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Preparedness of Arizona Speech-Language Pathology, Physical Therapy, and Occupational Therapy Practitioners Caring for People Living with Dementia

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Abstract This study explores the preparedness of Speech-Language Pathology, Occupational Therapy and Physical Therapy Practitioners to effectively care for people living with dementia in Arizona. Eighteen mixed profession focus groups were conducted with a purposive sample of 74 practitioners. Demographic data were collected along with perceptions of their dementia training, dementia knowledge, and comfort with working with patients with dementia. A qualitative, open-ended discussion format was used to further explore practitioner perceptions of their preparedness for working with individuals with dementia. While most respondents reported feeling knowledgeable about Alzheimer's disease and related dementias and comfortable working with affected patients, fewer demonstrated confidence in evidence-based therapeutic approaches. Most participants had not completed dementia-specific continuing education, and perceptions of entry-level training quality were variable, with more than half of the participants rating it as neutral or lower. Despite high levels of perceived general knowledge and comfort working with people living with dementia, interviews revealed knowledge gaps and challenges that impact the care provided. The qualitative analysis revealed four primary themes: (1) Therapeutic potential of patients with dementia is influenced by practitioner knowledge, patient characteristics, and carepartner support; (2) Practitioners require enhanced dementia-specific knowledge and communication strategies for best practice; (3) External factors, including setting specific challenges, reimbursement constraints, and carepartner/patient abilities, impact optimal care for patients with dementia; and (4) Practitioner Supports, including continuing education, carepartner resources, and interprofessional collaboration, are needed to improve care for patients with dementia. Findings highlight a critical need for enhanced educational preparation, ongoing professional development, and improved system-level supports for provision of effective care for people with dementia. Addressing these gaps through targeted training, improved caregiver resources, and strengthened interprofessional collaboration will better support practitioners and enhance therapeutic outcomes of patients with dementia. Advocacy efforts at the institutional, state, and national levels are needed to combat system-level barriers and allow for the provision of best practice in dementia care.

Keywords: *physical therapy, occupational therapy, speech-language pathology, Alzheimer's disease, dementia*

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1. Introduction

Alzheimer's disease and related dementias (ADRD) are a leading cause of disability and dependency among older people [1]. Alzheimer's disease is the most common neurodegenerative disease that causes dementia. Dementia is a clinical syndrome characterized by a progressive decline in memory and cognition which leads to changes in behavior and challenges to perform everyday activities. There may be different causes for dementia; however, Alzheimer's disease accounts for approximately 60-70% of cases worldwide [1]. According to the Alzheimer's Association 2025 Alzheimer's Disease Facts and Figures, over 7 million Americans aged 65 and older are living with Alzheimer's disease and 74 percent are aged 75 or older [2]. The prevalence of Alzheimer's, the most common type of dementia, in Arizona is currently 11%, consistent with the national average. This does not reflect any of the other common types of dementia, including Vascular Dementia, Frontotemporal Dementia, Lewy-body Dementia, and Parkinson's Dementia. This number is expected to grow significantly in the coming years in

Arizona [3], Arizona Department of Economic Security, 2022). As the condition progresses over the years, people living with dementia (PLwD) will need more assistance with gait, mobility, activities of daily living (ADLs), instrumental activities of daily living (IADLs), medication management, communication, and swallowing [4]. This necessitates the services of professionals such as physical therapy practitioners (PTPs), including physical therapists and physical therapy aids, occupational therapy practitioners (OTPs), including occupational therapists and occupational therapy assistants, and speech-language pathologists (SLPs). The complex healthcare needs of PLwD require management at various levels of care ranging from acute care, acute inpatient rehabilitation, skilled nursing facility/long term care, home health and outpatient rehabilitation. The level of care needed ranges from intermittent support to around-the-clock care. The increasing prevalence of ADRD coupled with the unique healthcare needs of PLwD require healthcare practitioners to possess specialized knowledge and skills. PTPs, OTPs and SLPs play an integral role in treatment of PLwD and need to be prepared to meet the preventative, rehabilitative, and palliative care needs of this population.

The preparedness of PTPs, OTPs and SLPs to effectively work with PLwD is often evaluated through their training experiences, professional attitudes, confidence and knowledge related to dementia care. Understanding their current level of training, competencies, and the integration of evidence-based practices is vital for improving the quality of care provided to PLwD. Experience and knowledge in ADRD vary according to the education and training received by healthcare professionals. Research indicates that both formal training and practical exposure significantly influence the confidence and competence of healthcare practitioners in delivering services to this population. Furthermore, attitudes and beliefs of healthcare professionals towards dementia could be affected by their knowledge and education, resources and support available at the job-setting, and the stage of dementia [5].

PTPs play a critical role in the management of PLwD, particularly optimizing mobility, function, safety, and quality of life across the disease trajectory. It is well documented that physical therapy interventions can reduce fall risk, increase walking ability and gait speed, augment functional independence, and promote neuroplasticity and cerebral perfusion through aerobic and strengthening activities [6]. Research has shown that PTPs perceive working with PLwD is complex and challenging and that it could be alleviated with advanced training [7]. They reported gaps in their knowledge regarding behavioral management and communication strategies leading to reduced confidence. PTPs find it difficult to work with people with dementia, feel less confident, unsatisfied, and prefer not to work with individuals in the later stages of dementia, perceiving treatment to be more challenging and less efficient at this stage due to limited rehabilitation potential [5]. This is echoed by [8] who conducted a scoping review highlighting the experiences and views of PTPs, revealing that many therapists struggle with their roles and face challenges in delivering effective care due to a lack of understanding and training on dementia specifics. A significant deficit exists in the dementia knowledge base, and there is a need for educational reform to incorporate more dementia-specific training into physical therapy curricula.

