Occupational therapists have the skills to practice in community centers, senior centers, adult daycare and wellness programs for community-dwelling elders and should be considered essential practitioners in these settings. (100% agreeance rate, n=6)
3. Occupational Therapists are essential to community-based health since they provide skilled (evidence-based, reasoned, therapeutic) services to individuals or groups that consider and impact the whole person (physical, mental, social) and their "family," their environment (personal and community) and occupations. (100% agreeance rate, n=6)
4. Occupational therapy is an essential service and should be easily available to all older adults in the community to decrease rising healthcare costs and hospital readmissions by optimizing quality of life, health and wellness (including periodic assessment and intervention for minor changes in status), increasing their safety, restoring their prior level of function with daily occupational tasks/routines (activities of daily living/instrumental activities of daily living), and to help decrease the burden of care

overall when discharged to their place of long-term residence. (100% agreeance rate, n=6)

5. Occupational therapists have the skills to successfully articulate the value and benefits of occupational therapy services within community-based practice among older adults. (88% agreeance rate, n=8).

Limitations To Community-based OT Practice

Data analysis of the SMEs responses, from the multiple rounds of questioning, revealed limitations to community-based OT practice among older adults that inhibit the growth of OTPs practicing in this area. Although agreeance was reached by the SMEs indicating OT as a valuable service within the community setting, they also agreed that the profession lacks a clear definition for community-based OT practice and the role of OTPs within community-based practice. By not adequately defining the role of OTPs in the community setting or defining community-based OT practice, community stakeholders do not have a clear understanding of how OT improves the QOL, health, and wellness among community-dwelling older adults. There is a need to accurately define the roles and paths to practice OT in non-traditional community-based practice.

Limited reimbursement of OT services in community settings has negatively impacted the number of OTPs working and developing programs in community practice. The SMEs were asked why only 2% of the OTPs' practice in non-institutional home health or community-based settings. They identified limited or low reimbursement of OT services in community-based OT practice as inhibiting the presence of OT in community practice. Community settings that do not offer OT have to compete with the competitive salaries offered by institutional settings. Most

community programs are grant or government funded, leaving them with limited monetary resources to hire OTPs at their desired salary.

In round one of the Delphi communications, the statement made by one SME could be summarized as, identifying OTPs as lacking in the skills to successfully articulate the value, benefits, and brand of occupational therapy services outside of the traditional practice settings. When all the SMEs were presented with the statement stating, OTPs lack the skills to articulate the value of OT services within a community setting, all but one SME disagreed with this statement. This question was then revised to ask if entry-level OTPs lack the capability to articulate the value of OT services within the community. This time all but one SME agreed with the revised statement. It is essential for academic institutions to incorporate advanced competencies to support and encourage entry-level OTPs to practice in community settings.

The SMEs provided further insight to why OT is limited in community practice. Below are comments made to support their opinions:

> “Many community-based models I see are grant funded or university focused. We are not always open to other models and I think we should be. We also have to consider reimbursement whether it be private pay or insurance. I think the opportunity here is huge but the path and definitions are not”
>
> “I believe people want to age in place and community-based OT can make this happen. I do not think we have well defined "community-based OT" practice. I also find lots of opinions on what is called community-based.”
>
> “Many of these centers do not know what OT is and how it can benefit the population. Funding is also an issue, as many of these facilities require limited government funds to operate. Not many of these facilities have OT and students do not have an opportunity to

perform Level 2 training in them. Also, these settings are not able to provide competitive salaries to OT."

As experts in the field of OT, the SMEs have a solid understanding of the profession's scope of practice, values, and benefits. Due to their expertise, it is concluded by this investigator, that entry-level OTPs require increased academic training in understanding community-based OT practice along with leadership and business skills. There is an opportunity to improve the presence of OT services within community settings by enhancing the competencies of entry-level OTPs. Out of the nine statements that reached agreeance three of them supported that there are limitations preventing the development of community-based OT programs serving the older adult population. Below are the three statements and their agreeance rate and respondent rate:

1. There is a need to accurately define the roles and paths to practice occupational therapy in non-traditional community-based practice. (100% agreeance rate, n=6)
2. Limited reimbursement of occupational therapy services in community settings has negatively impacted the number of occupational therapists working and developing programs in community practice. Greater education of occupational therapists and managers in community-based wellness and leisure locations and funders is needed to improve awareness of the impact occupational therapy can make outside of the "four walls" of traditionally reimbursed health care settings. This can be done directly or through public speaking, lobbying by individual practitioners or state associations, or participation on community-related boards which impact health initiative funding. (100% agreeance rate, n=6)

3. Within the community setting, most entry-level occupational therapists lack the knowledge, business skills, and leadership skills, to market themselves beyond established practice roles and locations. (88% agreeance rate, n=8).

