Contextual Factors Influencing Physiotherapists' Clinical Reasoning Related to Older Adult Clients' Finance and Economics

By

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Abstract

Introduction: Older adults experience age-related changes, including increased incidence of chronic health conditions, that can influence their participation in activities of daily living. Physiotherapists can address many of these changes associated with aging. However, older adults' finances can limit their participation in physiotherapy services. Yet, little is known about if physiotherapists consider older adult clients' finances in clinical reasoning.

Purpose: To examine if physiotherapists consider older adult clients' finances in their clinical reasoning, factors influencing inclusion of finance in clinical reasoning, and how dementia might influence their clinical reasoning related to client finance.

Methods: I completed a descriptive qualitative study involving nine Manitoban physiotherapists. Participants completed one-on-one, in-depth, semi-structured interviews. Interviews were audio recorded and analyzed using reflexive thematic analysis. Seven out of nine participants were women, and seven participants had practiced for over ten years. Multiple strategies were used to strengthen trustworthiness, including triangulation of perspectives in data analysis.

Results: I generated two themes by analyzing the interviews: (1) considering older adult clients' finances in clinical reasoning depends on contextual factors internal and external to the physiotherapists, and (2) diagnosis of dementia adds another layer to contextual factors. Examples of internal factors included past client and personal experiences, perceptions of the finances of older adults as a sub-population, and perception of regulatory and ethical

obligations. Examples of external factors included the clients not discussing their finances with the physiotherapists or the clients' preference about including finance in clinical reasoning. Physiotherapists used a variety of approaches to address the needs of clients with less finances available for physiotherapy services, including modifying their care plan, emphasizing self-management strategies, and changing billing methods.

Conclusion: Including clients' finances in clinical reasoning is a complex process. There were conflicts within each participant and across participants on if and how to consider clients' finances in their clinical reasoning. More educational or professional development related to this clinical reasoning area could help clarify some of the confusion or concerns physiotherapists have about incorporating client's finance in clinical reasoning. Doing so could help improve client access to needed physiotherapy services to optimize older adults' health and well-being.

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Dedication

If wishes were horses, you would be here, cheering the loudest as I receive my degree and be proud of what I have accomplished. Baami, this work is dedicated to your memory.

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Chapter I: Introduction

According to the World Health Organization, access to healthcare, including physiotherapy services, is a fundamental human right (Cousins & Lynch, 2011). However, older adults experience contextual factors, that is, their personal and environmental factors, that limit their access to the much-needed physiotherapy services despite having age-related changes affecting their daily function and an increased incidence of chronic diseases, including dementia (Canbaz et al., 2003). Although not all older adults will experience dementia, old age is a known risk factor for dementia. Dementia is a leading cause of disease burden and disability in the world, and it is associated with an increased rate of walking impairment, loss of balance, falls that can lead to injury, and a reduction in participation in activities of daily living (World Health Organization [WHO], 2023a).

To address age-related functional changes or chronic disease effects experienced by older adults, including the sequelae of living with dementia, the World Health Organization recommends access to physiotherapy services for all older adults with impairments or activity restrictions that can be addressed through physiotherapy care (WHO, 2017a; 2017b; 2023). Access to physiotherapy services can improve health outcomes by addressing mobility, balance, and muscle strengthening; all of this can improve participation in activities of daily living and help prevent mortality and morbidity in older adults, including those living with dementia (De Labra et al., 2015; WHO, 2021; WHO, 2022). Despite the importance of physiotherapy services for this population, older adults, including those with dementia, may experience barriers to accessing physiotherapy services in Manitoba, Canada (Kusch, 2017; Webber et al., 2022).

Specifically, older adults can experience financial or economic contexts that lead to barriers or delays in accessing and participating in physiotherapy services and in reaping the benefits of physiotherapy services for older adults (Lowe et al., 2014). To improve older adult clients' access to physiotherapy services, physiotherapists should consider older adult clients' contexts, including finances, in their clinical reasoning (Borell-Carrio, 2004; National Physiotherapy Advisory Group, 2017). However, there is limited literature on if and how physiotherapists consider older adult clients' finances in their clinical reasoning despite the importance of older adult clients' finances in access and engagement in physiotherapy services. In this thesis, I will present the results of a study in which I found that Manitoban physiotherapists do not always consider older adult clients' finances in their clinical reasoning and care plan. Considering clients' finances in their clinical reasoning depends on contextual factors, both internal and external to the physiotherapist.

Chapter II: Literature Review

In this literature review, I will describe the importance of physiotherapy services to older adult clients' health; describe the relationship between older adult clients' finances, health, and participation in physiotherapy services; describe the current knowledge about physiotherapists' clinical reasoning; and outline literature questioning and highlighting the need for physiotherapy practitioners to change their current clinical reasoning.

Aging and Physiotherapy

Collectively, the world's population demographic is aging, as a larger proportion of the population is now considered older adults than ever before (Christensen et al., 2009; Newman et al., 2023). This aging of the population is due to socioeconomic developments over the last 50 years (e.g. education, income, and housing), the accompanying reduction in fertility rates, healthcare developments, and an increase in life expectancy across developed countries (Christensen et al., 2009; Newman et al., 2023). Over one billion people worldwide are sixty years old and above, and this number will double its current figure to reach two billion by the end of 2050 (World Health Organization, 2023b). In Canada, over nine million people are sixty years and above, accounting for about 25% of the Canadian population (Statistics Canada, 2022). The aging population in Canada will continue to increase over the next decades due to increased life expectancy, low immigration, and low birth rates, making older adults a significant demographic (Christensen et al., 2009; World Health Organization, 2017; Statistics Canada, 2018; 2021). Growing old allows families to spend longer together and allows people to pursue their passions and careers; however, complex health conditions that are having

increased rates as people age or are associated with the aging process will impact the health sector (WHO, 2020; 2022).

Numerous physiological changes are associated with aging that can lead to chronic conditions or diseases. These chronic conditions or diseases can affect older adults' independence, increasing their dependence on others for care and reducing their quality of life (Saxon et al., 2022). The primary cause of disability and death after the age of sixty occurs due to age-related loss of sight, mobility, and hearing, as well as diagnostic conditions such as dementia, stroke, diabetes, and musculoskeletal conditions such as back pain and osteoarthritis (WHO, 2017b). Hung and colleagues (2011) estimated that the proportion of older adults in the USA experiencing one or more chronic diseases, such as stroke, heart disease, and impairments like cognition impairment, increased from 88.9% in 1998 to 92.2% in 2008. Similarly, the Canadian Community Health Survey ([CCHS], 2018) reported that at least 73% of older adults in Canada have at least one chronic disease or health conditions such as osteoarthritis, diabetes, osteoporosis, hypertension, and difficulties in participating in activities of daily living.

Of particular concern when considering the demographics and rehabilitation needs of older adults is dementia (Ashford et al., 2006; Centers for Medicare and Medicaid Services (CMS) 2018; Newman, 2023). Dementia is the leading cause of disease burden and disability worldwide among older adults and is a concern not just to older adults but to all of society (WHO, 2017). Dementia is an umbrella term used to describe progressive neurological diseases that result in the deterioration of brain structures and, in turn, mental functions, such as emotions, sensory perception, and cognition (e.g., memory, calculation, judgment, executive functions), and, as the disease progresses, physical functioning (Gustafson, 1996; Reis, 2018).

Dementia is the seventh leading cause of death among all diseases worldwide and is a public health priority (WHO, 2017a, 2019). Dementia currently affects about 50 million people, with approximately 10 million new dementia cases yearly worldwide (Prince et al., 2015). According to data collected between 2016 to 2017, Canada has over 432,000 older adults living with dementia, and there are 76,000 new diagnoses yearly (Public Health Agency of Canada, 2019).

Further, in addition to the large numbers of current and future people living with dementia, the symptoms of sequelae of dementia are also concerning. People with dementia experience a progressive decline in their ability to perform everyday tasks, such as activities of daily living and handling their finances (Ueda et al., 2013; Wadley et al., 2007). When compared with other older adults, older adult with dementia are at higher risk of sprains, fractures, impaired balance, and visuospatial impairment. The latter is a problem related to errors in judging the lengths of spaces or height of objects (Ueda et al., 2013; Wadley et al., 2007). However, although dementia is not considered a normal part of human aging, old age is a known primary risk factor for dementia (Prince et al., 2015). Of great concern to society as a whole is the high prevalence, including the large number of people currently living with dementia, the increasing number of people expected to develop dementia in the following years, and the resulting effects of dementia on a person's functioning and daily activities, their families, and their communities (Yasamy et al., 2013; Chow et al., 2018). How do we still ensure the health and well-being of this growing segment of the population while also ensuring that as a society we can support and afford the costs of care?