OTPs play a vital role in supporting individuals with dementia and their families through tailored interventions aimed at enhancing daily functioning and improving quality of life. The American Occupational Therapy Association (AOTA) has established practice guidelines for OTPs to support PLwD and their carepartners [4]. Recent literature shows a mix of positive attitudes but deficits in knowledge and skills. Gavin et al noted that personal experience with ADRD, particularly, familial dementia experiences, and not the number of years of specialized education was strongly associated with developing positive attitudes in undergraduate OT students towards working with PLwD and more likely to consider careers in dementia care. They further recommend developing empathy through various teaching approaches [9].

SLPs play a crucial role in managing the swallowing, communication and cognitive challenges faced by individuals with dementia, yet their current levels of preparedness and confidence in addressing the unique challenges associated with dementia care can vary considerably. Research indicates that many SLPs feel inadequately trained for the complexities of working with individuals with dementia. Studies show that SLPs report that their education often does not sufficiently cover dementia-related topics, leading to gaps in both theoretical knowledge and practical skills [10,11]. SLPs with more extensive experience and training in dementia are likely to demonstrate a greater understanding and competence in dealing with communication disorders associated with dementia compared to their less experienced counterparts [11]. This is supported by findings from [12] who noted a significant discrepancy between SLPs providing services to individuals with mild cognitive impairment (MCI) or early-stage dementia and those who have received formal training in these areas, highlighting a need for improved educational structures. A scoping review exploring the experiences and views of SLPs towards dementia care [10] identified several educational and research gaps in the effective provision of SLP services that need to be addressed to prepare professionals to provide effective care for individuals with dementia. Many SLP students and recent graduates express a pressing need for improved curricula that include detailed studies on dementia, especially concerning communication strategies and cognitive-communication approaches. Additionally, SLPs need to adopt a multidisciplinary approach, collaborating with other health professionals to facilitate comprehensive care for patients with dementia [12].

Arizona has attracted retirees from across the country due to its weather and advanced medical facilities. This has resulted in a growing aging population. Between 2013 and 2022, the number of older adults in Arizona grew by nearly 400,000 [3] and is expected to continue to grow in the coming years [13]. Recent advances in healthcare and medical technology have increased life expectancy across the United States. Arizona's life expectancy is 79 – 80 years [3] ck. With aging and increased life expectancy comes the risk of ADRD. Arizona is expected to see a rise in ADRD. There are 151,500 people aged 65 and over

living with AD in Arizona [2]. With an annual mortality rate of 38.4, ADRD is the sixth leading cause of death in Arizona [2,3]. The state of Arizona has been prioritizing the healthcare needs of older adults and PLwD through several state initiatives. The Arizona Department of Health Services (ADHS) has developed a state plan for Arizonans with ADRD and their carepartners [3] with 3 primary goals: 1) to increase access to care, support and treatment for Arizonans living with ADRD; 2) to enhance the safety and quality of care for Arizonans living with ADRD; 3) to facilitate early detection and diagnosis, and reduce the risk of dementia. The state plans to achieve the first goal by increasing access to services such as respite care, education, training, and a centralized repository for resources that can be easily accessed by both the individuals living with dementia and their carepartners. Developing a well-educated dementia ready workforce trained to work across diverse cultures is also one of the priorities of this goal. The need for evidence-based comprehensive dementia care programs that are person-centered and provide support to carepartners addresses the second goal of enhancing safety and quality of care. Finally, and probably the most important goal of the state plan is to promote healthy aging, ADRD screenings, early detection and diagnosis to allow for timely interventions. The vision of the State plan not only includes elimination of ADRD in Arizona but also to make provisions for accessible and acceptable quality care and support to people currently living with dementia. The 2025 Alzheimer's Facts and Figures report for Arizona, however, indicates a shortage of specialized healthcare workforce (including primary care physicians, geriatricians, nurses, psychologists, licensed therapists, social workers and direct care providers) to support PLwD. Given the projected increase in ADRD in Arizona, aligning state priorities with workforce demands necessitates specialized training for PTs, OTs and SLPs. There is currently, however, a significant data gap regarding the actual preparedness of the state's current PTs, OTs and SLPs to meet these complex needs. This study, therefore, aimed to explore the preparedness of Arizona PT, OT and SLP to effectively work with PLwD. Researchers sought to answer the following Research Question: How prepared do Arizona therapy practitioners feel to work with patients with dementia?

2. Methods

2.1. Study Design

Approval was received from Midwestern University's institutional review board to conduct this research study.

This study uses an exploratory qualitative study design using cross-sectional focus group discussions to collect data. This method allows PT, OT and SLP practitioners to express their perceptions, views and opinions about working with PLwD in adult practice settings

2.2. Recruitment

Participants were PTPs, OTPs, and SLPs working in adult practice settings in the state of Arizona. Practitioners were recruited from adult practice settings including Acute Care, Acute Rehabilitation, Skilled Nursing, Home Health, and Outpatient Rehabilitation. Purposive sampling was used to obtain a sample of healthcare practitioners who were employed in diverse adult practice settings. The goal of recruiting participants using this approach was to categorically identify preparedness issues and needs in these settings while working with PLwD.