Recommendations Provided By The SMEs

In addition to highlighting the value of OT and limitations in the presence of OT in community-based OT practice, the SMEs also agreed upon specific recommendations for overcoming the mentioned limitations. According to the SME's, the development of new roles for occupational therapy practitioners within community-based OT practice should start within academic programs as part of emerging practice education. Academic institutions should increase student involvement in program development and community projects leading to dissemination within their fieldwork experiences. The entry-level OT curriculum should increase the level of knowledge and application of community-based OT practice, to support positive growth in community-based OT practice.

One SMEs comment below supports the need for academic programs to be the advocate in developing new roles for OTPs;

> "I feel the development of new roles for OT practitioners within community-based OT practice would start in academic programs. Perhaps, future OT students could develop projects, etc. and create/investigate research supporting new ideas on how OT practice can expand."

There is a need to educate OTPs, community stakeholders, and managers in community-based wellness and leisure locations. Referral rates can increase when community stakeholders and managers understand the value and benefits of OT services for older adults. Practicing OT clinicians in traditional settings can provide input to patients at discharge regarding community

services that may be available to them. For reimbursement, funders must have a better understanding of the impact OT can make outside of the four walls of traditionally reimbursed health care settings. Different types of advocacy can be completed to improve healthcare funding related to community-based OT practice. These include public speaking, lobbying by OTPs or OT state and national associations, or OTPs participating on community-related boards.

The following comments from the SMEs support the need for the OT profession to increase advocacy for community-based OT practice.

> "We have to contact these centers and train them on our skills. Have in-services or presentations so they know what we do."
>
> "Be open to creative and innovative approaches, learn business acumen to start an effective practice, advocate for OT reimbursement in other ways"

One statement out of the nine statements that reached agreeance supported the recommendations provided by the SMEs to increase the level of awareness and presence of community-based OT practice among older adults:

1. The development of new roles for occupational therapy practitioners within community-based OT practice should start within academic programs as part of emerging practice education and student involvement program development and community projects leading to dissemination. This assumes community-based occupational therapy practice is occurring at an emerging practice level and has the potential to grow, not just occurring as an innovative community practice. (80% agreeance rate, n=5).

Study Limitations

This capstone project had several limitations including, the selection of the SMEs, the SMEs understanding community-based practice as an emerging area of practice, and the

experience of this investigator with using the Delphi Method. To start this capstone, project the investigator identified fifteen primary SMEs and an alternate list of five SMEs. The original list of SMEs had extensive background in community practice. Specifically, all the primary SMEs had published various research articles and books with a focus on community practice and the older adult population. However, only one of the SMEs on the original list of SMEs was able to commit to participating. Since the alternative list only had five OTPs, the investigator sought out to include six more SMEs. The investigator received eight consent forms out of the eleven consent forms sent out to the SMEs. There was a small sample size and inconsistency in round two response rate with six SMEs responding. This small sample size of eight SMEs and the variance of the response rate may have decreased the reliability and validity of the results.

Prior to beginning the research project this investigator reached out to the RAND corporation with the intention of speaking with research experts who have extensive knowledge and experience in using the Delphi Method. Unfortunately, this was unsuccessful leaving this investigator with limited expert assistance when developing this research project. During the rounds of questions, it was noted that one of the SMEs did not clearly understand the definition of community-based practice as an emerging area of practice. In fact, this SME discussed the benefits of OT among older adults residing in a Skilled Nursing Facility (SNF) or receiving home health care services. Due to required anonymity, it was not possible to determine this SMEs input across all three rounds. Finally, publication of new information after this research project began resulted in not including some expert opinion and an updated definition on community-centered practice versus community-based practice. Despite these limitations, this capstone project provides strong evidence to support an increase in OT presence in community-based OT practice among older adults.