Fortunately, many of the chronic conditions and diseases associated with aging, including dementia, are often amendable to physiotherapy or outcomes can be improved

through physiotherapy care. Consequently, the WHO recommends access to physiotherapy services such as early diagnosis, optimization of physical health, and multimodal exercises such as progressive resistance training, balance, strength, flexibility, and aerobic exercises, as well as functional training to address dementia and most age-related chronic diseases affecting older adults (WHO, 2015; 2017a; 2019). Physiotherapists are healthcare professionals who help individuals develop, restore, and maintain functional abilities and maximum movement throughout their lifespan using several modalities, including carefully graded exercises (World Confederation for Physical Therapy, 2019; Ontario Physiotherapy Association, n.d.). Physiotherapy can help improve older adults' balance, functional mobility, and lower limbs strength while also improving active participation in activities of daily living as well as reducing their risk of falls (Blankevoort et al., 2010; Christofoletti et al., 2008).

Specifically, for older adults living with dementia, physiotherapists can help improve the physical conditions of patients, have a positive impact on psychological and behavioral symptoms associated with dementia as well as reduce reliance on pharmacological intervention (Felton et al., 2020). In 2006, Groots and colleagues published a meta-analysis of 18 physical activity randomized control trial intervention studies for older adults with dementia; they found that physical activity improved cognition and participation in the activities of daily living among older adults living with dementia. Physical activity not only improves the health of older adults living with dementia but also reduces the risk of developing dementia (Hamer & Chida, 2009; Sofi et al., 2011; Gallaway et al., 2017; Stephen et al., 2017). Regardless of the health status of older adults, they often can benefit from access to physiotherapy services.

Access to Physiotherapy Services

Older adults' access to physiotherapy services is a concept that is important to this thesis due to the need for physiotherapy services for older adult clients. However, despite the importance of physiotherapy in the well-being of older adults, including older adults living with dementia, older adults experience contexts that limit their access to and participation in physiotherapy services in multiple geo-political areas around the world. In the United States of America (USA), access to publicly funded physiotherapy services is limited for older adults below 65. Medicare, the USA's publicly funded service, is primarily for older adults over 65 (US Department of Health and Human Services, n.d.). Medicaid is an insurance program for lower-income households where few states cover physiotherapy costs for people below 65 years who do not meet certain income thresholds (US Department of Health and Human Services, n.d.; US Government, n.d.). Older adults who are able to get Medicare- or Medicaid-funded physiotherapy treatment may have to wait for up to 72 days to access physiotherapy services (Curry et al., 2021). In contrast, Australia, Denmark, and the United Kingdom provide access to publicly funded physiotherapy services for people of all ages (EmployHealth, n.d.; National Health Services (NHS), 2022). While Australia limits the number of physiotherapy sessions covered yearly and Denmark pays only a partial payment for physiotherapy services, the United Kingdom's publicly funded physiotherapy services are available to people of all ages and financial means through the National Health Services (NHS) (Ministry of Health and Prevention, 2008; Employ Health, n.d.; NHS, 2022).

Like the United Kingdom, Canada has a universal healthcare system, although healthcare services are provided through the provincial government in Canada as opposed to

nationally provided service in the UK (NHS, 2022; Government of Canada, 2023). This difference in the administration of healthcare services may explain why physiotherapy services are less accessible to older adults in Canada than in the United Kingdom (NHS, 2022; College of Physiotherapists of Ontario, n.d.; Province of British Columbia, n.d.). For example, Ontario only provides outpatient physiotherapy services for a limited population, such as those 65 years old and above, children under 19, and people receiving disability support (College of Physiotherapists of Ontario, n.d.). This means older adults below the age of 65 may have to pay out of pocket in a private physiotherapy setting. Similarly, older adults in British Columbia also experience barriers to participating in physiotherapy services. Only ten outpatient physiotherapy visits are covered yearly by the government's medical service plan (MSP) (Province of British Columbia, n.d.). Further, the MSP pays only $23 per session for physiotherapy (Province of British Columbia, n.d.). This means that older adults may have to pay out of pocket for the difference in physiotherapy charges above $23 and the full amount for physiotherapy services if they exceed the ten sessions covered by the MSP (Province of British Columbia, 2020).

Older adults' access to publicly funded physiotherapy services in Manitoba is also limited, like in other provinces in the country. This limited access in Manitoba is due to the closure of most adult publicly funded physiotherapy services for those below 65 by the Winnipeg Regional Health Authority and the transfer of such services to private practice without public funding (Brodbeck, 2017; Canada Broadcasting Corporation, 2017; Kusch, 2017). Further, older adults over 65 also experience barriers to accessing publicly funded physiotherapy services due to the waitlist for physiotherapy services, especially those older

adults living in the rural parts of Manitoba, where physiotherapy services are not offered frequently in public health care centres (Manitoba Physiotherapy Association, n.d.). Older adults below the age of 65 and those above the age of 65 who cannot wait for or are ineligible to access publicly funded physiotherapy services will often have to pay out-of-pocket for private physiotherapy services (Manitoba Health, n.d.). In addition, older adults may have to pay for assistive devices or needed equipment in public or private physiotherapy settings if they do not have third-party insurance at all or at levels that cover the cost of needed physiotherapy services (Winnipeg Prosthetics & Orthotics, n.d.; Manitoba Health, n.d.). Further, older adults may also have to pay the associated cost of accessing physiotherapy services, such as transportation for in-person care or internet costs for remote physiotherapy care. These costs could be a barrier to care as older adults' ability to pay depends on their finances since many older adults may not have third-party insurance due to their retirement status (Allin & Hurley, 2009).

Cost-related barrier to accessing physiotherapy services is a reality for many people in Canada, including older adults. For example, Canada has the fourth-highest cost-related barrier (affordability of healthcare services) to accessing healthcare services out of 11 countries surveyed by the Commonwealth Fund (Doty et al., 2021). Over 20,000 participants from Canada and 10 other developed countries filled out the survey, where affordability was measured by the number of skipped appointments due to the inability to pay existing or new medical bills (Doty et al., 2021). Osborn and Moulds (2014) had similar results in their 2014 Commonwealth Fund survey analysis of 15,617 older adult participants from Canada and ten other developed countries. Canada ranked 3rd highest in cost-related barriers to accessing healthcare. When

Doty and colleagues (2021) compared high-income and low-income access to healthcare, Canada had the third highest cost-related barrier to healthcare. This means older adult clients' access to physiotherapy services in the Canadian healthcare system may be dependent on their financial situations.

Older Adults' Finances, Financial Well-Being, and Financial Capability

Understanding older adults' finances and the factors that influence it is important in discerning if older adults' experience cost-related barriers to accessing and participating in physiotherapy services. Financial well-being and financial capability are related terms used to describe an individual's financial context (Kempson & Poppe, 2018a). Financial well-being is the extent to which anyone can fulfill their present financial needs and meet such obligations in the future, while financial capability is the practices and methods of making financial decisions that affect a person's financial well-being (Kempson et al., 2017; 2018a). Financial well-being in Canada is measured by the Financial Consumer Agency of Canada (FCAC) based on factors such as household income, savings, and the ability to cover monthly expenses without borrowing (FCAC, 2021).

The FCAC survey of 2021 established that most older adults in Canada do not have good financial well-being. The FCAC survey was completed by 1,935 Canadians of all ages. By analyzing the data from the survey, the FCAC extrapolated that only 16.5% of older adults in Canada have good financial well-being while also asserting that having good financial well-being is not a guarantee that any individual will not experience cost-related barriers to accessing needed services or supports, which could include physiotherapy services (FCAC, 2021; 2023).

Recent data from the FCAC financial well-being survey 2023 (data not presented in age groups) show that more Canadians now worry about money, have more debts, and have difficulty covering their monthly expenses than they did in 2021 (FCAC, 2023). This is concerning as older adults' financial well-being can influence their access to and participation in physiotherapy services.

