

pronouncements (eg, “I know I’m well when my doctor tells me I’m well”^[14]). In contrast to these findings, a study by Miller and Iris^[15] found that older adults have a greater sense of self-efficacy toward their health status as they age, hypothesizing that this leads to greater engagement in their health care.

Over the past several years, senior housing communities have recognized the value of wellness-focused care and have developed whole-person programs that encompass interventions from all 6 wellness domains^[15]. A survey deployed to 81 Continuing Care Retirement Communities (CCRC)^[16] sought to examine the current state of wellness programs. The majority of CCRCs included in the study had offered, at a minimum, foundational components of activities within multiple domains of wellness, or they articulated plans to develop such activities within the next 12 months. Older adults were most likely to participate in interventions organized around group social activities, followed in order of popularity, by health check-ups and fitness assessments. Organized sports, employment, and individual health and fitness coaching garnered minimal participation. CCRC-supported wellness-programs offered emotional and occupational interventions less frequently than activities focused on the other dimensions of wellness.

Community-driven wellness interventions in CCRCs have had a positive impact on health outcomes^[16] with respondents reporting a moderate impact on health care operational costs, use of health care centers, use of medication, reduced emergency room visits, reduced hospital readmissions and a reduced number of falls. Also, wellness programs positively influenced older adult and family satisfaction and improved health care decision-making. Although the programs demonstrated positive outcomes, the greatest challenge was soliciting resident participation^[16]. Marginal participation may be related to a failure to design interventions around the values, motivations, and priorities of older adults. Allocating resources to the development of community-based wellness interventions without identifying and incorporating older adult’s wellness priorities is not likely to substantially increase participation or enhanced community health outcomes.

As policy makers, health care providers, and scientists prepare to provide evidence-based preventive care for an aging US population, wellness-centered interventions administered in the community must be recognized as viable tools for reducing the increasing economic burden of caring for older adults. Thoughtful reallocation of dwindling resources will maximize benefits and reduce the financial and societal costs associated with maintaining acuity among older adults^[2]. Review of the current literature demonstrates that theoretically derived definitions of wellness have been established for older adults^[4] using measures such as physical activity, social engagement, freedom from pain, and absence of disease, all of which are associated with wellness^[13,14]. As such, older adult communities have established programs to embrace wellness care^[16]. Few of these programs specifically engage older adults to understand their wellness priorities. Older adult’s wellness priorities are similarly absent in the current literature. The primary aim of this study is to understand older adults’ wellness priorities.

Method

This study sought to answer 2 questions: (1) What is the wellness priority among older adults within each of the 6 dimensions of wellness (occupational, social, intellectual, physical, emotional,

and spiritual)? (2) Do older adults have wellness priorities in areas other than the 6 dimensions of wellness?

Theoretical framework

According to William Hettler in *The Six Dimensions of Wellness*^[10], wellness is multidimensional; the integration of 6 dimensions completes a person. Hettler’s framework provides a method of analyzing older adults’ wellness priorities in a multi-dimensional holistic framework that incorporates 6 domains. The theoretical definitions for each dimension are listed in **Table 1**.

Sample

Nationally, COLLAGE is recognized as a consortium of organizations seeking to improve the quality of life for older adults and establish a leading model for keeping older adults across all socioeconomic levels active and independent^[17]. This organization represents older adults living in CCRC, residing in moderate-income and federally subsidized housing, receiving home care, and actively participating at local community centers.

Individuals from the COLLAGE consortium from 22 states who completed a Wellness Assessment Tool (WEL) between the years of 2007 and 2012 (n = 9783) were initially included in this analysis. Adults younger than age 65 who were not living in the community at the time of the assessment were excluded from the study. Older adults who did not list a wellness priority were also excluded, yielding a total sample of 848.