Future Directions

In 2018, a new conceptual framework, the Community-Centered Practice Framework, was developed by Australian OTPs. These OTPs saw the need to provide a guide for delivering client-centered OT services for OTPs practicing in community settings (Hyett et al., 2018). There are four stages to using the community-centered practice framework:

1. Community Identity
2. Community Occupations
3. Community Resources and Barriers
4. Participation Enablement.

According to Hyett et al., (2018) "Occupational therapists are well placed to design and implement the community-centered health interventions promoting equity and increasing peoples control over their health and lives" (p. 2). The community-centered practice framework provides OTPs with the guidelines for improving OT services within communities serving all populations. Most importantly this framework, "enables occupational therapists to maintain their unique occupation focus, which is critical for the design and establishment of occupational therapists' community practice roles" (Hyett et al., 2018, p. 12).

This framework could be used in academic settings to support students during fieldwork experiences in a community setting, or to support instructor guided projects during academic training. It would be beneficial for OTPs to begin using the framework to document client outcomes so that this data can be utilized for advocacy purposes. Through advocacy OTPs can speak at forums addressing public policy and speak to community stakeholders, and government officials, regarding the importance of OT services within community settings and petition for funding.

Additional scholarship may be needed to integrate the WFOT position paper into an AOTA position paper and OT practice within the USA. According to Hyett et al. (2018), "a community-centered practice approach should be adopted, which expands community-based roles to enable working with, not simply within communities" (p. 7). Although this capstone project focused on community-based OT practice among older adults, future research is needed to validate the benefits of incorporating the Community-Centered Practice Framework within the academic setting and among OTPs who are practicing within the community settings with the older adult population. Future research can provide evidence to bridge the gap between academic learning and clinical practice, with understanding how to theoretically, philosophically, and practically incorporate the OT profession within community practice (Hyett et al., 2018). Continued research is needed to support the utilization of this new framework as a reliable and valid guide to empower OTPs to develop and maintain their role in community practice.

Conclusion

In the US, the fastest growing population within the community is the older adult population and so far nationally only 2% of OTPs practice in non-institutional community-based OT practice. Based on research and literature presented in this paper, the community-dwelling older adults are facing an occupational injustice. There is a deficiency in community services to adequately meet their physical, cognitive, and emotional needs. Without appropriate community services, community-dwelling older adults are at risk for social isolation and decreased engagement in occupation. This will ultimately affect their overall QOL, health, and wellness leading to disease that could remove them from their natural living environment within the community.

Community-based OT practice provides older adults with access to interventions that

focus on improving overall health, wellness, and QOL. OTPs have the skills and knowledge to understand the impacts of aging on occupational engagement. SMEs identified OT as an effective intervention for improving QOL among community-dwelling older adults. The data supports the need for the expansion of community-based OT practice among community-dwelling older adults to improve health, wellness and QOL for the prevention of disease. SMEs agreed that academic settings have an obligation to build the competencies of entry-level OTPs to promote new OT roles within community practice. Since the start of this project a new practice framework, Community-Centered Practice, which provides OTPs with a conceptual guide to practice with older adults within the community setting was published by the WFOT.

As the older adult population continues to grow, OTPs must determine how they will implement services that not only meet the physical, emotional, and cognitive needs, but the environmental and contextual needs of the older adult population. Older adults deserve the right as any other population, to have access to services that promote health and wellness. The OT profession must overcome the barriers that are limiting the profession's growth in community-based practice by increasing research and evidence-based practice within community-based OT practice.

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Appendix A

Definition of Terms

1. Aging in Place- living in the same environment, typically one's home, as one ages (Wagenfeld, 2016)
2. Aging in the Community- older adults aging in their neighborhoods with networks that provide support to facilitate well-being and QOL for older adults to successfully age in their community (Thomas, 2016).
3. Community- as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings (MacQueen et al.2001, p.1930).
4. Community Dwelling Elders- older adults who live within the community (Wagenfeld, 2016).
5. Community Health- "*community Health* refers to the *health* status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their *health*" (McKenzie et al., 2005).
6. Health- a level of emotional resources, social resources, and physical abilities a person has and can use to successfully meet their needs (Wagenfield, 2016)
7. Health Promotion- a plan or program that facilitates a person taking control of and improving his/her health (Wagenfeld, 2016).
8. Home and Community Health (Community Practice) as Defined by Professional Communities. (n.d.):
    a. occupational therapy professionals and students whose practice environment is in the home and community, including home health, adult day care, senior housing,

wellness programs, community mental health centers, home modification, and accessibility consultation.

b. the home and community health special interest section promotes community-based practice by identifying exemplars and sharing models for community practice, as well as networking with community-based services and agencies and promoting occupational therapy roles in these settings.