Several factors contribute to older adults possibly not having good financial well-being. The first financial contextual factor that can affect older adults' financial well-being and potentially limit their access and participation in physiotherapy services is fixed or limited income in the context of inflation and overall lower buying power of economic units (Service Canada, 2022). Older adults receive pensions and/ or have retirement savings that are usually fixed, limited, or both; this retirement income is usually significantly lower than what they earned while working despite their expenses remaining relatively constant (Service Canada, 2022). This can limit the available financial capital individuals can use to access or engage in needed care, including physiotherapy care. According to the report submitted to the Deputy Minister, Ministry of Health, Seniors and Active Living in Manitoba by the Canadian healthcare consulting firm Health Intelligence Incorporated, almost 50% of older adults living alone in Manitoba earn below $20,000 annually, far below the Canadian standard for having 'good' financial well-being and below the income required to be above the poverty line (Peachy et al., 2017, FCAC, 2021). The current income to be above the poverty line in Winnipeg is $50,942 and $46,779 in Brandon as of 2022 (Statistics Canada, 2023b). In addition, the value of money set aside in retirement savings funds continues to decline due to inflation, which increased rapidly in recent years (Statistics Canada, 2023). For example, in the last three years, Canada's average

consumer price index (CPI) rose from 0.1% to 3.3%, with Manitoba reporting a CPI rate of 2.6% (Statistics Canada, 2023; Bank of Canada, 2023). This increase in CPI suggests Manitobans and other Canadians are paying more for goods and services, which may further decrease their limited resources, and potentially reduce the amount of money available to spend on physiotherapy services.

Financial exploitation is the second financial contextual factor that can affect older adults' financial well-being and potentially limit older adults' access and participation in Physiotherapy services. Older adults are at high risk of financial exploitation, such as financial misappropriation, theft, fraud, or coercion, thereby jeopardizing their financial well-being, while older adults living with dementia are at greater risk of being victimized or abused financially (Huang & Lawitz, 2016; Gamble et al., 2014; Peterson et al., 2014). Lack of social support, depression, and cognitive decline put older adults at risk of financial exploitation, which can deplete their already limited funds and, consequently, influence their financial well-being (Lichtenberg, 2016; Beach et al., 2018). Lichtenberg and colleagues (2013) and Lichtenberg and colleagues (2016) estimate that one in twenty older adults above the age of sixty will experience financial exploitation, while Kemp and Perez estimated that 46.7% of 6,297 older adults sampled have experienced financial exploitation (Kemp & Perez, 2023). Paks and Shadel (2011) assert that the prevalence of this exploitation is under-reported as many victims are unaware they have been exploited or unwilling to admit the exploitation. According to the framework of financial exploitation of older persons by Rabiner and colleagues (2004), factors that increase the likelihood of financial exploitation in older adults include social isolation, loneliness, and living alone.

The last financial contextual factor that can potentially limit older adults' access to and participation in physiotherapy services is financial capability decline. As described earlier, financial capability is the ability of any individual to apply financial knowledge, skills, and attitude to engage in needed financial behaviours, where increased financial capability can promote financial well-being (Xiao & O'Neil, 2016). Although some researchers use financial capability and financial literacy interchangeably, Kempson and Poppe (2017) distinguished the two terms. In their model, financial literacy is what individuals know, while financial capability includes financial literacy and what individuals do (i.e., real-world behaviors) based on their knowledge, skills, attitudes, or confidence.

Older adults experience decreased rates of financial capability secondary to increased rates of diagnosis of mild cognitive impairment and dementia (Ukraintseva, 2006; WHO, 2019), which can lead to financial errors, decline in financial well-being, and reductions in available financial resources that might be valuable to accessing and participating in physiotherapy services or other health and well-being needs (Marson, 2001; Manivannan et al., 2022). Manivannan and colleagues (2022), in their mixed-method study involving 97 participants (mean age of 74.5± 15.6 years), found that older adults experiencing cognitive or memory-related decline often forgot they had paid a bill and subsequently paid it again, while other older adults with dementia exhibited increased impulsivity and spending that leads them to accrue debt. Giebel and colleagues (2023), in their qualitative study with unpaid caregivers or family members of people living with dementia, submitted that older adults with dementia often lose their ability to manage their finances before receiving a dementia diagnosis, leaving them vulnerable to financial mismanagement. These behaviors may lead to concerns about

preserving the family's assets and affording long-term care, such as private physiotherapy services and equipment needed to manage dementia (Manivannan et al., 2022).

Financial capability issues, reduced income, and inflation have led to an increase in debt, poverty, and a reduction in disposable income among older adults, which can limit the funds they have available to access or participate in needed healthcare, such as physiotherapy services (Statistics Canada, 2019). According to Marshall (2017), one in three retirees retired with an average debt of $60,150. These debts include mortgages, payday loans, student loans, lines of credit, and credit card debt (Marshall, 2017). Statistics Canada (2019) estimated that an average of 4 out of every 10 of older adult families live in debt, including debt such as mortgage debt and consumer debt. In addition, over 300,000 older adults live below the poverty line (Statistic Canada, 2023c). The household debt to disposable income has doubled from 86 cent per dollar earned to 1.76 per dollar earned (Statistics Canada, 2019); this means that an average household owes $1.76 for every dollar they earn (Statistics Canada, 2022). Low disposable income may make more older adults retire in debt, reduce their financial well-being and the amount of money they can spend on important things such as their health (Statistics Canada, 2019), which may, in turn, hinder or limit older adults' access and participation in physiotherapy services.

Health Disparity and Inequitable Access to Healthcare Services

Older adults' financial well-being can influence not only their access to physiotherapy services but also their health. People with poor financial well-being have worse health outcomes with medical treatment, lower life expectancy, and are more likely to become sick or

develop chronic health conditions (Schoeni et al., 2005; Peterson et al., 2021). Specific to older adults, financial well-being is directly related to healthy aging, with older adults with decreased financial well-being being at higher risk of disease. For example, an analysis of the National Health Interview Survey (NHIS) data from 1982 to 2002 consisting of almost 200,000 older adult participants established that people with poor financial well-being have a higher incidence of disease and difficulty participating in instrumental activities of daily living than their counterparts who have increased financial well-being (Schoeni et al., 2005). Petersen and colleagues (2021) also found in their cross-sectional study of over 10,000 older adults in Denmark that older adults with poor financial well-being were more likely to receive a diagnosis of dementia after a referral and have more severe cognitive impairment when compared to older adults with good financial well-being.

Despite the higher incidence of disease among older adults with poor financial well-being, there is evidence that suggest that individuals with poor financial well-being have lesser access to healthcare services, including physiotherapy services, when compared to older adults with good financial well-being (Agyemang-Duah et al., 2019). Reduced financial well-being is associated with a lesser likelihood of screening for diseases, preventative care, and healthcare utilization (visit to healthcare facilities) to address medical conditions in studies conducted in Austria, Spain, and Chile (Viera et al., 2006; Brunner et al., 2013; Rotarou & Sakellariou, 2018). Agyemang-Duah and colleagues (2019) conducted interviews and focus group discussions with 30 older adults with poor financial well-being and their caregivers in Ghana. They reported that factors that lead to the underutilization of healthcare services by poorer older adults include

transportation costs, low income, costs associated with healthcare utilization, and the non-comprehensive healthcare system that requires older adults to pay for some services.

The significant role older adult clients' financial well-being plays in access to healthcare, including physiotherapy services, and the incidence of diseases gave rise to the inverse care law (Cookson et al., 2021). Tudor Hart coined the inverse care law (ICL) in 1971 to chronicle the dual injustice faced by socially disadvantaged individuals who tend to experience more disease but receive less care. According to Hart (1971), characteristics of socially disadvantaged individuals are low income, area deprivation (e.g., socioeconomically disadvantaged areas), female gender, non-white ethnicity, and low social class. Thirty years after coining the law, Pell and colleagues (2000) affirmed that the ICL is not a law enforced by nature but by the dehumanized economic factors facilitated by an equally dehumanized society that subject access to healthcare to financial means. The WHO (2000) echoed Hart's assertion that everyone should be able to access healthcare services equally, irrespective of their financial status.

The World Health Organization has highlighted several ways to increase more equitable healthcare access by 2030 (WHO, 2021). First, everyone should be able to access high-quality healthcare at an affordable rate. The cost of accessing care should not lead to financial difficulties. Second, the healthcare sector and practitioners should monitor for signs of health inequalities through clients' health outcomes and the quality of health service delivered. Finally, practitioners, such as physiotherapists, must collaborate with other sectors influencing equity to reduce inequitable access to healthcare, including physiotherapy services (WHO, 2021).

