Feasibility of a Lifestyle Redesign®–Inspired Intervention for Well Older Adults

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OBJECTIVE. We examined the feasibility of Aging Well by Design, a Lifestyle Redesign®–inspired intervention for community-dwelling older adults. The original Lifestyle Redesign program was shortened to 3 mo and implemented as a community outreach program of a major health care system.

METHOD. Community-dwelling older adults participated in the 12-wk program, which emphasized an occupational approach to healthy aging. Outcomes evaluated were recruitment, attendance, resource use, participant satisfaction, and subjective benefit to participants.

RESULTS. The 13 participants, ages 66–88 yr, attended an average of 10 of 12 sessions. The intervention was completed as planned, physical resources were suitable, and financial resources were adequate. Participants expressed satisfaction with the program's facilitator, group discussions, and materials. Perceived benefits were social relationships, awareness of community resources, and change in attitude toward aging.

CONCLUSION. Implementation of a 3-mo Lifestyle Redesign–inspired program within a health care system was feasible.


Health promotion is increasingly important, and it is expected to be part of the new paradigm of health care (Hildenbrand & Lamb, 2013). As part of health care reform, providers have responsibility for a broad spectrum of health care needs, and routine health maintenance plays an important role. Clark et al. (1997, 2012) demonstrated that Lifestyle Redesign® is an effective approach to health promotion for community-dwelling older adults. However, clinicians perceive this 6- or 9-mo program (depending on the study) as too long and resource intensive for health care systems to implement. Therefore, it is useful to know whether a shorter version, delivered as community outreach by a major health care system, is feasible. This study investigated the feasibility of Aging Well by Design, a shortened version of the Lifestyle Redesign program.

Literature Review

Engagement in meaningful activities is associated with positive health outcomes and should be the foundation of health promotion programs for older adults in the community (Stav, Hallenen, Lane, & Arbesman, 2012). Lifestyle Redesign (Mandel, Jackson, Zemke, Nelson, & Clark, 1999), a program designed to foster lifestyle change by encouraging greater participation in meaningful activities, facilitates such occupational engagement, delays age-related decline in function, and reduces health care costs (Clark et al., 1997, 2012; Hay et al., 2002). In the original studies, occupational therapy intervention consisted of weekly small-group sessions...
for 6 or 9 mo and monthly individual sessions between the occupational therapist and each participant. People who participated in the Lifestyle Redesign program maintained self-reported health and quality of life. Both the no-intervention control group and the social activity control group, however, experienced declining health and quality of life, demonstrating that the occupational therapy intervention reduced health decline and promoted well-being (Clark et al., 1997, 2012).

Although Lifestyle Redesign is beneficial, the majority of health care systems have not adopted this approach (Clark, Park, & Burke, 2013). Clark and colleagues (2013) suggested that this lack of program adoption may be due to the absence of a well-defined knowledge translation plan. Such a plan needs to overcome potential barriers, such as the dearth of funding for prevention, the scarcity of clinicians working in community settings, and participants’ time constraints. A shorter program provided within an existing health care system may offer a solution. Therefore, the purpose of the current study was to test the feasibility of Aging Well by Design, a health system–sponsored 3-mo Lifestyle Redesign–inspired intervention for community-dwelling older adults.

Method
The aim of this feasibility study was to determine whether implementation of the Aging Well by Design program was possible rather than to determine behavior change outcomes among participants. Following the recommendations of Tickle-Degnen (2013), results are presented by means of descriptive statistics, qualitative data, and descriptions of administrative and physical infrastructure.

Setting
This study was implemented through the rehabilitation department of a large health care system. The primary investigator (Theresa Cassidy), a licensed occupational therapist who worked in the outpatient department, traveled to a nearby affiliated primary care clinic and held the sessions in the conference room. The conference room, which was accessible from the waiting room, had a large table, comfortable chairs, and easy access to a small kitchen and bathrooms. We chose this site because of its central location in the city, bus route access, and ample parking.

Participants
Eligible participants were English-speaking, community-dwelling adults age ≥65 yr who had passed the Mini-Cog, on which failure is indicated by not recalling any of the three words or by incorrectly drawing the clock and not recalling one or two words (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000). Participants did not need to be patients of the primary care clinic at which the program was implemented. We recruited participants through advertisements at primary care physicians’ offices, senior centers, and a local publication of the health care system.