9. Home Health Care- home health care services are provided by home health agencies to clients who are homebound and need skilled care (Wagenfeld, 2016)
10. Home Health Occupational Therapist- (Sieber & Vance, 2013)
    a. occupational therapy can perform admission visits.
    b. occupational therapy qualifies a Medicare patient for continued home health eligibility.
    c. occupational therapy can collect OASIS data at any time point after the start of care.
    d. occupational therapy can assist in aide supervision and training of home health aides
    e. patients and their families are concerned about your patients' abilities to take care of themselves and to manage at home safely.
    f. occupational Therapy is concerned about their patients' ability to manage their conditions**.** Management of chronic diseases is in large part management of daily activities
    g. occupational therapy contributes to stronger outcomes—for your patients and your agency

11. Emerging Practice-
    a. “multifaceted concept [that] encompasses diverse professional roles, a variety of contexts for the provision of services, as well as the development of innovative business models” (Holmes & Scaffa, 2009a, p. 81)
    b. emerging practice areas develop from occupational therapists who are working in traditional settings and develop a vision and innovative ideas that enable them to serve their clients in a better way (Wagenfeld, 2016).
12. Medical Model- the traditional approach to assessment and treatment, focused on remediation of pathology. In a medical model, approach, the physician or other health care provider is generally regarded as the expert, while the client, usually referred to as a “patient”, is a recipient of services (Wagenfeld, 2016).
13. Occupational Justice- like social justice and human rights in general, are concerned with ethical, moral, and civic issues such as equity and fairness for both individuals and collectives but specific to engagement in diverse and meaningful occupation” (Wilcock & Townsend, 2014, p. 542-543).
14. Productive Aging- used to describe the societal contributions of older adults, including paid employment, volunteer activities, caring for others, and daily activities (Wagenfeld, 2016)
15. Social Isolation- when an individual isolate themselves from participation in society or communication among other peers.
16. Social Justice- accentuates the importance of equal opportunity across race, gender, class, income, ability, or disability to abolish inexcusable inequalities (Wilcock & Townsend, 2014).

17. Well-being- an emotional satisfaction with life in general (Wagenfeld, 2016)
18. Wellness- taking control of choices to increase satisfaction in life and improvement in overall health (Wagenfeld, 2016)

Appendix B

A panel of expert Occupational Therapists

1. Participant 1- OTD, OTR/L- Assistant Professor Creighton University Author of Program Development and Grant Writing for OT. Expert in community OT practice and the aging population
2. Participant 2- Dr.OT, OTR/L, CLT- Director of Rehabilitation for Genesis Rehabilitation. Expert in the aging population
3. Participant 3- JD, OTR/L, FAOTA, DASPE, CCM, CDMS, CPE- Adjunct professor, occupational therapy program development consultant, Program Manager for multiple community organizations, and former AOTA President. Expert in community OT practice and the aging population
4. Participant 4- Ed. D, MHSA, OT/L- Assistant Professor at Keiser University MSOT program Ft. Lauderdale campus. Expert in the aging population
5. Participant 5- COTA/L, CEAS II- Academic fieldwork coordinator for the OTA program at Keiser University Miami campus. Expert in community OT practice and the aging population.
6. Participant 6- OTD, OTR/L- Clinician specializing in aging and professor. Expert in the aging population and community practice
7. Participant 7- MS OTR/L- Clinician specializing in aging
8. Participant 8- BS, COTA/L- Area director of operations for Therapy Management Corporation, clinician specializing in aging and Keiser University Clinical Coordinator. Expert in community OT practice and the aging population.