Calls for Equity Within Physiotherapy

In line with the WHO's charge that healthcare practitioners should work on reducing inequitable access to healthcare services, including physiotherapy services, there is a growing movement in physiotherapy on the need to move from the current normative view of physiotherapy practice to client-centred physiotherapy practice. The current normative view of physiotherapy practice, the biomechanical perspective, has traditionally been central to the identity of the physiotherapy profession (Nicholls & Gibsons, 2010). The current biomechanical perspective views the body as a machine without acknowledging the relationship between an individual's physical body and their contextual factors, such as financial well-being (Nicholls & Gibsons, 2010). This is despite financial well-being associations to health, health outcomes, and access to and participation in physiotherapy services. According to David Nicholls (2017), the current normative biomechanical view cannot be continued as physiotherapists need to move from treating the body like a machine to exploring physiotherapy practice from political, psychological, sociological, and economic standpoints. Others also argue that physiotherapy practice needs to move to a client-centered practice where a client's contextual factors, including finance, are considered in clinical reasoning (Harris, 1993; Cervero, 1998; Epstein, 2000; Higgs and Jones, 2008). In Canada, David Nicholls' ideal was echoed by Michel Landry when he stated that physiotherapists in Canada need to rethink the scope of their clinical practices, accountability, patient access, and payment for services rendered, as these can affect clients' access, including older adult clients' access and participation in physiotherapy services (Landry, 2009 as cited by Gibsons et al., 2010).

Physiotherapists' Clinical Reasoning

A good understanding of how a client's context can influence their physical health is vital for clinical reasoning and, ultimately, clients' health outcomes (Borell-Carrio et al., 2004). Clinical reasoning, also known as practice decision-making, involves making meaning through multiple factors such as clients' complaints, practice models, and workplace and clients' contexts (Jones et al., 2008). The goal of clinical reasoning should be to facilitate client-centered care (Higgs and Jones, 2008). Client-centered care is the process of including a client's contextual factors, such as social, psychological, and financial factors, in a shared decision-making process between the patient and the physical therapist (Harris, 1993; Cervero, 1998). It involves knowledge from practice, metacognition (awareness and understanding of one's thought process), and reasoning (Higgs and Jones, 2008). Various types of clinical reasoning physiotherapists utilize in their clinical decision-making are presented in Table 1 below. The various types of clinical reasoning were synthesized from various literature describing the types of clinical reasoning.

Table 1

Physiotherapists' Clinical Reasoning, Definition, and Evidence of Use

Type of Clinical Reasoning	Definition	Evidence of Use
Predictive	Predictive reasoning is where the physiotherapist predicts future scenarios that might occur, and in response to such prediction, they explore options and the possible	McGlinchey and Davenport (2015), in their qualitative research involving seven neuro physiotherapists, reported that physiotherapists withdrew their

	implications of each option (Edward et al., 2004; Jones et al., 2008)	services from stroke patients when they stopped making progress because of others who needed their services. This is an instance of predictive reasoning because therapist predicted future therapies would not create additional gains in function.
Diagnostic	Diagnostic reasoning describes physiotherapists arriving at a diagnosis based on functional and physical impairment a client exhibits (Doody & McAteer, 2002; Jones et al., 2008)	May and colleagues (2008), in their qualitative research with 26 expert physiotherapists, reported that diagnostic reasoning was the most used clinical reasoning among clinicians for impairments, pattern recognition, and diagnosis.
Narrative	Narrative reasoning involves utilizing patients' context, culture, experience, and beliefs in understanding illness and disability experience.	May and colleagues (2008) also reported in their qualitative research with 26 physiotherapist participants that physiotherapists often utilize narrative reasoning in communicating with clients about management plans. The therapist was able to get information about the clients' context and general life story or narrative through communication. This information provided a basis for diagnosis and treatment.
Ethical	Ethical reasoning describes the anxiety and resolution of any ethical dilemma that might occur during the treatment of patients (Jones et al., 2008). They are decisions physiotherapists have to make about moral, political, and economic problems (Neuhaus, 1988; Gordon et al., 1994; Barnitt &Partridge, 1997)	Praestegaard and Gard (2013), in their qualitative research with 21 private practice physiotherapists, reported that physiotherapists admitted to manipulating the dates so that patients with poor financial well-being could continue receiving free physiotherapy services paid for by the Danish government even though it was illegal. This is ethical reasoning as therapists

		had to make decisions that were moral to them despite it being illegal.
Pragmatic	Pragmatic reasoning describes what is attainable based on the personal and practice context of the therapist, which includes financial factors such as available resources and reimbursement (Schell &Cervero, 1993)	In their mixed methods study, O'Brien and colleagues (2021) reported that physiotherapists often consider patients' factors, such as payer and insurance, when prescribing walking aids to stroke survivors and clients living with brain injury. This is pragmatic reasoning because they were adjusting their recommendation based on ability to pay.
Collaborative	Collaborative reasoning describes the shared decision-making process and knowledge transfer between the clients and the physiotherapists (Jones et al., 2008; Edward et al., 2009)	In their article, Edwards and colleagues (2004) described a physiotherapist who prescribed an Ezi walker, which cost about $350 to a patient. The woman thought it looked like her four-wheel shopping trolley. Looking at the clients' financial situation and understanding the aim of the walker, the physiotherapist and the patient worked together to modify her existing trolley to perform the same function as the Ezi walker. This is collaborative reasoning because the therapist and the client worked together to modify her trolley.

Several factors affect physiotherapists' clinical reasoning: workplace practice models, physiotherapists' personal factors, and patients' contextual factors (Smith et al., 2007). The physiotherapy workplace practice context that can influence clinical reasoning includes: (1) physiotherapist's client load, where the more patients a physiotherapist has to attend to, the

less time they have to spend on each patient; (2) decision-making guidance system, which is the existence of an informal or formal decision-making protocol or pathways in the workplace; and (3) the prevailing healthcare model adopted in the workplace (Smith et al., 2007; Swinkels et al., 2011; Holdar et al., 2013). Physiotherapists' factors include: (1) years of practice and personal experience, where research has shown that the more experience a physiotherapist has, the broader their understanding of the patient, and the more they can produce more effective outcomes (Jensen et al., 2000; Resnik & Jensen, 2003; Edward et al., 2004); (2) the capacity to carry results of research into practice; and (3) belief of the relevancy of such research results to their clinical practice (Kamwendo, 2002; Grimmer-Somers et al., 2007). Clients' contextual factors include: (1) clients' understanding of their conditions, (2) state of health, and (3) financial well-being (Higgs and Jones, 2008; O'Brien et al., 2021).

Justification for Research: Identifying the Gap

Older adult clients' financial well-being plays a significant role in accessing and participating in private physiotherapy services and paying for needed equipment and assistive devices prescribed in public and private physiotherapy settings. However, older adults experience financial barriers in accessing and participating in physiotherapy services. Physiotherapists can improve older adult clients' access to and participation in physiotherapy services by including clients' finance in their clinical reasoning for people who were able to access at least one physiotherapy session. Despite the importance of older adult clients' financial well-being in physiotherapists' clinical reasoning, only a few studies have examined if and how physiotherapists consider clients' financial well-being in their clinical reasoning with mixed results (Table 2). Studies from countries around the world, such as findings from Sander

and colleagues (2013; United Kingdom), Singla and colleagues (2015, Australia), Madsen and colleagues (2016; Denmark), and Daluiso-King and Hebron (2022; England), report that physiotherapists do not routinely consider clients' financial well-being in their clinical reasoning. They did not consider clients' finances in clinical reasoning due to factors such as (1) poor understanding of its relevance in clients' clinical presentation (Singla et al., 2015), (2) lack of capacity in assessing for this (Sanders et al., 2013; Singla e al., 2015; Daluiso-King & Hebron, 2022), and (3) belief that it is not within the immediate scope of their practice (Sanders et al., 2013; Singla et al., 2015; Daluiso-King & Hebron, 2022). O'Brien and colleagues (2021; 2023) and Sturm and colleagues 2024, reported that physiotherapists from many countries often consider clients' financial well-being in their clinical reasoning.

However, none of the previous studies described in this section were conducted in Canada, which has a provincially administered healthcare system and a healthcare context different from that of previously done studies. Also, none of the previous related studies were specific to the older adult population. This gap in literature suggested a need for a Canada-based study on physiotherapists' clinical reasoning relating to older adult clients' financial well-being, considering its importance in access to and participation in physiotherapy services. In addition, I explored the influence of dementia or age-related cognitive impairment on physiotherapists' clinical reasoning related to older adults' finances due to the effect cognitive impairment may have on financial well-being.