Flyers and invitations were distributed to the respective professional state associations. Invitations were sent via email to 201 SLPs, 81 OTPs, and 96 PTPs. Interested practitioners were instructed to contact the principal investigator (PI: T.T) via telephone or email to learn more about the study. The potential participants were informed that the objective of the study was to understand the preparedness of PT, OT and SLP practitioners, from the state of Arizona, to work with PLwD. They were told that participation would include signing an informed consent, completing a demographic survey and a 1-hour focus group discussion, and that they would receive $100 as compensation for their time. Informed consent was obtained electronically, via Redcap. Participants were informed that participation in the study was voluntary and that they could withdraw from the study at any time without penalty or negative consequences. Participants were also notified that other participants within the same focus group would hear their responses. Additionally, permission was obtained from the participants to record the focus group discussions.

2.3. Data Collection

The preparedness of PTPs, OTPs, SLPs to work with PLwD was explored through a mixed profession focus group discussion because this experience replicates the interprofessional collaborative experience the practitioners might have related to preparedness in working with PLwD. First, the participants completed a demographic questionnaire. The demographic questionnaire gathered preliminary data related to practitioner education, experience, current work settings and perceptions of preparedness for working with PLwD. The participants were then informed that they would be contacted by the PI to schedule a date and time for the focus group discussion.

Eighteen mixed profession focus groups of one hour duration were conducted via video conferencing software, Microsoft Teams®. An average of four participants were included in each group depending on the availability of the participants. Group discussions were moderated by the researchers, one researcher per focus group. Moderators who did not have previous experience with focus group moderation were trained specifically for this study by the PI. The discussions focused on practitioner knowledge of ADRD and comfort level in working with PLwD diagnosis. Interview questions for the focus group discussions were developed based on a thorough literature search and collaboration with interprofessional colleagues with experience in dementia care.

Focus group discussions began with introductions and a general discussion regarding dementia. To determine the participants' experience with PLwD, their perceptions, views and opinions, the researchers led the focus group with the following prompts: 1) What are your thoughts

about therapeutic potential of a person with ADRD? 2) What do you wish you knew prior to working with PLwD? 3) What challenges have you experienced in your setting with this population? 4) Talk about the supports you'd like for continuing education/training for working with PLwD in your setting. 5) What has improved/would improve your comfort level in working with this population in your setting? A semi-structured interview technique was used to elicit responses for the above questions from the participants.

All focus groups were audio and video recorded with transcriptions and subsequently reviewed by the researchers for the purpose of analysis.

2.4. Data Analysis

Transcripts generated in real-time by Microsoft Teams® during the focus group meetings were saved in PI's drive. Transcripts were reviewed by student researchers to verify that the transcript generated by Microsoft Teams® accurately matched the participants' responses. Data were not cleaned. The transcripts were reviewed, coded, and then combined into themes using [14] six phases of thematic analysis.

One researcher and two graduate students from each profession read and generated codes by labeling key aspects of the text that related to the research question. Codes were reviewed and collapsed into themes reflecting overarching narratives in the data. The researchers reviewed the themes relative to the codes to assess the overall quality and trustworthiness of the themes. Themes were defined and described by identifying specific quotes from participants and returning to the research question-preparedness of Arizona PT, OT, SLP practitioners for working with PLwD. Finally, a narrative, thematic analysis was achieved via consensus among the researchers ensuring data accuracy and verifying saturation.

3. Results

3.1. Demographic Analysis

3.1.1. Descriptive Statistics

Demographic descriptive statistics were run for the full cohort, stratified by profession. Continuous variables were summarized using means and standard deviations (SD), and categorical variables using frequencies and percentages. Table 1 shows the demographics stratified by profession. A total of 74 practitioners (25 PTPs, 33 OTPs, and 16 SLPs) participated in the study. The mean age of participants was 34.97 years (SD = 7.76). Mean ages by profession were 35.52 years (SD = 7.46) for OT, 35.44 years (SD = 8.67) for PT, and 33.13 years (SD = 7.03) for SLP. Most participants identified as White (full cohort: 77.03%; OT: 66.67%; PT: 80.00%; SLP: 93.75%), not Hispanic or Latino (full cohort: 78.38%; OT: 84.85%; PT: 76.00%; SLP: 68.75%), and female (full cohort: 79.73%; OT: 81.82%; PT: 68.00%; SLP: 93.75%). More than half of the participants reported a master's degree (52.70%) as their highest level of education, followed by a doctorate (35.14%). This varies within OTP, PTP and SLP groups. Just under half of the cohort reported a master's degree (48.65%) as their entry-level professional degree, followed by a doctorate (35.14%). This varied within OTP, PTP and SLP groups. The mean graduation year was 2014 (7) for the full cohort, 2013 (7) for OT, 2014 (8) for PT, and 2016 (7) for SLP.