Measurement

Wellness was measured using the WEL, a patient-centered instrument that allows older adults to express interest in, or intention to, participate in wellness activities. This tool seeks to investigate behaviors in the following areas: exercise and physical fitness, nutrition, social relationships, emotional and spiritual dimensions, practices affecting health and wellness, recreation, sleep, and wellness priorities. Assessment data are collected through a one-on-one conversation with trained personnel, or independently by participants with a subsequent review with a staff member. Staff trainees are registered nurses, social workers, activity directors, or fitness staff member^[17]. With the assessment complete, the older adult is provided an opportunity to identify 1 or more personal wellness priorities. Priorities are established through conversation with the trained personnel and entered as text in an open-ended response in an electronic program that is housed within the COLLAGE database. CCRCs enrolled in COLLAGE have access to their population-specific data to guide intervention development; participants receive a print out of their WEL report and wellness priorities and review their outcomes yearly with trained personnel.

Analysis

To understand participants’ wellness priorities, particularly as they relate to Hettler’s^[10] 6 primary wellness priorities mentioned above, a subsample (15%, n = 128) of the larger data set (n = 848) was content coded by systematic examination of data used to identify patterns and themes in written and verbal communications^[18]. Because this study sought to expand upon previously identified themes and patterns (ie, Hettler’s Six Dimensions of Wellness)^[10], the coding approach was 2-fold. The

Table 1
Hettler’s theoretical dimensions of wellness and operationalized examples.

Dimension of Wellness	Definition	Examples
Social wellness	Ability to form and maintain positive personal and community relationships	Social engagement (movies, concerts, activities) in groups Support groups Pets Family Computerized games
Intellectual wellness	Commitment to lifelong learning through continuous acquisition of skills and knowledge	Crossword puzzles Education courses Reading Musical instruments Crafts/arts Writing Cognitively ability (Alzheimer disease, dementia, losing mind, etc.)
Physical wellness	Commitment to self-care through regular participation in physical activity and healthy eating	Physical activity (walking, running, gardening, yoga, Pilates, weight training, video fitness, group fitness) Nutrition interventions Physical health (disease, falls)
Emotional wellness	Ability to acknowledge personal responsibility for life decisions and their outcomes with emotional stability and positively	Stress-reduction interventions (positive affirmations, stress education classes) Happiness Well-being Does stress have a negative effect on your quality of life?
Spiritual wellness	Having purpose in life and a value system	Religious activity involvement (church, prayer, Bible study) Spiritual activities (meditation, yoga, tai chi)
Occupational wellness	Meaningful paid or unpaid work	Volunteering Career

initial cycle involved a summation of data within the theoretical framework using provisional content coding^[19] to determine if, and how, the data corroborated or expanded upon the 6 dimensions of wellness; resultant summaries were grouped into more specific themes and constructs in stage 2^[19]. A list of codes and definitions for each wellness priority previously identified and recorded by previous researchers (Table 1) was applied with provisional coding used to detect inconsistencies between our study data and Hettler’s 6 wellness priorities. A pattern and focused coding technique^[19,20] facilitated the synthesis of emerging themes and integration of theoretical ideas that elaborated on or integrated multiple dimensions of wellness. The data analysis was conducted using pen and paper, and Microsoft Excel.

Results

Of the 128 participants, the mean age of adults in the sample was 83.29 years; 73% of the sample was female and 27% male. On the basis of content coding of the data, 94.5% of eligible participants articulated 1 or more of the following wellness priorities: physical wellness (n = 82, 64.1%), social wellness (n = 57, 44.5%), emotional wellness (n = 21, 16.4%), intellectual wellness (n = 15, 11.7%), spiritual wellness (n = 5, 3.9%), and occupational wellness (n = 4, 3%; Table 2). Also, 52 participants (40.1%) reported a desire to achieve 2 or more of the core wellness priorities, and 13 participants (10.2%) reported nonspecific or general wellness priorities (eg, “stay healthy through all 6 dimensions”).

Table 2
Wellness frequencies and sample goals in 6 wellness domains.