Table 2

Literature Matrix of Past Studies on Physiotherapists' Clinical Reasoning Related to Older adult Clients' Finances (n=7articles, listed in chronological order of publication date)

Author, Year, and Country of Publication	Research Method	Research Purpose	Result	Recommendations/ Implication For Practice
Sanders et al., 2013 UK	Secondary analysis of semi-structured interviews with 12 physiotherapists.	To explore how physiotherapists balance the mechanical and psychosocial components of patients' back pain care	(1) Merging biopsychosocial factors with traditional physiotherapy treatment was challenging. (2) Physiotherapists attempt to navigate clients' biopsychosocial problems by addressing the health beliefs of clients and setting boundaries on clinical roles (3) Psychosocial factors potentially limited clients' adherence to physiotherapists' advice.	There is a need for physiotherapist-patient consultations observational studies and comparison of the result of observation to patients' and clinicians' accounts.
Singla et al., 2015 Australia	Semi-structured interview of 9 private practice physiotherapists.	To explore if private practice physiotherapists assess patients' psychosocial status	(1) Physiotherapists showed a poor understanding of the role of psychosocial factors in patients' clinical presentation, (2) physiotherapists were unclear on how to assess for psychosocial factors in patients	Further research is needed to determine if this research results are representative of other physiotherapy practices.

Madsen et al., 2016 Denmark	530 therapists answered an experimental factorial vignette survey describing four fictitious patients (Occupational therapist:173 Physical therapist:357)	To investigate if clients' socioeconomic factors influence therapists' clinical judgments.	They found no statistically significant association between the patient's socioeconomic status and physiotherapists' clinical judgments	Varying judgements among participants when presented with the same case suggest differences in clinical reasoning among professionals. More research is needed on the relationship between patients' socioeconomic status and physiotherapist's clinical judgment.
O'Brien et al., 2021 USA	Mixed method study with 67 participants. 57 participants answered the survey, and 19 participants participated in focus group discussions	(1) To describe the clinical reasoning process used to prescribe assistive devices during inpatient rehabilitation in patients with stroke and (2) to determine if physiotherapists' clinical reasoning is affected by the type of facility they work and the diagnosis	Three factors affected physiotherapists' clinical reasoning. (1) Primary factors such as balance, strength, and function; (2) therapists' factors such as experience, training, and objective tools; and (3) patients' factors such as diagnosis and payer or insurance	An understanding of the clinical reasoning involved in prescribing walking aids can help us understand how the process involved in prescription and consistency or divergency in clinical reasoning.
Daluiso-King & Hebron (2022) England	Systematic review with seventeen articles included	(1) To explore the relevance and conceptual transparency of Biopsychosocial model (BPSM) and expand on BPSM framework for practice	(1) Physiotherapists did not often use the BPSM in their clinical reasoning because they had the perception that psychosocial factors were outside the scope of their practice (2) The use BPSM enhanced person-centre care	There is a need to reconceptualize the current BPSM. The current BPSM does not accurately represent the complexity of person-centred approach. A new BPSM that can support holistic

				person-centred care is required.
O'Brien et al., 2023 USA	A mixed-method study with 74 PTs and PTAs	(1) To describe the factors influencing the clinical reasoning process used to prescribe walking aids in-home care physiotherapy (2) To describe practice contexts related to walking aids prescription	Nine factors influence physiotherapists' clinical reasoning related to walking aid prescription. Insurance versus self-pay was one of the nine factors considered.	Knowledge of factors that influence clinical reasoning related to walking aid prescription can benefit early carrier physiotherapists' training.
Sturm et al., 2024 Austria	Descriptive qualitative research with 200 respondents from 72 countries	(1) To explore, map, and describe factors involved in physiotherapists' ethical decision-making process	Forty-three factors were identified. They include: (1) physiotherapist's personal factors, (2) relational factors, (3) organizational factors, (4) societal factors, (5) situational factors, which include physiotherapists' and clients' finance	Physiotherapy practitioners and students need to understand, reflect, and utilize ethical reasoning in their clinical reasoning.

Purpose and Objectives

The purpose of this proposed study was to explore if and how physiotherapists in Manitoba, Canada, consider older adults' financial well-being in their clinical reasoning and care plan to improve access and participation in physiotherapy services.

The following objectives guided this research:

1. To examine why physiotherapists consider or do not consider older adult clients' financial well-being and financial-related access and participation in physiotherapy care in their clinical reasoning and care plans.

2. To describe the barriers and facilitators to considering older adult clients' finances and economics in their clinical reasoning and care plans.

3. To investigate if and how other older adult clients' diagnosis of dementia or cognitive impairment affects the clinical reasoning and care plans associated with older adult clients' finances and economics.

Chapter III: Methods

Theoretical Frameworks

Two distinct frameworks (i.e., the Access to Care Framework and Financial Well-Being Model) are foundational to my thesis. They are discussed below.

1. Access to Care Framework

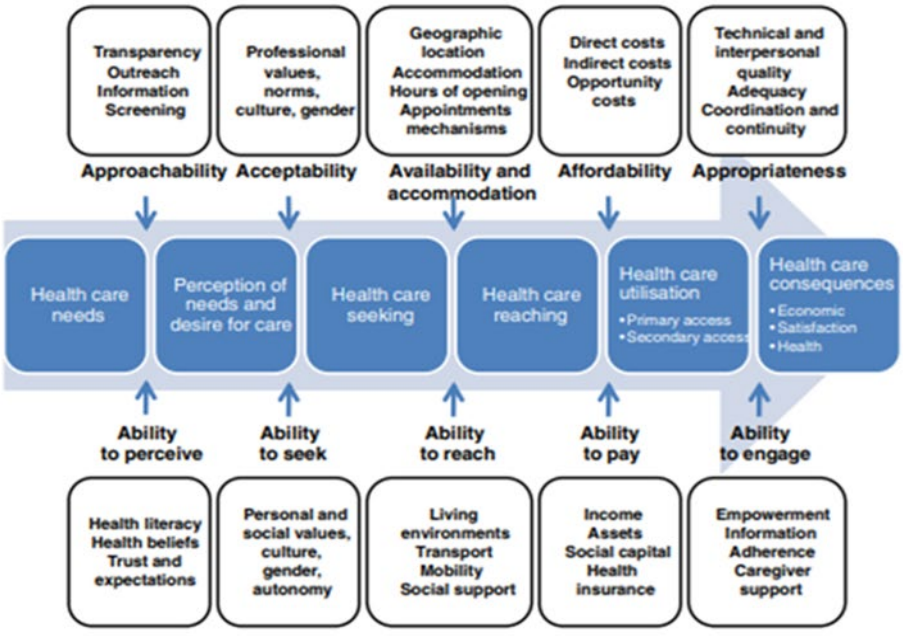
Access to healthcare is vital to the health and well-being of individuals, including older adults (WHO, 2017a; 2019). The importance of access to healthcare in human life has resulted in the formulation of frameworks around access and participation in healthcare services (Penchansky & Thoomas, 1981; Shengelia et al., 2005). One such framework is the one delineated by Levesque and colleagues (2013) that I used in my thesis. This framework provides a broad perspective of how healthcare costs, such as physiotherapy services, can affect access and its impact on the utilization of needed care.

The Levesque and colleagues (2013) model (Figure 1) guided my thinking about access to physiotherapy services. This model describes access and participation in healthcare services, which could be inclusive of physiotherapy, as being dependent on factors related to demand (i.e., patients' or clients' need for services) and supply (in this research, the supply being physiotherapy services). Within "supply", accessibility to services relies on approachability, acceptability, availability, affordability, and appropriateness. In contrast, the "demand" is influenced by factors such as the ability to perceive, seek, reach, pay, and engage in the need for healthcare services. The dynamic congruence, or lack thereof, of dimensions of accessibility (i.e., supply) and abilities of the individuals, families, or communities (i.e., demand) would

dictate if the processes of accessing adequate healthcare can happen (i.e., healthcare needs, perceptions of needs and desire for care, health care seeking, healthcare reaching, health care utilization, health care consequences); a mis-congruence between respective supply and demand factors can mean that there were barriers to healthcare access that can limit clients' abilities to seek, utilize, or reach healthcare services. In framing my study, I did not use the whole framework for my research. Instead, I focused on how the affordability of services and accessing services, which is measured in direct costs, indirect costs, and opportunity costs, and clients' ability to pay measured in income, assets, social capital, and health insurance, can influence access, including the ability to reach, pay, and engage, in needed healthcare services (Levesque et al., 2013).

Figure 1

Access to Care Framework (Levesque et al., 2013, p 5)



Note: Figure used with permission of author and copyright holder (see email Appendix A)

Specifically, in this framework, the affordability dimension of supply appreciates that healthcare often requires time and resources to access and engage in the needed healthcare services, including physiotherapy services. This includes direct costs, such as the cost of care associated with accessing private physiotherapy services and purchase of equipment and assistive devices in public or private physiotherapy settings. Indirect costs include the time and money expended on transportation to the treatment location; as well as opportunity costs which are the benefits (needed items or wants) clients would have to give up to access and participate in the needed physiotherapy services (Levesque et al., 2013). The client's ability to pay for private physiotherapy services and equipment and assistive devices in private or public physiotherapy settings depends on income, savings, and loans or borrowing, which are all major determinants of financial well-being in Canada. In essence, this framework explained the possible relationship between access and finance and the various factors that might influence access and participation in physiotherapy services and would be the further focus of my study.