3.1.2. Dementia-Specific Training

Participants reported mixed perceptions of the quality of dementia training received during their professional coursework. Overall, 39.19% rated their training as neutral, 36.49% as high quality, and 21.62% as low or very low quality, with only 2.70% rating their training as very high quality. Reported years since training varied, with half of the cohort (50.00%) completing training 1–5 years ago, 14.86% between 6–10 years ago, and 22.97% more than 10 years ago. Most participants (68.92%) reported not having taken any continuing education courses specific to ADRD. Patterns were generally similar across professions, although SLPs reported slightly higher rates of low or very low quality coursework (37.50%) compared to other groups. Table 2 shows the training of the participants in terms of perceived quality of dementia training while in school, years of on the job training as a clinician, and continuing education courses.

3.1.3. Knowledge, Confidence, and Comfort

Most participants reported feeling knowledgeable about ADRD (full cohort: 71.62%, OT: 78.79%, PT: 56.00%, SLP: 81.25%). However, confidence was lower regarding evidence-based therapeutic approaches, where 37.84% reported being unsure and 14.86% reported not being knowledgeable. This varied within OT, PT and SLP groups. In contrast, most participants indicated being either comfortable/very comfortable working directly with

PLwD (full cohort: 93.25%, OT: 90.91%, PT: 92.00%, ST: 100.00%) and with carepartners (full cohort: 87.84%, OT: 81.82%, PT: 88.00%, ST: 100.00%). Similar patterns were observed for collaboration across professions, with 59.46% reporting being comfortable and 27.03% very comfortable for the full cohort. Table 3 displays the self-perceived confidence of the practitioners in general knowledge, evidence-based interventions, working with carepartners, and collaboration with other health care providers regarding individuals with Alzheimer's or related dementias.

Table 1. Cohort Demographics

	Total (n=74)	OT (n=33)	PT (n=25)	SLP (n=16)
Age, mean (SD)	34.97 (7.76)	35.52 (7.46)	35.44 (8.67)	33.13 (7.03)
Race, n (%)				
American Indian/Alaska Native	1 (1.35)	0 (0.00)	0 (0.00)	1 (6.25)
Asian	2 (2.70)	1 (3.03)	1 (4.00)	0 (0.00)
Black or African American	3 (4.05)	2 (6.06)	1 (4.00)	0 (0.00)

	Total (n=74)	OT (n=33)	PT (n=25)	SLP (n=16)
More than one Race	9 (12.16)	7 (21.21)	2 (8.00)	0 (0.00)
Unknown/Not Reported	2 (2.70)	1 (3.03)	1 (4.00)	0 (0.00)
White	57 (77.03)	22 (66.67)	20 (80.00)	15 (93.75)
Ethnicity, n (%)				
Hispanic or Latinex	14 (18.92)	4 (12.12)	6 (24.00)	4 (25.00)
Not Hispanic or Latinex	58 (78.38)	28 (84.85)	19 (76.00)	11 (68.75)
Unknown/Not Reported	2 (2.70)	1 (3.03)	0 (0.00)	1 (6.25)
Gender, n (%)				
Female	59 (79.73)	27 (81.82)	17 (68.00)	15 (93.75)
Male	15 (20.27)	6 (18.18)	8 (32.00)	1 (6.25)
Highest Level of Education, n (%)				
Associate	6 (8.11)	3 (9.09)	3 (12.00)	0 (0.00)
Bachelor	3 (4.05)	3 (9.09)	0 (0.00)	0 (0.00)
Master	39 (52.70)	21 (63.64)	2 (8.00)	16 (100.00)
Doctorate	26 (35.14)	6 (18.18)	20 (80.00)	0 (0.00)
Entry-Level Professional Degree				
Associate	8 (10.81)	5 (15.15)	3 (12.00)	0 (0.00)
Bachelor	4 (5.41)	2 (6.06)	0 (0.00)	2 (12.50)
Master	36 (48.65)	20 (60.61)	2 (8.00)	14 (87.50)
Doctorate	26 (35.14)	6 (18.18)	20 (80.00)	0 (0.00)
Graduation Year with Professional Degree, mean (SD)	2014 (7)	2013 (7)	2014 (8)	2016)7)

Table 2. Dementia-Specific Training

	Total (n=74)	OT (n=33)	PT (n=25)	SLP (n=16)
Dementia training quality in professional course work, n (%)				
Very low quality (I was completely unprepared)	3 (4.05)	1 (3.03)	0 (0.00)	2 (12.50)
Low quality (I was unprepared)	13 (17.57	6 (18.18)	3 (12.00)	4 (25.00)
Neutral	29 (39.19)	12 (36.36)	11 (44.00)	6 (37.50)
High quality (I was fairly prepared)	27 (36.49)	14 (42.42)	10 (40.00)	3 (18.75)
Very high quality (I was well prepared)	2 (2.70)	0 (0.00)	1 (4.00)	1 (6.25)
Years practicing in current setting, n (%)				
Less than 1 year	9 (12.16)	4 (12.12)	4 (16.00)	1 (6.25)
1-5 years	37 (50.00)	18 (54.55)	9 (36.00)	10 (62.50)
6-10 years	11 (14.86)	7 (21.21)	2 (8.00)	2 (12.50)
Greater than 10 years	17 (22.97)	4 (12.12)	10 (40.00)	3 (18.75)
Dementia Continuing Education Course Completion, n (%)				
No	51 (68.92)	24 (72.73)	18 (72.00)	9 (56.25)
Yes	23 (31.08)	9 (27.27)	7 (28.00)	7 (43.75)