	Frequency	Percentage	Example Goal
Physical wellness	82	64.1	“Looking for accurate diagnosis for medical problem”; “Improve sleep” “Improve knees and ankles”; “find a way to improve incontinence” “To be pain free” “I want to keep swimming every other day” “To have better balance and decrease falls” “Lose 5 pounds then maintain weight”
Social wellness	57	44.5	“Maintain independence living in a apartment” “To enjoy my time with my wife and family and friends” “Continue to maintain her apartment and take care of her dog” “To get back into activities I enjoy and try new ones”
Emotional wellness	21	16.4	“To keep sense of humor and sense of balance” “Enjoy life despite having Parkinson’s” “Have peace of mind”
Intellectual wellness	15	11.7	“Learn new things,” “write poetry” “I like challenges and want to stay busy” “To participate in mental exercises for memory”
Spiritual wellness	5	3.9	“Explore opportunities for Bible study”
Occupational wellness	4	3	“Continue with volunteering”

Physical wellness priorities in 6 subcategories comprised 64.1% of aggregate wellness priorities and included general physical health (eg, stay out of the hospital, improve sleep, control medications); specific health issues and ailments (eg, stomach problems, acid reflux, incontinence); pain management (eg, decrease pain); physical activities, including increasing and maintaining current physical activities (eg, swimming, weight lifting); walking, balance exercises, and mobility (eg, stay mobile, improve balance, stand on own); and diet or weight-related (eg, lose weight, eat right).

A large percentage of wellness priorities (44.5%) reflected efforts to achieve social wellness with priorities in 4 subcategories: independence, family and friends, pets, and social engagement/activities. Thirty-eight participants identified independence, which was defined as living in one's own home, being able care for the self, or being able to drive, as an important wellness priority. Nineteen participants identified family and friends as important factors in social wellness; 6 participants reported staying healthy so they could be social with others and take care of or spend time with other family members (eg, spouse, grandchild). Thirteen subjects reported wanting to maintain or improve their social relationships. For example, subjects wanted to enjoy their time with family and friends, and be more supportive of or compassionate toward others.

The third wellness category, emotional wellness, encompassed 16.4% of all wellness priorities in the aggregate. The 3 primary subcategories included positivity, positivity despite stressors and general wellness. Eleven subjects focused their emotional wellness efforts on being positive, such as keeping a sense of humor, being content and living life to the fullest, and keeping a positive frame of mind. Two subjects grounded their positivity in their failing health. For example, one subject's priority was to "enjoy life despite having Parkinson disease" and a second subject's priority was to "learn to live with reduced vision." Five participants reported additional, more general emotional wellness priority, such as staying active emotionally, maintaining a quality of life, being more motivated, and having peace of mind.

The fourth category, intellectual wellness, included 11.7% of participants' priorities. Intellectual wellness included 3 subcategories: specific activities, quality of activities, and mind/memory. Participants listed various activities they engaged in regularly, (or wished to) to improve their intellectual wellness: reading, writing, quilting, and playing an instrument are some of the activities identified. One participant reported seeking challenges and a desire to stay busy. The remaining 8 participants who identified intellectual wellness priority focused on mind and memory, with 2 subjects wanting to stay active mentally, 5 seeking to improve or maintain memory, and 1 wanting to "keep tasks and thoughts clear and straight."

Occupational and spiritual wellness priorities were important to limited numbers of participants with, 3% and 3.9% prioritizing wellness in these areas, respectively. In describing occupational wellness priorities, 1 participant reported wanting to reduce volunteer work while another wished to continue volunteering. Another participant wanted to work part-time for wages. In the spiritual wellness category, 1 participant reported more general priorities. A second participant wanted to explore opportunities for Bible studies, and a third participant wanted to "live one day at a time ... enjoy each day God has given" him.