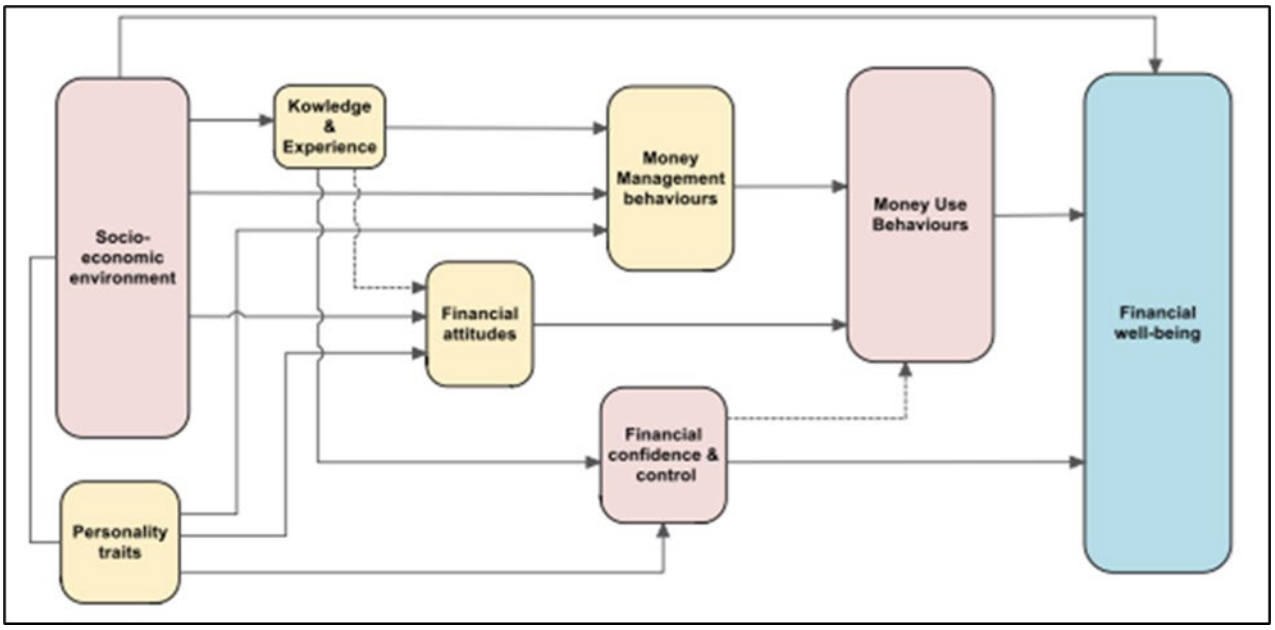
2. Financial Well-Being Model

As discussed in the literature review, financial well-being plays a vital role in the access to care and participation of older adult clients in physiotherapy services. Financial well-being is the extent to which anyone can fulfill their present financial needs and obligations and the ability to meet these needs in the future. In contrast, financial capability is the practices and methods of making financial decisions that affect a person's financial well-being (Kempson and Poppe, 2018a). Financial capability is also described as an individual's ability to use relevant

financial knowledge and engage in desired financial behaviors to improve their financial well-being (Xiao & Neill, 2016). To understand how several factors interact to determine the financial well-being of any individual, Kempson and Poppe published three iterations of their financial well-being frameworks between 2017 and 2018 (Kempson et al., 2017; Kempson & Poppe 2018a; 2018b). I used the Kempson and Poppe framework (2018a) in this study to explain the various factors that influence older adult clients' financial well-being (Figure 2).

Figure 2

The Financial Well-being and Capability Model (Kempson & Poppe, 2018a, p 74).



Note. Factors that directly affect financial well-being are in pink boxes and the factors that indirectly influence financial well-being are in yellow boxes. Figure used with permission of author and copyright holder (see email Appendix A). Error in spelling of 'knowledge' is from source document.

I choose the Kempson and Poppe (2018a) framework for financial well-being because: (1) it is an expanded version of the Kempson and Poppe 2017 version utilized by the Financial Consumer Agency of Canada (FCAC) (2021) survey of Canadians' financial well-being described in the older adult finance part of this literature review, and (2) it includes factors such as impulsivity, self-control, and social status that are missing from the other models. These factors missing from other models are important to my research as they explain why older adult clients could potentially have poor financial well-being, resulting in difficulty in accessing and participating in physiotherapy services.

In alignment with Kempson and Poppe's financial well-being framework (2018a; Figure 2), several factors affect financial well-being and are classified into direct and indirect factors. The first factor that directly influences the financial well-being of individuals, including older adults, is socioeconomic factors, a combination of socio-demographic and economic variables. They include gender, age, family circumstances, employment status, income and expenditures, and any changes in income and expenditures (Kempson & Poppe, 2017; 2018a). As explained in the literature review, socioeconomic factors are particularly important in older adult clients who, due to their age, are mostly retired and have experienced a drop in their income even though their expenditure has stayed fairly constant. Consequently, they may have poor financial well-being due to their socioeconomic environment. The second factor that can directly influence the financial well-being of older adults is financial confidence and control (Kempson & Poppe, 2017; 2018a). This describes the ability to manage daily monetary matters, plan for the financial future, and make decisions on financial services and products. Managing monetary matters and planning for the future can be challenging for older adults, especially

older adults with dementia or age-related cognitive impairment. As discussed in the financial well-being portion of the literature review, older adults with dementia often experience difficulties managing their finances, are prone to financial abuse, and are at risk of losing the family assets that could help them pay for accessing physiotherapy services (Marson, 2001; Manivannan et al., 2022; Rogers et al., 2023).

The last factor that can directly influence the financial well-being of older adult clients is money use behavior or financial capability (Kempson & Poppe, 2018a). Financial capability is determined by the ability of an individual to manage their spending within their means, not to borrow to cover their daily expenses, and actively saving for the future (Kempson & Poppe, 2018a; 2018b; FCAC, 2021). Income and expenses greatly influence active saving and not borrowing to cover daily expenses. A drop in income, like when an older adult retires, may significantly influence the amount of money left to cater to living expenses, which could lead to older adults borrowing to cover their daily obligations and consequently negatively impacting their financial well-being (Kempson & Poppe, 2018a). Further, older adults are not generally in the developmental or financial growth phase (i.e., not actively saving money); instead, they are spending their savings due to potential income drop after retirement, which could also negatively impact their financial well-being and, consequently, their ability to pay for physiotherapy services.

Personality traits, financial attitudes, knowledge, and money management behaviours directly influence financial capability (Kempson & Poppe, 2018a). These factors are also the indirect factors that influence financial well-being. Money management includes being able to make an informed decision, budgeting, and keeping track of how money is spent. Financial

knowledge and experience includes being able to choose the right financial products, understanding financial risks, and experience with managing finances. Personality trait includes impulsivity, self-control, and action orientation, which are important to older adult clients, especially those with dementia who often exhibit impulsivity and have difficulty with self-control. Impulsivity is the tendency to take actions and make decisions on impulse rather than after careful thoughts (Moeller et al., 2001). Tamam and colleagues (2014), in their qualitative study, including 76 patients who are 60 years and over, discovered that the prevalence of Impulsivity is 22.4% among older adults. Impulsivity can negatively affect the financial well-being of older adults and, consequently, their access to and participation in physiotherapy services. In summary, this framework helped me understand various factors that can influence older adult clients' finances and, consequently, their participation in physiotherapy services.

Research Design and Paradigm

To address the objectives of this study, I used descriptive qualitative research and an experiential reflexive thematic approach, as described by Braun and Clarke (2022). Qualitative research can be descriptive and analytical because it seeks to comprehend, describe, and analyze the complex processes, meanings, and perceptions that people have and form due to their experiences, settings, and surroundings (Ravitch & Carl., 2021). An experiential qualitative approach centers on how participants express their experiences (Braun & Clarke, 2022), which is important to this research, where I sought to understand and describe the clinical reasoning of physiotherapists relating to the financial well-being of older adult clients, including those clients living with dementia.