Appendix C

Letter of Invitation

Dear Sir/Madam,

Re: Community-Based Occupational Therapy Practice Among Older Adults: A Delphi Study

My name is Kristin Antolino. I am a doctoral student at Nova Southeastern University Dr. OT Program. Because of your expertise, I am kindly requesting your participation in this limited participant doctoral research study that I am conducting titled: Community-Based Occupational Therapy Practice Among Older Adults: A Delphi Study. Literature review identifies an occupational injustice among community-dwelling older adults, as they do not have access to community occupational therapy services that facilitate improved health, wellness, and quality of life for the prevention of disease. The intention is to identify the importance of community-based OT services among older adults to improve health, wellness, and QOL for the prevention of disease. Through cyclical feedback from occupational therapy experts such as yourself, the intent of this study is to build consensus to forecast practice guidelines for increasing the presence of occupational therapy in community-based practice among older adults.

Through the utilization of survey method, the study involves three or four rounds of questionnaires via electronic survey. Each questionaries' is estimated to take 30 minutes to complete. We hope to complete all rounds of questions within 6-weeks.
Participation is completely voluntary with no compensation. The study is completely anonymous, and your information will not be shared with other participants. I do request if you accept to participate that you send your CV to confirm eligibility according to the inclusion criteria, which states you must be an OTP for a minimum of 5 years with expertise in community-based OT practice and older adults.

Your participation in the research will be of great importance to assist in identifying how to decrease the occupational injustice among community dwelling older adults who are not provided with the equal opportunity to participate in community-based occupational therapy.

Thank you for your time and participation

Sincerely,
Kristin Antolino, MOT, OTR/L

Kristin Antolino, MOT, OTR/L, Doctoral Student, Nova Southeastern University
Email: charoudi@mynsu.nova.edu
IRB#: 2019-90; Title, "Community-Based Occupational Therapy Practice Among Older Adults: A Delphi Study

Faculty Mentor
Dr. Lawrence Faulkner
Email: lfaulkne@nova.edu

Appendix D

Informed Consent

General Informed Consent
NSU Consent to be in a Research Study Entitled
Community-Based Occupational Therapy Among Older Adults: A Delphi Study

Who is doing this research study?

College: Dr. Pallavi Patel College of Health Care Sciences, Occupational Therapy Department
Principal Investigator: Kristin Antolino, MOT, OTR/L
B.A. Elementary Education and Master of Occupational Therapy

Faculty Advisor/Dissertation Chair: Dr. Lawrence Faulkner, PhD, OTR/L

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to identify the importance of community-based occupational therapy (OT) services among older adults to improve health, wellness, and quality of life for the prevention of disease. Through utilization of the Delphi Method, anonymous structured communication between subject matter experts (SMEs) in the field of OT practice will:
1. explore indicators that inhibit the presence of OT in community-based practice for the older adult
2. identify OT as an essential service within the community to improve the health, wellness, and QOL for the prevention of disease among older adults.
3. forecast how increased presence of OT in community settings can decrease occupational injustice among the older adult population

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are identified as an expert in community-based OT practice among older adults. Through cyclical feedback from occupational therapy experts such as yourself, the intent of this study is to build consensus to forecast practice guidelines for increasing the presence of occupational therapy in community-based practice among older adults.

This study will include about 10 subject matter experts.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, you will complete 3-4 rounds of questions through electronic survey. This survey will guide you to completing 30 minute Questionnaires. You will complete the initial open-ended survey within 2 weeks of receipt.
After completion of the round one questionnaire you will complete each subsequent questionnaire within a week of receiving it. Each subsequent questionnaire should take 15 minutes to complete. You will be asked to commit to 6-week time-frame to complete this study

Research Study Procedures - As a participant, this is what you will be doing: To begin round one, you will receive a Survey Monkey link to your email. Once you have received the link, you will click on the link and the survey will begin. The first page is the informed consent and you must click yes to agree with the terms and conditions of this research study to begin. After you have clicked yes you will have 2-weeks to answer 5 open-ended questions. The questionnaire will take about 30 minutes to complete. After the 2-week time frame to complete the round one questionnaire, you can expect a round two questionnaire survey link to be emailed to you within 1-week. When you receive the survey link to round two questionnaire you can click on the link and the survey will begin. You will have 1-week to complete the round two questionnaire. After the 1-week time-frame to complete the round two questionnaire you can expect to receive a round three questionnaire survey link within 1-week. When you receive the survey link to round three questionnaire you can click on the link and the survey will begin. You will have 1-week to complete round three questionnaire. If consensus is not reached by the end of the round three a fourth round will be used. If at any time you have questions, please reach out to the researcher.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. The benefits of the study include voicing your opinions, thoughts, and concerns regarding community-based occupational therapy services among older adults. We hope the information from this study will identify the importance of community-based OT services among older adults to improve health, wellness, and QOL for the prevention of disease and forecast practice guidelines to increase the presence of OT in community-based OT practice among older adults