Table 3. Practitioner Knowledge, Confidence, and Comfort

	Total (n=74)	OT (n=33)	PT (n=25)	SLP (n=16)
Knowledge of ADRD, n (%)				
Not at all Knowledgeable	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)
Not Knowledgeable	7 (9.46)	4 (12.12)	3 (12.00)	0 (0.00)
Not Sure	10 (13.51)	2 (6.06)	7 (28.00)	1 (6.25)
Knowledgeable	53 (71.62)	26 (78.79)	14 (56.00)	13 (81.25)
Very Knowledgeable	4 (5.41)	1 (3.03)	1 (4.00)	2 (12.50)
Knowledge of ADRD Evidence-Based Practice, n (%)				
Not at all Knowledgeable	3 (4.05)	0 (0.00)	3 (12.00)	0 (0.00)
Not Knowledgeable	11 (14.86)	7 (21.21)	3 (12.00)	1 (6.25)
Not Sure	28 (37.84)	16 (48.48)	10 (40.00)	2 (12.50)
Knowledgeable	30 (40.54)	8 (24.24)	9 (36.00)	13 (81.25)
Very Knowledgeable	2 (2.70)	2 (6.06)	0 (0.00)	0 (0.00)
Comfort Working with PLwD, n (%)				
Not at all Comfortable	1 (1.35)	1 (3.03)	0 (0.00)	0 (0.00)
Not Comfortable	2 (2.70)	1 (3.03)	1 (4.00)	0 (0.00)
Not Sure	2 (2.70)	1 (3.03)	1 (4.00)	0 (0.00)
Comfortable	49 (66.22)	22 (66.67)	17 (68.00)	10 (62.50)
Very Comfortable	20 (27.03)	8 (24.24)	6 (24.00)	6 (37.50)
Comfort Working with PLwD Carepartners, n (%)				

	Total (n=74)	OT (n=33)	PT (n=25)	SLP (n=16)
Not at all Comfortable	1 (1.35)	0 (0.00)	1 (4.00)	0 (0.00)
Not Comfortable	2 (2.70)	1 (3.03)	1 (4.00)	0 (0.00)
Not Sure	6 (8.11)	5 (15.15)	1 (4.00)	0 (0.00)
Comfortable	46 (62.16)	19 (57.58)	18 (72.00)	9 (56.25)
Very Comfortable	19 (25.68)	8 (24.24)	4 (16.00)	7 (43.75)
Comfort Collaborating with other Professions regarding shared PLwD, n (%)				
Not at all Comfortable	1 (1.35)	0 (0.00)	1 (4.00)	0 (0.00)
Not Comfortable	6 (8.11)	6 (18.18)	0 (0.00)	0 (0.00)
Not Sure	3 (4.05)	2 (6.06)	0 (0.00)	1 (6.25)
Comfortable	44 (59.46)	20 (60.61)	15 (60.00)	9 (56.25)
Very Comfortable	20 (27.03)	5 (15.15)	9 (36.00)	6 (37.50)

3.2. Thematic Analysis

Four key themes emerged from the participant responses during the focus group discussions: 1) Therapeutic potential of patients with dementia is influenced by practitioner knowledge, patient characteristics, and carepartner support. 2) Practitioners require enhanced dementia-specific knowledge and communication strategies for best practice. 3) External factors, including setting specific challenges, reimbursement constraints, and carepartner/patient abilities impact optimal care for patients with dementia. 4) Practitioner support, including continuing education, carepartner resources, and interprofessional collaboration, are needed to improve care for patients with dementia.

3.2.1. Therapeutic Potential of Patients with Dementia is Influenced by Practitioner Knowledge, Patient Characteristics, and Carepartner Support

Practitioners identified that the therapeutic potential of a PLwD is determined by a combination of three key factors: the practitioner, the patient, and the carepartner. Practitioner factors specifically encompass the therapist's knowledge about, confidence in, and approach for working with PLwD. Related to knowledge and confidence, one SLP stated: "*I would just print resources and give them to family members [and say] 'This is what you should do', because I didn't know [what to do]*." The clinician's ability to adjust their approach based on the specific needs of each patient is an example of a practitioner-related factor influencing the therapeutic potential of PLwD. An OTP highlighted this when stating the need to "*find the [areas] that [the patient has] the most ability to function in, and [adjusting] your approach … depending [on] where [the patient is] in [the disease process]…*"

Practitioners observed that the therapeutic potential was also influenced by patient-related variables, particularly the stage and severity of their dementia and accompanying comorbidities. Many participants reported a higher therapeutic potential for patients in the early stages of dementia but indicated a dependency on additional resources and environmental supports as the severity of the condition increased. For example, an SLP shared, "*I think [therapeutic potential depends] on the stage of dementia. I think the less severe, the greater the potential, possibly for some learning and I think that the more advanced the disease becomes, [the therapist is] more dependent on caregiver instructions, cueing, diet, and environmental modifications.*"

Another SLP participant indicated how even the label or diagnosis itself could impact potential with the misunderstanding that individuals with dementia cannot benefit from therapy services. "*I personally feel like sometimes that label can hinder possible therapeutic potential because either MDs aren't putting in the consults [or] nursing [isn't]putting in the consults, so that pre-labeling or … associations with those diagnoses in the charts could also hinder possible outcomes*."

An OTP highlighted patient behaviors and cooperation as a patient-specific factor that can dictate therapeutic potential. "We have behavior rounds; so anyone that's exhibiting behaviors, we get together with the neuropsychologist and all the different team members in one room with case management, nursing, to talk about the plan, the plan for the day, the plan for the week and what we're doing to modify behaviors and facilitate participation in therapy."