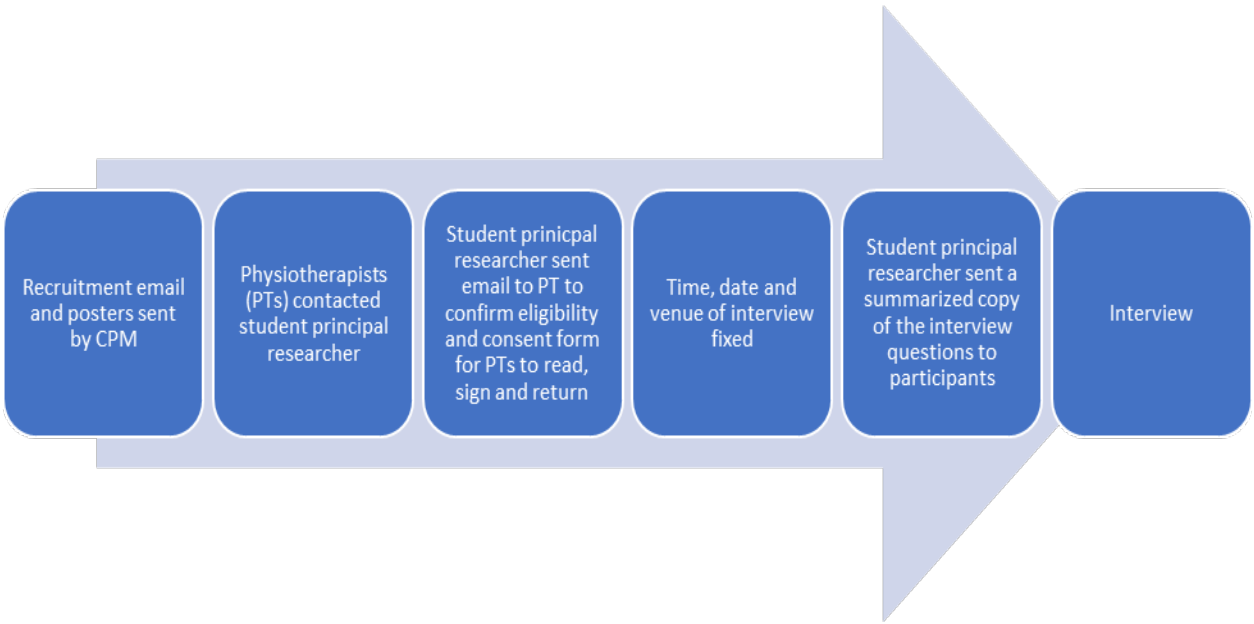
Reflexive thematic analysis (described in more depth in the analysis section below), like all research work, is rooted in and informed by a philosophical, theoretical paradigm, which includes one's ontology and epistemology (Braun & Clarke, 2022). Ontology relates to one's theory about the nature of reality, while epistemology is the theories about the nature of knowledge and how knowledge is produced (Crotty, 1998; Braun & Clarke, 2022). This research was underpinned by critical realist ontology, as I believe that truth about reality is subjective because the human perception of the truth is influenced by interactions with others and the person's context (Danermark et al., 2002; Braun & Clarke, 2022). Critical realism ontology is a combination of the ontology realism, which is the truth exists independent of anyone, and the epistemology relativism you cannot access the truth in its pure form (Braun & Clarke, 2022). Critical realism argues the truth exists independent of anyone's description or ideas but that our experiences of the truth are socially located which can lead to different conceptualization and interpretation of the truth by various individuals (Braun & Clarke, 2022). I situated my research in a constructivist epistemology in line with the ontological assumption that the truth is socially influenced (Pilgrim, 2014). Constructivism asserts that an individual's knowledge is a cultural and social construct, and people create their understanding and knowledge not just in schools or academic environment but through individual experiences and by reflecting on those experiences (Gerstenmaier & Mandl, 2001; Fosnot, 2013).

This ontological and epistemological assumption is important in my research as participants in this study were physiotherapists in Manitoba who might have had similar education and clinical experiences in the same institutions or the same developed country (Canada). However, due to my ontological and epistemological positions, I argued that they

could have had other different experiences, such as sociocultural and economic backgrounds, which influenced their clinical reasoning differently. Furthermore, these individual physiotherapists will have reflected differently on their experiences, leading to differences in their knowledge and clinical reasoning. Due to possible differences in the participants' experiences, reflection, gender, and years of practice that can influence clinical reasoning (Epstein et al., 2016; O'Brien et al., 2021), I used the methods within this paradigm to explore participants' interpretation of their clinical reasoning which, according to Gubrium and Holstein (2009), is the goal of a qualitative interview.

Figure 3

Flow Chart of Various Stages Involved in This Study



Recruitment Strategy

I recruited participants through the College of Physiotherapy of Manitoba (CPM). The justification for this recruitment strategy is that it is mandatory for practicing physiotherapists in Manitoba to belong to the College of Physiotherapy of Manitoba. I asked CPM to provide recruitment support by sending the study poster with an overview of the study, the eligibility criteria, and the recruitment email describing the study to physiotherapists within their roster. Interested potential participants contacted me (the student investigator) via email to signify their interest in participating in the study or desire to learn more about the study. Figure 3 above shows all the stages participants went through to take part in this study.

Recruitment and Sampling

I included physiotherapists from the Canadian province of Manitoba who met the eligibility criteria described below. The inclusion criteria were:

i. physiotherapists who have practiced for at least two years,
ii. physiotherapists who are practicing or have practiced in a clinical setting within the last five years, and
iii. physiotherapists who self-reported to have worked with older adults in private or public care practice or at least have some older adult client practice experience in Manitoba.

The exclusion criteria were:

i. physiotherapists who were unable to communicate in the English language, or
ii. physiotherapists whose workplace guidelines or policies did not permit them to participate in this research (i.e., during informed consent, participants were asked if

they were aware of any workplace policies or regulations that would prohibit them from participating in research that discuss their work in a physiotherapy clinic).

To provide a rationale related to the years of practice inclusion criteria, I made this decision based on clinical reasoning evidence. Experience is one of the factors involved in clinical reasoning (Higgs & Jones, 2008). Physiotherapists included in this research had to have practiced for at least two years or more because previous research by O'Brien and colleagues (2021) identified that entry-level physiotherapy qualifications may not prepare physiotherapists for the complex clinical reasoning process. Instead, many new physiotherapists may rely on their more experienced senior colleagues for guidance to develop their clinical reasoning process, which may require some years of practice before clinical reasoning and clarity about one's clinical reasoning develop.

Twelve physiotherapists signified interest in participating in this study after sending recruitment materials (appendices B and C) but only 10 physiotherapists met the eligibility criteria to partake in this study. Out of the ten physiotherapists who met the eligibility criteria, only nine completed the informed consent process and participated in this study. A smaller number of participants can be included in qualitative studies, especially in a homogenous group, as the goal of a researcher using constructivist epistemology is to understand depth rather than breadth (Boddy, 2016; Malterud et al., 2016). To improve the depth of the data from my small sample size, I attempted to use maximum variation sampling to recruit participants with varying years of experience, gender, and educational level if they met the eligibility criteria enumerated above (Miles & Huberman, 1994; Palinkas et al., 2013). However,

due to the relatively lower response to my recruitment call, I recruited everyone who showed interest in the study and met the eligibility criteria.

Data Collection

I sent individuals who signified their intention to participate in this study a copy of the study informed consent form (Appendix D), and I provided them the option of meeting me, the student principal researcher, by phone or online to go through their list of questions or concerns. I asked interested individuals to return the consent form to me after they had completed it if they felt confident that all their questions had been answered. After completing the consent forms, participants were asked to select their preferred interview setting, which could be through a teleconferencing site (e.g., Zoom or Teams) or a telephone call. Prior to their individual interview, I sent participants a summary copy of the interview questions to prepare them for the interviews. With permission from the participants through their consent forms, I recorded all interviews either with an external digital audio recorder or through the online recording and transcription option of the online platform chosen to be used by the participant.

I used semi-structured interviews (appendix E) with the nine eligible physiotherapists who participated in this study to capture each participant's current opinion and experience relating to older adult clients' finance in clinical reasoning. In alignment with the ontology and epistemology of my research, that knowledge is individually created through social experiences, I was able to learn about each participant's experience to get a broader range of experiences and perspectives about my research topic. In addition, I encouraged the participants to explain their views with open-ended questions as recommended by multiple sources (Patton, 1987;

Britten, 1995; De Marrais & Lapan, 2003). Where I wanted participants to explain further, I used probes or follow-up questions as needed in each interview. Demographic information (appendix F) was collected as part of the interview process at the end of the semi-structured interview. I, the student principal researcher for this study, either transcribed the external audio recordings from the semi-structured interviews verbatim to a written format, or I downloaded the University of Manitoba Zoom computer-assisted transcripts and checked these computer-generated transcripts for correctness while listening to the audio. Demographic information was compiled on an Excel sheet.