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. The researcher will securely maintain all information collected during this study on her computer with secured password and username. Only the researcher will have access to online material, computers used, and documents saved on a USB. Data transferred onto Microsoft Excel spreadsheets will be de-identified to further protect participant's confidentiality. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you without permission. All confidential data will be kept securely locked in the researcher's office. All data will be kept for 36 months from the end of the study and destroyed after that time by permanently deleting documents on USB, computer, and Survey Monkey.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:
Kristin Antolino, MOT, OTR/L can be reached at 561-997-4648

Research Participants Rights
For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790

IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

Tell the researcher you agree to participate in this research study. You will be given a signed copy of this form to keep. You do not waive any of your legal rights agreeing to this form.

AGREE TO THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date
Printed Name of Person Obtaining Consent and Authorization	Signature of Person Obtaining Consent & Authorization	Date

Appendix E

Round One Questionnaire

Round One Questionnaire- Community-Based OT Practice Among Older Adults

Dear Panelist,
You are invited to take part in a research study regarding community-based OT practice among the older adult population. The researcher is inviting occupational therapy experts in community-based older adult OT practice to be in the study. This document is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by Kristin Antolino MOT, OTR/L, who is a doctoral student at Nova Southeastern University DrOT program.

Background Information:
The purpose of this capstone project is to identify the importance of community-based OT services among older adults to improve health, wellness, and QOL for the prevention of disease. Through utilization of the Delphi Method, anonymous structured communication between subject matter experts (SMEs) in the field of OT practice will:
1. explore indicators that inhibit the presence of OT in community-based practice for the older adult
2. identify OT as an essential service within the community to improve the health, wellness, and QOL for the prevention of disease among older adults.
3. forecast how increased presence of OT in community settings can decrease occupational injustice among the older adult population,

Procedures:
If you agree to be in this study:
1. You will complete 3-4 rounds of questions through electronic survey. Each Questionnaire should take approximately 30 minutes to complete. You will complete the initial open-ended survey within 2 weeks of receipt.

2. You will complete each subsequent questionnaire within a week of receiving it

3. You will be asked to commit to 6 week time frame to complete this study

Voluntary Nature of the Study:
Participation in this study is completely voluntary. Everyone will respect your decision of whether or not you choose to initiate or continue in the study. Additionally, this study is completely anonymous, no one except the researcher will know your responses to each round of questions.

Risks and Benefits of Being in the Study:
Being in this study would not pose risk to your safety or well-being.

The benefits of the study include voicing your opinions, thoughts, and concerns regarding community-based occupational therapy services among older adults. This study aims to identify the importance of community-based OT services among older adults to improve health, wellness, and QOL for the prevention of disease and forecast practice guidelines to increase the presence of OT in community-based OT practice among older adults.

Contacts and Questions:
If you have questions now or at a later time, you may contact the researcher, Kristin Antolino, via charoudi@mynsu.nova.edu. You can ask any questions you have before you begin the survey.

Statement of Consent
I have read the above information and understand the study well enough to make a decision about my involvement. By clicking, YES, I understand and agree to the terms described above.

- o Yes
- o No

Round One Questions

- The value of round one questions are vital to the development of round two questions. Therefore, you are provided with 2 weeks to answer these questions.
- Please provide a detailed explanation for the following questions. When answering these questions, please refer to community-based OT practice as an emerging practice area for the older adult population. Home Health services and inpatient/outpatient rehabilitation or hospital-based OT practice are excluded from this definition.
- After each question you will see a level of confidence rating. Please indicate how confident you feel in your answer to each question

1. In your opinion, how can community-based OT impact the overall health, wellness, and quality of life of older adults living in the community?

2. List and describe current or emerging community-based OT practice areas for the older adult, where OT's are or should be considered essential?

3. Based on the answer in question #2, Why do you think OT's are essential for these interventions?

4. Why do less than 2% of the OT practitioners provide OT services in non-institutional home health or community-based practice?