Finally, participants identified carepartner support and readiness for carepartner training as a factor that affected therapeutic potential. One SLP participant stated, "*If you have a good, solid caregiver, somebody who's going to be able to follow through with those cues and do them properly, then their potential is good.*" Another SLP participant agreed "*When there's strong family support, there's more education that I generally am able to provide. And that usually… transfers to improve[d] potential*."

3.2.2. Practitioners Require Enhanced Dementia-specific Knowledge and Communication Strategies for Best Practice

The participants indicated that practitioners desired more dementia-specific knowledge and communication skills before engaging with PLwD. Practitioners' commentary reflects the need for a better understanding of the disease, a broader knowledge base for profession-specific treatment strategies, and interpersonal communication skills specific to PLwD and their families. One PTP stated, "*There isn't enough...I haven't seen enough education out there about, dementia, the diagnosing of it… how to treat it … from a therapy standpoint*"

When discussing general knowledge of profession-specific treatment strategies an OTP referenced early challenges in "learning those deescalation strategies, not only just the verbal components, but …how [you can] use your body to help a patient with dementia move. [For

example] they don't use their walker at home because they furniture surf. So where can I position myself to make them feel comfortable? All of that therapeutic [skill] that we provide… does make or break your session sometimes." Another example highlighting the profession specific knowledge gap is noted by an SLP who stated the need for "other ways to look when you don't have coworkers"... I Google it and then I go on Pinterest and try to find activities. But it would be nice to just have other things in my back pocket because it's like, if this activity doesn't work, then what?"

Communication strategies for working with PLwD was frequently cited as a need for improving care for this population. An OTP said, "*Just [knowing] best practices for communication with clients with dementia [would have been helpful]. A lot of times …it's really not intuitive.*" Another OTP agreed that this knowledge would have been beneficial early in their career, "*For my first four years of working as an occupational therapist, I really didn't have [dementia specific] training. I wish I had known back then that every behavior or response that a client with dementia has is because they are experiencing something either within or outside of them that's causing frustration and [they don't have] an appropriate way to communicate that*." A PTP concurred stating, "*Communication I feel is my biggest weakness when working with this population. I feel that it's almost like a mind barrier. I feel like "how do I talk to this person?" And I know that I have to simplify my communication, but I don't know how and I know that I need to relate to these people*."

Interpersonal communication strategies were not only needed for PLwD, but also for their family members. For example, an SLP highlighted the discomfort with having difficult conversations about the prognosis of PLwD, "*I think especially for me being younger when I graduated and trying to talk to adults or older people about these sensitive topics, I just didn't really feel comfortable…I didn't know how to have those uncomfortable conversations."*

3.2.3. External Factors, Including Setting Specific Challenges, Reimbursement Constraints, and Carepartner/patient Abilities Impact Optimal Care for Patients with Dementia

Practitioners identified several external challenges when working with PLwD, which constituted the third major theme derived from the responses of the participants. External challenges included three main categories: 1) Setting specific challenges including culture, environment, and reimbursement factors, 2) Carepartner abilities, presence, and knowledge and 3) Patient limitations.

Challenges within the employment setting frequently stemmed from cultural and environmental factors. One OTP highlighted how the environment could either facilitate or impede functional treatment: "*Sometimes you walk into a memory care unit… and the culture is just awful. You [think], I don't want to work [here]. …you talk to caregivers and they roll their eyes or you talk to somebody about doing something different or changing something up, and there's just nothing. That's one of the biggest … frustrations I have. [In contrast] when you go into a place that has a really great culture [that is] willing to do new things and … that's the best kind of environment. …That's one of the biggest challenges I have*." An SLP stated, "*Because I work at different location settings, I see the difference. …Some locations have better ways to mimic a home environment, [and] some are just as basic as just the sink. That's what we can practice at with some functional activities, whereas others have a full kitchen. Some [environments] are not very adaptable [and] can just make it hard to really be functional and very realistic and practical with therapy*."

Other setting specific challenges discussed included productivity demands and inconsistent staffing. One PTP stated, "*Another barrier is the time to educate nursing assistants and nurses [on patient handling], as they're always really busy and short staffed and we don't always have the time and the productivity needs are highest…So I think educating staff [about patients] is really hard with productivity demands and I think the progress demands in a skilled rehab is challengin*g."

Navigating reimbursement and payor source challenges was frequently referenced as a challenge for practitioners. A PTP stated, "*[When payer sources] don't see progress, medical necessity goes out the window and they don't give us more visits. From [an] insurance standpoint, it can be frustrating."* Similarly, declining numbers of treatment sessions and shortened lengths of stay due to reimbursement factors were noted by an SLP who said, "*we don't get the days that we might [have] gotten when I was a new grad. When I was a new grad, my patients were getting 14 to 21 days and now I feel like they're getting 5 to 10."* An OTP added, "*Having limited time to actually teach the patient the skill or go over a a different approach with the patient just with 30 minutes is sometimes just not beneficial in my eyes*."