Discussion

The primary aim of this qualitative analysis was to address the gap in the literature characterizing older adults' wellness priorities within a multidimensional wellness framework. The top 3 priorities among older adults included in this analysis were physical, social, and emotional wellness priorities. Physical wellness, reflected in 6 subcategories, was overwhelmingly identified as the highest priority ($n=64.1\%$). The subcategories included general health management; coping with specific health issues or diseases; pain management; physical activity; and diet or body weight. Priorities in the social wellness dimension included 4 subcategories: independence, family and friends, pets, and social engagement/activities. The majority of participants ($n=38\%$) identified independence, or the ability to remain in their home, provide adequate self-care, and retain the ability to drive, as their highest priority. Sixteen percent of emotional wellness priorities fell into 3 subcategories: positivity, positivity despite stressors, and general wellness.

Results align with Vom Hymboldt et al's^[13] findings, identifying physical activity and absence of disease as strong predictors of older adult's belief in their ability to be well. Analysis also associated with Campbell and Kriedler's^[14] study which observed that mobility and social activity are critical components of older adult's well-being. Although physical activity, management of health issues, diet, and weight were also assigned priority by many older adults in our sample, Centers for Disease Control (CDC)^[15] data indicate poor performances in these areas: 27.5% meet the criteria for obesity; 32% are not physically active; and 40% did not receive an influenza vaccination. The disparity reflected in these study findings suggest that older adults require enhanced support systems to enhance their physical wellness and facilitate meeting physical wellness priorities. Older adults are interested in activities centered around physical wellness and demonstrate engagement when provided appropriate opportunities and support; the greatest participation in wellness program interventions in CCRCs included group social activities, health check-ups, and fitness assessments^[16]. Study of CCRC wellness programs shows that they offer few emotional wellness interventions. Emotional wellness was another dimension of wellness identified as a top priority among older adults in this analysis. While participation was recognized as the greatest challenge to wellness programming in CCRCs, offering interventions aligned with self-identified older adult priorities may increase engagement. Wellness programs within CCRC communities have demonstrated positive health and wellness outcomes; effective programs should be expanded beyond CCRCs and aligned with older adult priorities. Data from the CDC^[4] suggest that the current approach to wellness in aging may not meet older adult's physical health needs or priorities.

The secondary aim of our analysis was to identify areas outside of Hettler's^[10] 6 domains that were perceived as a priority among older adults. This analysis revealed the critical role of establishing wellness priorities as a strategy for maintaining independence among older adults. Independence was revealed as a common theme threaded across participants' wellness priorities, reflecting relative consistency between Hettler's^[10] overarching theoretical framework and self-reported wellness priorities revealed in the data used in this analysis. Independence represented the ability to engage socially with family and friends; to live according to their current standards; to remain at home, and to enjoy life.

Independence was viewed as the primary outcome, and behaviors within each wellness domain were seen methods of sustaining independence. A threat to wellness priorities, such as a debilitating illness, not only negatively impacts older adults' health, but also their ability to maintain their current lifestyle and level of independence. Outside the 6 domains, independence appears to be an overarching construct which encompasses, and builds on Hettler's^[10] 6 dimensions. Independence is not the seventh dimension of health, but rather it is a lifestyle quality manifested vis-a-vis personal priorities related to the 6 original dimensions of wellness, or perhaps represents the outcome of achieving wellness in 6 domains. Older adults may view the outcome of wellness and independence, and thus greater participation in programming may be seen if activities were marketed toward independence rather than wellness.

Our findings align with Rowe and Kahn's^[21] model of successful aging, which is defined as engagement with life, absence of disease and disability, and intact physical and cognitive function. This 1998 model was developed to highlight the modifying effects of aging but did not include the voice of the older adult. Our study aimed to identify older adult wellness priorities, rather than define successful aging as reflected in wellness. Although older adults' priorities align with the constructs of Rowe and Kahn's^[21] model, our analysis revealed that success might be interpreted by older adults as independence and wellness priorities provide a pathway for achieving "success." Following a systematic critical review of successful aging models, researchers have critiqued current models as they do not include the older adult's priorities and they omit extrinsic factors that impact behaviors, such as policy, economics, socioeconomic class, and culture^[22]. Others argue that defining "successful" aging is polarizing, condescending, and degrading, as it contributes to ageism and discrimination aimed at older adults who do not age "successfully"^[22]. Currently, few older adults living in the United States meet the criteria for successful aging (11.9%), which has led many to seek to expand the definition and loosening current guidelines^[23] or perhaps focusing on older adults priorities would be a more effective method to measure success.