5. How can the OT profession best develop new roles for OT practitioners within community-based OT practice among older adults? [Consider various options including, academic programs, OT associations, and accrediting bodies.]

6. How confident do you feel about the answers provided to the above questions?

    - Extremely confident
    - Very confident
    - Somewhat confident
    - Not so confident
    - Not at all confident

Appendix F

Round Two Questionnaire

You are invited to continue your participation in a research study entitled Community-Based Occupational Therapy Practice Among the Older Adult Population: A Delphi Study. For round two of the study, you may answer or leave blank any or all questions or statements. You may also choose to request removal from this study at any time by emailing me your request.
This is the 2nd questionnaire of an expected 3-round Delphi study. The following statements are based on previous feedback from the Delphi group in which you are a recognized expert. When considering your response to any statement or question, take it as a whole. If you respond to any question or stamen with a strongly disagree, disagree or no opinion comment, you are encouraged to provide a comment in Question #10 so we can reach consensus by developing a better statement. Even if you agree, comments will be considered and appreciated in order to develop better statements for round 3.
As a reminder, we have defined Community-Based Occupational Therapy Practice as an emerging practice area for the older adult population. Home Health services and inpatient/outpatient rehabilitation or hospital-based OT practice are excluded from this definition.

Statement #1 - Community-Based Occupational Therapy Practice improves overall safety, quality of life, well-being, and health of older adults through engagement in meaningful occupations including preparation for aging, social participation and leisure.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #2- Occupational therapists have the skills to practice in community centers, senior centers, adult daycare and wellness programs for community dwelling elders, and should be considered essential practitioners in these settings.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #3- Occupational Therapists are essential to community-based health since they provide skilled (evidence-based, reasoned, therapeutic) services to individuals or groups that consider and impact the whole person (physical, mental, social) and their "family", their environment (personal and community) and occupations.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #4- There is a need to accurately define the roles and paths to practice occupational therapy in non-traditional community-based practice.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #5- The development of new roles for occupational therapy practitioners within community-based OT practice should start within academic programs as part of emerging practice education and student involvement program development and community projects leading to dissemination.
This assumes community-based occupational therapy practice is occurring at an emerging practice level and has the potential to grow and is not just occurring as an innovative community practice.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #6- Occupational therapists lack the skills to successfully articulate the value, benefits and "brand" of occupational therapy services outside of the traditional practice settings.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #7- Within the community setting, occupational therapists lack the knowledge, business skills and leadership skills, to market themselves and expand the profession outside of traditional settings.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #8- Limited reimbursement of occupational therapy services in community settings has negatively impacted the number of occupational therapists working and developing programs in community practice. Greater education of occupational therapists and managers in community-based wellness and leisure locations and funders is needed to improve awareness of the impact occupational therapy can make outside of the "four walls" of traditionally reimbursed health care settings. This can be done directly or through public speaking, lobbying by individual practitioners or state associations, or participation on community-related boards which impact health initiative funding.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Statement #9- Occupational therapy is an essential service and should be easily available to all older adults in the community to decrease rising healthcare costs and hospital readmissions by optimizing quality of life, health and wellness (including periodic assessment and intervention for minor changes in status), increasing their safety, restoring their prior level of function with daily occupational tasks/routines (activities of daily living/instrumental activities of daily living), and to help decrease the burden of care overall when discharged to their place of long-term residence.

- Strongly Agree
- Agree
- No Opinion
- Disagree
- Strongly Disagree

Question #10- Please provide any thoughts or comments in reference to the above questions or statements, created from the questions in the previous Round of questioning or to the definition of community based occupational therapy used in this study. In this 2nd round, comments are strongly encouraged.

Appendix G

Round Three Questionnaire

You are invited to continue your participation in a research study entitled Community-Based Occupational Therapy Practice Among the Older Adult Population: A Delphi Study. You may answer or leave blank any or all questions. You may also choose to request removal from this study at any time by emailing me your request at charoudi@mynsu.nova.edu.
This is the 3nd questionnaire to start the 3rd-round of this Delphi study. The statements are based on previous feedback from the Delphi group in which you are an esteemed member. The researcher is asking for you to review the remaining statements. When considering your response to any statement, take it as a whole. If you disagree with a portion of a statement, please mark it appropriately and provide a comment. If you respond to any question with a strongly disagree, disagree or no opinion comment, you are encouraged to provide a comment.
As a reminder, we have defined Community-Based Occupational Therapy Practice as an emerging practice area for the older adult population. Home Health services and inpatient/outpatient rehabilitation or hospital-based OT practice are excluded from this definition.