Another factor that impacted the care provided to these individuals included challenges associated with carepartners including carepartner abilities, presence, knowledge, and burnout. Highlighting the value of carepartners for treatment carryover, one OTP practitioner stated, "*Carryover is huge, so if there's not someone there to repeat those tasks, I just find it hard to progress with the patient.*" Similarly, a PTP said, "*It can be challenging in this [outpatient] setting; a lot of times, caregivers will bring patients to us and drop them off, and they're not always able to be present for sessions. So carryover is a big one, or even being able to provide the education to the caregiver if we're not really seeing them or just seeing them in passing. Even getting them to do exercises between sessions or anything to carry over in the home can be hard outside of our clinic."*

Treatment carryover was also referenced as a patient-related challenge. One OTP shared, "*I think it all just falls back to carryover …that's the biggest [challenge] for me*." Other patient-related factors that impact care include behavioral challenges. An OTP said, "*How far can I go before it starts to trigger some of the behaviors or um when do they get really upset and what can I do to calm them down? Those types of things are kind of challenging*." Further highlighting the impact of patient-related behaviors on care, another OTP said, "*When there's a patient who is …agitated [due to] dementia, I really feel like I'm ill-prepared to manage those situations*."

3.2.4. Practitioner Supports, Including Continuing Education, Carepartner Resources, and Interprofessional Collaboration, are Needed to Improve care for Patients with Dementia

After identifying themes related to therapists' challenges and needs for increased preparedness for working with PLwD, researchers analyzed the data to pinpoint specific references to needed supports. The support practitioners mentioned fell into several categories: 1) Professional development and knowledge: 2) Resources and supports for working with families 3) Opportunities for collaboration and knowledge sharing within work settings

Regarding professional development and knowledge, participants desired continuing education on behavior management, strategies for communicating with and motivating patients, additional education regarding dementia symptomatology and treatments, and dementia specific assessments and outcome measures. An OTP stated, "*treatment approaches in general would be helpful as well as just like general documentation language in terms of goal writing, you know and how to document the skill and the justification for the service*." A PTP confirmed, "*more continuing education courses for us where we as clinicians can get an idea of like here's some handouts, but also here are some techniques on how to communicate with someone with dementia or maybe give them options rather than telling them what to do or trying to best meet them where they're at to make the session a little bit more beneficial for all parties…"* Participants also reflected on what has improved or would improve their comfort level in working with PLwD as well as how they wanted to receive resources. They referenced learning from real patient experience and observations as the most influential factors on comfort level. Quick access to resources was desired to combat productivity requirements and workplace pressures.

Practitioners also desired resources and strategies to use to help family members, or to help themselves in working with family members of PLwD. Identification of resources specifically for patient families was a noted necessity. An OTP stated, "*having some concrete things to give to family members to improve their education and resources for them and for myself as a clinician would have been helpful as a new clinician*." A PTP confirmed, "*... having some better handouts that are backed by research, that we can hand out, and give to them to help support them*." Practitioners also desired strategies and resources for increasing carepartner participation and support. A PTP mentioned the need for support groups for families "*to get them hooked up to things once they leave the hospital*." An SLP shared their need for support in talking with patients and carepartners, "*I wish I knew how… to communicate better with family members. I don't feel like in Graduate School we learned a lot of those kind[s] of counseling, especially with ... hard conversations*."

Practitioners consistently expressed the desire for opportunities for open interprofessional communication and greater knowledge sharing within work settings. Hands-on learning and observation of profession-specific peers, as well as interprofessional learning and participation in journal clubs was noted as important to enhancing their knowledge and comfort level for supporting PLwD and their families. An OTP commented she found discussion with her colleagues at the hospital was valuable when she was unsure on how to proceed," …reading journal articles here and there and learning newer current practice, what [are] research-based interventions. We've tried to do some journal clubs at my work. Those have helped, and they've helped spark that discussion of how can we apply this for patients in our setting." Similarly, an SLP commented that "*discussing trickier cases with your colleagues that you know have more experience in the field…listening to other professions like occupational therapy, physical therapy because they might have information not related to your profession that could be very useful in your interactions with those patients.*" The lack of familiarity with other healthcare professionals' patient management highlighted a corresponding need for interprofessional learning.

4. Discussion

This study examined Arizona therapy practitioners' perceptions of preparedness for working with PLwD, including their knowledge of best practices, their confidence in working with this population, and the challenges they experience. A central finding was the notable difference between perceived general knowledge and comfort working with these individuals, and their confidence in implementing evidence-based therapeutic interventions. Participants reported a high comfort level in working with PLwD; however significant gaps were identified in clinicians' evidence-based knowledge and official training. Over a third of the participants, 37.8%, expressed uncertainty regarding evidence-based interventions and dementia-specific clinical decision making. Practitioners reported a desire for a better understanding of the disease, a broader knowledge base for profession-specific treatment strategies, and interpersonal communication skills specific to PLwD and their families. Participants also frequently reported feeling underprepared for managing patients' behavioral and psychological symptoms, having difficult conversations with families, and delivering person-centered, appropriate care for the current stage of the disease process. Participants felt dementia-specific communication strategies, including de-escalation techniques, and navigating sensitive conversations with carepartners regarding prognosis and disease progression were lacking in their training.

Our findings suggest that foundational exposure to PLwD in entry level education is inconsistent and minimal with over 60% of the participants rating their training as neutral or lower. This aligns with concerns in rehabilitation education that dementia-specific competencies such as communication strategies, behavioral management, and carepartner education are inconsistently emphasized in professional curriculums [10,11,15]. The self-reported high comfort levels with treatment in spite of knowledge gaps suggests this may be derived more from clinical exposure than from formal training. This was supported by qualitative data indicating learning from real patient experiences and observations was most influential to improving comfort level with

PLwD. These findings suggest that professional program curricula should include increased early clinical experiences with PLwD that include both evidence-based practices and ADRD-specific interpersonal skills.