Our analysis reveals that older adults prioritize wellness, but do not appear to receive adequate support in achieving health priorities. A great percentage of older adults do not meet recommended physical health guidelines set forth by the CDC^[5]. Hence a low percentage of older adults are prepared to age "successfully." Policy makers, health care professionals, and other stakeholders must review the current wellness practices, with an eye to aligning those practices with older adults' values, preferences, and priorities. Providing support and resources to facilitate achievement of older adults' physical, social, and emotional wellness priorities will promote their independence. Failure to prioritize implementation of evidence-based, community-centered wellness programs, behavioral interventions recommended through a shared decision-making framework, and policies that support wellness across socioeconomic classes and cultures is a failure to provide quality, patient-centered care.

It may be impossible to agree on a model that classifies an older adult as "successful" or "well" considering definitions of aging success vary widely among older adult populations. Wellness is a continuum^[3] that reflects older adults' ability to create and reflect on personal priorities and values^[7-12]; these cannot be standardized. Wellness is an evolving process; achieving a high level of wellness in one domain positively affects wellness in other

domains^[7]. Although we identified independence as an outcome of achievement within each of the 6 domains of wellness, we found that wellness in just 1 domain facilitates independence. For example, engaging in walking facilitated the ability to walk independently. According to Rowe and Kahn's^[24] definition of successful aging, an older adult with a disability could not age "successfully." In our findings, a disability did not equate with dependence. Older adults with visual, hearing or physical disabilities could hypothetically utilize devices and aids to compensate for disability to remain independent.

Health care providers must commit to guiding patients in achieving their sense of wellness. But, barriers exist within our current health care system. Our current system is based on a disease model, with less attention on the cultural aspects that influence the patient^[25]. But, to understand wellness, we need to understand illness, which is a multifaceted domain extending beyond the physical to the social, psychological, and cultural^[26,27]. Given the time spent with a primary care provider (PCP) is often 13–16 minutes^[27] it is quite difficult for providers to spend additional time with their patients to identify, through shared decision-making, wellness priorities. This problem will only increase, as the prevalence of chronic disease is continuing to rise along with a need for more primary care providers^[28,29]. Older adults can be overwhelmed by this disease-focused framework.

Limitations and future research

Important to note is the sample size. Determining causal factors or generalizing our findings to a larger population was not the purpose of this analysis. Rather, the purpose was to examine wellness priorities identified by respondents in the study sample to facilitate the emergence of new themes. The small sample size allowed us to examine individual data points (ie, stated wellness priority) independently of others while allowing flexibility to compare and contrast all data points. This exploratory approach allowed identification of new patterns and themes. Future efforts will test the conclusions regarding independence and the 6 original wellness priorities with data from the larger COLLAGE data set. Testing newly identified themes across a larger sample will allow for more robust and verifiable conclusions that will inform policy making and implementation. Additional limitations include omission of socioeconomic status in the data and potential self-selection bias generated by independent living individuals who participated in the wellness assessment. Older adults who are more motivated to focus on wellness or those who live in varied care settings may articulate different wellness priorities than those who are less motivated or those who do not live independently.

Future research should examine older adults' wellness needs and accessible, relevant resources with a focus on gathering their input on resources, systems, environments, and infrastructure that would support their ability to engage in wellness behaviors and to remain independent as they age. Such research should investigate the wellness priorities of older adults across socioeconomic groups and care settings (ie, long-term care, residential care, or those enrolled in home care) to enhance understanding of the impact of these additional variables on wellness in aging.

Conflict of interest statement

The authors declare that they have no financial conflict of interest with regard to the content of this report.

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