1. Occupational therapists have the skills to successfully articulate the value and benefits of occupational therapy services within community-based practice among older adults.
    - Strongly Agree
    - Agree
    - No Opinion
    - Disagree
    - Strongly Disagree

2. Please provide your comments to question #1

3. Within the community setting, most entry-level occupational therapists lack the knowledge, business skills, and leadership skills, to market themselves beyond established practice roles and locations.
    - Strongly Agree
    - Agree
    - No Opinion
    - Disagree
    - Strongly Disagree

4. Please provide your comments to question #3

Appendix H

Final Participant Survey: Consensus Report

Thank you for your participation in the research study entitled Community-Based Occupational Therapy Practice Among the Older Adult Population: A Delphi Study. You have helped to reach consensus among all subject matter experts (SMEs). This consensus has identified the importance of community-based OT services among older adults as an essential service to improve health, wellness, and QOL for the prevention of disease.
At this stage we are providing the established consensus outcomes and are asking for final comments. Final consensus is met when agreeance among SMEs is measured as 70% of all SMEs strongly agreeing or agreeing with the questions posed (Nicola-Richmond, Pepin, and Larkin, 2016, Hasson, Keeney, & Mckenna, 2011). Below are the statements that have exceeded the 70% agreeance threshold.

6. Community-Based Occupational Therapy Practice improves overall safety, quality of life, well-being, and health of older adults through engagement in meaningful occupations including preparation for aging, social participation, and leisure.

7. Occupational therapists have the skills to practice in community centers, senior centers, adult daycare and wellness programs for community-dwelling elders and should be considered essential practitioners in these settings.

8. Occupational Therapists are essential to community-based health since they provide skilled (evidence-based, reasoned, therapeutic) services to individuals or groups that consider and impact the whole person (physical, mental, social) and their “family,” their environment (personal and community) and occupations.

9. Occupational therapy is an essential service and should be easily available to all older adults in the community to decrease rising healthcare costs and hospital readmissions by optimizing quality of life, health and wellness (including periodic assessment and intervention for minor changes in status), increasing their safety, restoring their prior level of function with daily occupational tasks/routines (activities of daily living/instrumental activities of daily living), and to help decrease the burden of care overall when discharged to their place of long-term residence.

10. There is a need to accurately define the roles and paths to practice occupational therapy in non-traditional community-based practice.

11. The development of new roles for occupational therapy practitioners within community-based OT practice should start within academic programs as part of emerging practice education and student involvement program development and community projects leading to dissemination. This assumes community-based occupational therapy practice is occurring at an emerging practice level and has the potential to grow, not just occurring as an innovative community practice.

12. Occupational therapists have the skills to successfully articulate the value and benefits of occupational therapy services within community-based practice among older adults.

13. Within the community setting, most entry-level occupational therapists lack the knowledge, business skills, and leadership skills, to market themselves beyond established practice roles and locations.

14. Limited reimbursement of occupational therapy services in community settings has negatively impacted the number of occupational therapists working and developing programs in community practice. Greater education of occupational therapists and managers in community-based wellness and leisure locations and funders is needed to improve awareness of the impact occupational therapy can make outside of the “four walls” of traditionally reimbursed health care settings. This can be done directly or through public speaking, lobbying by individual practitioners or state associations, or participation on community-related boards which impact health initiative funding.

1. Please provide any comments to the statements provided above

2. Please provide any comments regarding future directions for this topic / practice area.

Appendix I

Participant Survey: Final Consent for Future Publications

Thank you for your participation in the research study entitled Community-Based Occupational Therapy Practice Among the Older Adult Population: A Delphi Study. I am required to provide the qualifications of all subject matter experts as part of my doctoral project report. I would like to acknowledge you by name as a valued contributor in my Dr. OT project report and future presentations and papers.

1. Do I have permission to use your name and credentials for any future publications?
    - o Yes
    - o No

2. If I have your permission to use your name and credentials for any future publications, please provide your preferred name and credentials.

3. Would you like the final analysis of data and results sent to your email?
    - o Yes
    - o No