Program Description
The Aging Well by Design program was created to address the varied health and well-being needs of the community-dwelling older adult population in our local area. The program consisted of 12 weekly 2-hr group sessions facilitated by an occupational therapist and an older adult hospital volunteer. Two 60-min individual sessions with the occupational therapy facilitator, which took place at the participant’s home or the group meeting site, were offered to individualize the class material, set personal goals, and address participants’ needs on an individual basis. For example, 1 participant who struggled with depression was able to talk about her challenges, set a goal of attending the eight remaining group sessions, and learn about support group and counseling resources.

The program’s content was based on Lifestyle Redesign (Clark et al., 2012; Jackson, Carlson, Mandel, Zemke, & Clark, 1998). All topics covered in the Lifestyle Redesign studies were also presented in Aging Well by Design with the exception of multicultural awareness. Because of Aging Well by Design’s compressed time frame, we focused on one topic per session rather than spending multiple weeks on one topic. Table 1 lists the setting, participants, and duration of the Aging Well by Design program compared with the Lifestyle Redesign program in the Well Elderly studies (Clark et al., 1997, 2012). Supplemental resources for developing specific module content included reports of Lifestyle Redesign–inspired intervention studies (Carlson, Clark, & Young, 1998; Mountain & Craig, 2011), a doctoral dissertation on a Lifestyle Redesign–based program (Lipshutz, 2001), and the first-edition handbook for Lifestyle Redesign (Mandel et al., 1999).

Session activities and discussions were designed to empower participants to increase their sense of well-being by making health-supporting activity choices. For example, participants examined their daily activities and discussed ways to include exercise or to add stress management as appropriate. The schedule of topics was as follows: the Power of Occupation; Health and Aging: Changes in Occupation; Meaning and Identity; Life Balance: Time and Energy; Outing; Health through Occupation: Physical and Mental Activity; Dining as an Occupation; Transportation and...
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Occupation; Outing; Social Relationships; Community and Home Safety; Celebration and Closing.

Each participant received a binder to organize handouts and program information and received class notes after each session. The two community outings, a tour of the modern library and an adapted yoga class, were interspersed throughout the program to give participants a chance to explore new occupations in a supported environment. The content of the modules introduced participants to resources in the community such as senior center programming, transportation options, and counseling resources.

Aging Well by Design used four program delivery methods that are integral to all Lifestyle Redesign–based programs: didactic presentation, peer exchange, direct experience, and personal exploration (Jackson et al., 1998). For example, on the topic of transportation and occupation, the didactic portion included education about how transportation availability influences people’s occupational choices. A guest speaker from Metro Transit gave a presentation about the public bus system, and another guest speaker, a mobility manager for the community, led a discussion about the relationship between housing and transportation concerns. Peer exchange was facilitated to encourage sharing of current and expected future modes of transportation. The direct experience consisted of participants examining bus schedules and maps to learn what transportation strategy could work for them. Participants were asked to write down, then discuss, how they would get around if they did not have a car for a week. The personal exploration aspect encouraged reflection on how transportation enables or limits occupations, and participants discussed their response to the idea of eventual driving retirement.

Measures

Per Tickle-Degnen (2013), we assessed recruitment rate, program attendance, program completion rate, the process of the intervention, resource management needs, and participant satisfaction. We obtained gender, age, education, living situation, and medical history information via questionnaire. The process of intervention and resource management aspects were assessed with feasibility questions such as “What was the response to program advertising?” “What was the refusal rate for participation?” “Was the physical capacity of the site adequate?” and “Were the time frames realistic?” (Tickle-Degnen, 2013).

The participant satisfaction survey included questions about the facilitator, the group discussions, the activities, and the handouts. Items were scored on a 4-point Likert scale (ranging from strongly agree to strongly disagree) with space for comments.

Participants also completed the SF–36 (Hays, Sherbourne, & Mazel, 1993) as a measure of health-related quality of life (HRQOL), the Engagement in Meaningful Activities Survey (Goldberg, Brintnell, & Goldberg, 2002), the Meaningful Activity Participation Assessment–Frequency (Eakman, Carlson, & Clark, 2010), and the Geriatric Depression Scale–Short Form (Sheikh & Yesavage, 1986). Results from these measures are not reported in this article because our intent was only to determine feasibility, and the sample size was insufficient to draw conclusions. Each participant completed a 45-min exit interview with the first author (Cassidy) in which they were asked open-ended questions about expectations going into the program, whether their expectations were met, and what they thought was beneficial about the program (questions available on request to first author). The exit interviews took place individually at the group meeting site or at participants’ homes. They were audio recorded, transcribed, and coded for themes using generic qualitative analytic coding (Kahlke, 2014) by the first author and verified by the other authors.