Although practitioners' perceived gaps in their knowledge, the thematic analysis revealed that the clinician's knowledge and skills are not the only influencers on the therapeutic potential of PLwD. Factors such as the patient's stage of the disease process, comorbidities, and carepartner support were also perceived as influential. Practitioners believed carepartners were instrumental in helping with treatment carryover, especially as the disease progressed. Yet resources for families and skills in communicating with families were consistently identified as perceived deficits. This suggests that additional supports for carepartners and training in how to educate and communicate with carepartners are critical to improving therapeutic potential for PLwD.

Another important theme was that external and systemic barriers negatively influence the care practitioners provide to PLwD. Systemic barriers such as productivity pressures, limited time for personal and staff education, and reimbursement constraints limiting treatment were seen across all three professions. Other barriers included shortened length of stay, limited treatment session time, and pressure to demonstrate measurable progress. These limitations identified across practice settings and disciplines inhibit opportunities for knowledge growth, impact carepartner education, and interfere with implementation of best practices for PLwD. Advocacy efforts at the institutional, state, and national level are needed to combat these significant barriers and maximize therapeutic potential PLwD.

The study also emphasizes the importance of interprofessional learning and collaboration. Participants expressed a desire for shared opportunities to observe other professions and participate in collaborative learning and problem solving. This highlights the importance of moving educational training away from profession specific pathways towards an integrated, team based model. This is consistent with other literature, including the World Health Organization's recommendations for interprofessional practice and education [16]

Results of this work with Arizona practitioners is consistent with literature indicating healthcare practitioners are lacking in knowledge related to dementia care (e.g., Staples and Killian, 2012; White et al, 2023), utilize practice patterns inconsistent with best practices (McGrath & O'Callaghan, 2014) and overall, are inadequately prepared for working with PLwD(Mayer et al., 2023).

To summarize, Arizona OT, PT, and SLP practitioners do not feel prepared for working with PLwD. The participants identified clear drivers to improve care delivery. Desired supports included targeted continuing education or training that focuses on communication strategies, behavioral management, evidence-based interventions, access to research informed resources for caregivers, and increased opportunities for interprofessional collaboration. Participants expressed a desire for shared opportunities to observe other professions and participate in collaborative learning and problem solving. Participants highlighted experiential learning as particularly valuable with opportunities of case-based discussion and observation as supports. This suggests that traditional didactic approaches alone may not be sufficient to build practitioner competency and confidence when working with this population.

Researchers identified limitations of this study and made recommendations for future research. This study employed a purposive sampling strategy to recruit practitioners working in adult healthcare settings with PLwD. While this approach permits a deep dive into the perspectives of the participants, it limits the diversity of the sample. In addition, the number of participants across professions was not equal. A higher percentage of OT participants may have influenced study findings. Another limitation of this study is that it did not include other allied health professionals who frequently work with PLwD such as psychologists/neuropsychologists, nursing professionals, audiologists, optometrists, dieticians, case managers, social workers, and other direct care providers. Future research should expand the sample to include additional health care practitioners to validate these results across a variety of adult healthcare contexts. Further, the qualitative nature of this work did not allow exploration of specific objective outcomes that could influence practice. Future research should focus on evaluating targeted educational interventions and system level strategies needed to improve the care provided to individuals living with dementia.

5. Conclusions

This study highlights the need to better prepare and support dementia care practitioners through a multi-dimensional approach. Although participants reported high levels of comfort working with PLwD, major gaps in formal training, evidence-based practice application, and interpersonal skills needed to work with PLwD and their carepartners were identified. Therapeutic outcomes were understood to be multifactorial, encompassing practitioner competence, the patient's clinical presentation and carepartner involvement. Further, the provision of optimal care was limited by factors perceived to be outside of practitioners' control such as setting-specific constraints that limit functional treatment and interprofessional practice, and regulatory constraints limiting treatment dosage. Subsequently, participants identified knowledge, communication, interprofessional collaboration, and system-level supports as tools necessary for providing optimal person-centered care.

Recommendations for further research include expanding the sample size and geographic scope, conducting quantitative validation studies, and evaluating effectiveness of dementia-specific trainings. Related topics include evidence-based practice implementation barriers, carepartner integration strategies, setting-specific challenges, and interprofessional collaboration models. Future research should prioritize the development and evaluation of targeted educational, organizational, and policy-level interventions to address identified gaps in dementia care preparedness and to ultimately improve rehabilitation outcomes for PLwD.

Results from Arizona health care practitioners suggest four calls to action: educational improvements at the graduate level; workplace support inclusive of interprofessional training and collaboration opportunities; accessible clinical resources; and systems level reform. These changes are necessary to develop a more competent, confident, and well supported rehabilitation workforce.

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Statement of Competing Interests

The authors have no competing interests.

List of Abbreviations

ADL	activities of daily living
ADRD	Alzheimer's disease and related dementias
IADL	instrumental activities of daily living
MCI	mild cognitive impairment
OTP	occupational therapy practitioners
PLwD	people living with dementia
PTP	physical therapy practitioner
SLP	speech-language pathologist

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