Table 1. Comparison of Study Characteristics: Well Elderly Studies and Aging Well by Design Study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Well Elderly</th>
<th>Well Elderly 2</th>
<th>Aging Well by Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Government-subsidized housing complex for older adults</td>
<td>Wide array of community settings</td>
<td>Conference room of primary care clinic</td>
</tr>
<tr>
<td>Length of intervention, mo</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Participants at baseline</td>
<td>Community-dwelling adults age ≥60 yr with an average physical functioning score of 77/100 on SF–36</td>
<td>Community-dwelling adults age ≥60 yr with an average physical functioning score of 38 (mean = 50) on SF–36 Version 2</td>
<td>Community-dwelling adults age ≥65 yr with an average physical functioning score of 72/100 on SF–36</td>
</tr>
<tr>
<td>Therapist affiliation</td>
<td>Licensed occupational therapist working in a community-based program, funded by NIH grant</td>
<td>Licensed occupational therapist working in a community-based program, funded by NIH grant</td>
<td>Licensed occupational therapist working for the rehabilitation department of a large health care system</td>
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Note. NIH = National Institutes of Health.
Procedure

All relevant institutional review boards approved the study. Participants signed a consent form, completed demographic and HRQOL questionnaires, and then began the intervention program. Exit interviews were completed 1–4 wk after completion of the program.

Results

Recruitment and Attendance

Twenty-two potential participants inquired about the program across 4 wk of advertising. We had planned on two simultaneous groups but, as a result of slow recruitment, decided to start the first group with 7 participants while recruitment continued. Therefore, the groups were staggered. Of the people who inquired, 5 chose not to participate, and 2 failed the cognitive criteria for participation. Refusal reasons included duration of commitment and schedule conflicts. Fifteen participants (14 women, 1 man) enrolled in the programs. However, 2 dropped out about halfway through, citing a change in other commitments and conflicting times. Participants completing the program (n = 13) attended an average of 9.9 (standard deviation = 1.1) of 12 sessions (range = 8–11). For individual sessions, each participant completed at least 1 session, and 5 participants completed 2 sessions.

Participants

Participants were ages 66–88 yr and lived independently in the community, and all but 1 drove themselves to the sessions, indicating a high level of function. Of the participants, 49% had a college degree. All participants except 2 were retired. Seventy-eight percent of participants lived in a house; 50% lived alone.

Feasibility of Data Collection

Administration of study questionnaires took about 30 min; all questionnaires were more than 95% complete. The participant satisfaction survey took 10 min of the final session. The facilitator kept reflective notes after each session, and the hospital volunteer took notes on the group discussions to be handed out at the next session. All participants completed the exit interviews according to plan.

Physical and Financial Resources

The group sessions were held in the conference room of a primary care office. The occupational therapy facilitator (author Cassidy) used the phone, computer, and copy machine at the outpatient rehabilitation department to plan, schedule, and prepare for the group sessions. She provided her own transportation to the group and individual sessions.

The local hospital of a statewide health care system sponsored Aging Well by Design. The chief executive officer of the hospital supported the program because it extended the hospital’s mission into the community. She made it possible to obtain funding from the hospital’s Leadership Circle for supplies and food ($1,000) and allowed the Rehabilitation Department to pay for the therapist’s time. The program stayed within the projected budget.

Personnel and Supplies

The occupational therapy facilitator was allowed work time to prepare for and run the groups. All of the phone calls and scheduling, correspondence with participants, and snacks for each week were arranged by the occupational therapist. Between planning and running the groups and individual sessions, the occupational therapist spent an average of 10 hr/wk on the intervention. A hospital volunteer who helped run the groups was instrumental in discussions, taking session notes, and helping with set up and clean up, which took an additional 4 hr/wk. Supplies included three-ring binders for each participant, name tags, dry erase markers and board, and photocopied handouts. Light refreshments were also provided.

Impact on Participants

In this article, we report only on the qualitative themes emerging from the exit interviews because there were too few participants to statistically examine quantitative data. All participants selected agree or strongly agree on all of the program satisfaction questions on the participant survey regarding the facilitator, the group discussions, the activities, and the handouts. They all indicated they would recommend the program to a friend.

Three themes related to program participation emerged from the exit interviews in response to the question “In what ways, if any, do you feel the program was beneficial to you?” One theme was the benefit of social relationships. For some participants, meeting new people was the reason they were interested in the program. In general, participants enjoyed getting to know the other attendees, and the program helped them to see the importance of social relationships. One participant stated, “I have enjoyed the class tremendously. And the one really positive, positive thing that came out of it, we are all meeting each other after the class.”

A second theme was awareness of community resources. Participants enjoyed sharing resources and learning from each other. Group members were encouraged to bring
resources about services, classes, and volunteer opportunities to the sessions. These resources were added to the class notes. One participant noted, “I learned a lot of things I wasn’t aware of. There are so many things, but you don’t know exactly where to find them.”

The third theme was that the participants had changes in attitudes toward aging because of the program. One participant reported,

Yes, I have, I definitely can say I have [made changes]. I think it’s more of an attitude change, more than a behavioral or actions taken. Knowing that, um, it’s only me stopping me from acting on the things. Like I know I can go out and meet people, or going to this, or I can explore that. And those are things I didn’t even think about before.

Another participant discussed a change in perception of aging:

I think what I will carry with me in the aging process is that you can age well. Things can happen that you are not expecting, but we need to be putting all of these things in place if you don’t have them in place already.

Discussion

Prevention and wellness are key parts of health care reform in the United States (Hildenbrand & Lamb, 2013). Lifestyle Redesign is built on the idea that teaching individuals about the importance of occupation and helping them to find meaning and engagement in daily activities can have long-term health-promoting effects (Jackson et al., 1998). Despite results that support the effectiveness of Lifestyle Redesign (Clark et al., 1997, 2012), there is little implementation of this program for older adults through existing health care organizations.

The Aging Well by Design study addressed potential barriers and demonstrated that a 12-wk Lifestyle Redesign–inspired program was feasible with the resources that were available to a large health care system. Recruitment was sufficient to hold two groups. Therapist time was reasonable and would decrease with repetition of the program because much of the agenda and course materials could be reused. The high attendance rate indicates that program frequency, intensity, and duration were acceptable to community-dwelling older adults. We acknowledge that the shorter time frame may have affected participant engagement or absorption of information and that we relied on participant feedback to determine feasibility. Participants were satisfied with the program, felt that it was beneficial to them, and would recommend the program to a friend.

We recommend two changes for future programs. First, we underestimated how long participant recruitment would take: More recruitment time should be planned and advertising increased, including using different media. In addition, individual sessions were not as much of a focus as expected. Sessions were offered but not required. Every participant completed at least one individual session, and several completed two, but they did not specify these sessions as a benefit of the program. The reason for this difference from the Lifestyle Redesign studies is not clear and warrants further study. Because individual sessions are a particularly resource-intensive aspect of the program, future studies should further evaluate the inclusion of individual sessions and who is likely to benefit most from them.

Participants identified that a benefit of the program was increased social relationships. Such increase in social connectedness is similar to that found by participants in previous studies of Lifestyle Redesign (Clark et al., 1997, 2012). The increase in social relationships experienced by the participants is important because although social isolation is a growing concern for older adults, social engagement is strongly related to both well-being and physiological health (Dahan-Oliel, Gelinas, & Mazer, 2008).

Two additional themes that participants identified as a benefit of the Aging Well by Design program were increased awareness of community resources and changes in their attitudes about aging that they experienced as a result of the program. These benefits offer avenues to develop positive control beliefs. Perceived control is linked to health and well-being (Lachman, 2006) and has been upheld as a key to successful aging (Carlson et al., 1998). Our qualitative results are similar to those of other Lifestyle Redesign–based programs that facilitate the development of “new perspectives,” the “incentive to act” (Lipshutz, 2001, p. 48), and “confidence, self-efficacy, and overall well-being” as outcomes (Mountain & Craig, 2011, p. 48).

Limitations and Future Research

Although our sample was small, as is appropriate for a feasibility study, the small sample limited our ability to draw conclusions about participant outcomes. However, this feasibility study lays the groundwork for a larger efficacy trial in which dosing, participants’ short-term and long-term behavior change, and quality of life and potential moderating variables such as participants’ functional ability can be examined. In addition, future studies should look at potential benefits of the Aging Well by Design program with groups that have a greater variety of functional ability because our participants were all high-
functioning, well older adults. The format and topics of Aging Well by Design are general in nature and could be customized to a particular population, as has been done by Lund, Michelet, Kjeken, Wyller, and Sveen (2012) for stroke. Future research should examine the feasibility of customizing the group intervention for individuals with other diagnoses or those at risk for a certain condition.

Implications for Occupational Therapy Practice

The results of this study suggest that it is feasible for occupational therapy practitioners, with support from their facility, to deliver a 3-mo Lifestyle Redesign–based program targeting prevention of age-related decline in health. ▲

References


Goldberg, B., Brintnell, E. S., & Goldberg, J. (2002). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. Occupational Therapy in Mental Health, 18, 17–44. https://doi.org/10.1300/J004v18n02_03