Data Analysis

The qualitative data was analyzed following the six steps to the thematic analysis as described by Braun and Clarke (2022): familiarization, coding, theme generating, theme reviewing, theme defining and naming, and reporting. Thematic analysis is one of the data analysis methods used in qualitative research to identify, analyze, and interpret patterns and meaningfully label these patterns, otherwise known as themes (Clarke & Braun, 2017; Braun & Clarke, 2022). I used thematic analysis to analyze my data because it applies to experiential research designs such as mine. Experiential design is used to capture the views, experiences, and perspectives of my participants in relation to the available data, and it allowed me to inductively analyze my data (Braun & Clarke, 2022; Clarke & Braun, 2017). I uploaded eight out of nine of the interview transcripts to Nvivo software version 12 to assist in the analysis process. I then proceeded with the first step in my thematic data analysis, immersion. I immersed myself entirely in the transcript to become acquainted with my data. I read the

complete transcripts several times and listened to the audio recordings during the immersion process. After immersion, I used an inductive approach to complete the coding process. Inductive approach involved using data content to develop codes (coding) (Ravitch & Carl, 2021; Braun & Clarke, 2022). Using an inductive approach, I looked through my data to identify phrases, sentences, and data meaning sections related to my study objectives. I then named these words into codes relevant to my research purpose and objectives (i.e., words related to physiotherapists' descriptions of their clinical reasoning related to older adult finances were developed into codes). After the initial coding was done, I had difficulties developing themes from the codes. To simplify the data analysis process, I sought guidance from Gale and colleagues' framework approach (2013). In particular the description of the coding processes in the article supplemental file (Gale et al., 2013), that included a step of iterative coding and development of categories prior to developing themes. Using the framework approach process of Gale and colleagues (2013), which they identify as being congruent with multiple approaches for qualitative analysis including thematic analysis, I classified my codes into categories (appendix G).

After the analysis of eight out of nine transcripts into codes and categories, I was able to develop a thirteen-page codebook including all categories, codes, relationship between different categories and definitions of the codes and categories. I intentionally did not code the last (ninth) transcript to enable triangulation of perspectives in the coding process (i.e., a strategy for trustworthiness and rigor). I was able to triangulate perspectives with two other coders: my research supervisor (Dr. Lisa Engel), who is an occupational therapy professor, and also a physiotherapy instructor in Manitoba (Sarah Conci), the latter who could have met the

inclusion criteria for this study but who was not an included participant. We analyzed the last data with the codebook I developed. In this process, each coder (myself, LE, & SC) independently coded the ninth transcript by using the categories and codes in the developed codebook I provided. Coders were instructed to note where there needs to be a new code if they felt the meaning unit in the transcript did not fit within the current codebook. The last interview transcript was coded with reviewers' comments on Microsoft Word documents, as not all coders had access to Nvivo. After completing the last transcript's coding process, I compiled each coder's (i.e., my own and those of LE, and SC) coding for comparison on Microsoft Word. All coders then met to discuss and compare our coding before I transferred the agreed-upon codes to Nvivo. After the triangulation process and again using NVivo software, I went through the first eight transcripts to re-analyze them with the new agreed-upon codes. This triangulation helped me to review my categories and combine them to generate my themes and related sub-themes. I met with my research supervisor (Dr. Engel) multiple times over the 3 months timeline to review my developing themes and related sub-themes (i.e., naming, defining, and descriptions of the themes and sub-themes) as supported by the data. I refined the relationship between the categories and ensured each theme I developed had a unique concept (i.e., theme defining as described by Braun & Clarke (2022)). The final step in my analysis process is presenting the result in this thesis.

Reflexivity

As important as it is to my research paradigm to acknowledge that participants' knowledge is socially constructed, it was also crucial that I turned the scrutinizing lens on myself as a researcher in the process known as reflexivity (Braun & Clarke, 2022). Recognizing and

accepting responsibility for one's situatedness within the research, its potential effects on the setting and subjects being investigated, the questions posed, the data being collected, and its interpretation is known as reflexivity (Berger, 2015). At the heart of reflexivity is subjectivity, which describes my situatedness in my research work and is the primary tool for practising reflexivity while doing thematic analysis (Braun & Clarke, 2022). My reflexivity during this research was an ongoing process as it influenced all parts of my study, from the phenomenon of interest to the interpretation of gathered data (Braun & Clarke, 2022). Throughout the research process, I continuously reflected on my assumptions, expectations, and actions and how my socio-demographic position or stance related to the intersections of my worldview, gender, age, ethnicity, culture, social class, religion, and beliefs by practising the processes described below (Braun & Clarke, 2022; Finlay & Gough, 2008).

As the first step in this reflective research process, I outlined how my experiences and background may affect this research. I am a young black female international student researcher from a third-world country who grew up poor for most of my life before my family was able to "climb up" to the middle class later in my life; this was after training and practicing as a physiotherapist in Nigeria and before migrating to Canada for my graduate studies. My social class taught me the importance of money and how money can limit your access to many essential services, such as private physiotherapy services, especially in a third-world country like Nigeria, where I grew up. Also, as a physiotherapist who trained and practiced in a third-world country, I am familiar with the experience of patients begging for money to run tests, buy items needed for the care of themselves or their loved ones, or pay hospital bills. My social position made me realize the importance of clients' financial well-being in accessing needed

services, including physiotherapy services, which informed the research topic. This also could create potential bias in my analysis, which I reflected on often throughout the research, as I believe that access to affordable physiotherapy services should be available for people that need it.

However, while social positioning informed my research topic and methods, it was also an impediment as participants in my studies were Manitoba-based physiotherapists who grew up, studied, or practiced in different contexts than my own, where the government and third-party insurance covers more healthcare services than in Nigeria. This difference in practice context made developing and framing research questions to answer my research objectives challenging. It took several iterations, editing, and consultation with my research supervisor, master program committee, and other healthcare practitioners in Canada to develop a list of questions that sufficiently addressed my research question in a Canadian context. Also, some participants did not share my view on how finances can influence access to care. It was important to control my emotions and potential biases and remain neutral while interviewing participants, irrespective of their described clinical reasoning regarding older adult clients' finances and economics, as participants' perceptions of me might affect what they reveal during an interview (Smith & Sparkes, 2016). Despite my precaution in remaining aware of my positionality during the interview, it is possible that participants' perception of me as a black international student with no clinical practice experiences in Canada might have influenced how they answered the questions.

In a sense, I was an outsider to the participants' experiences, having different backgrounds and views of some participants while simultaneously being an insider because I

am a physiotherapist interviewing other physiotherapists. According to Hellawell (2006) and Berger (2015), the advantages of insider research include ease of recruiting participants, building rapport and trust, figuring out who is withholding information, and coming up with the right questions. Insider research could also influence what I consider significant in participants' accounts and what I might overlook in their responses and presenting unbiased participants' accounts. Therefore, I kept a reflexive journal throughout this research journey to record my thoughts and reflections, which was a tool to facilitate critical discussion and make sense of my research journey (Braun & Clarke, 2022).

Techniques to Enhance Trustworthiness and Rigour

Enhancing trustworthiness and rigour is essential in any study (Hadi & Closs, 2016). The first step I took in ensuring rigour and trustworthiness is reflexivity, as guided by Braun & Clarke (2022). I reflected on all my decisions I made in this study (i.e., from choosing the research topic till the preparation of a final report). All my reflections, feelings, and ideas about interpretations of data were written in a reflexive journal. By routinely reflecting on my decisions and actions, I was able to be more aware of my positionality and possible influence during the research process. Secondly, I completely immersed myself in the data by listening to the audio recording several times and reading the transcribed data. This helped me familiarize myself with the data and gain an understanding of what each participant discussed. Thirdly, after compiling my initial set of categories, two other coders and I coded the last interview transcript (i.e., triangulation of perspectives). After coding, all coders had discussion and agreement meetings that led to my current themes. Finally, I kept a written and detailed note of all decisions made in the analysis process and the rationale for every decision made (i.e.,

audit trail). By utilizing the methods described above, I sought to increase trustworthiness and rigour in my research.

Ethical Considerations

I sought and received ethical approval from the University of Manitoba's Health Research Ethics Board (HREB; Bannatyne Health Research ethics number: HS25918). There were potential, albeit minimal, risks associated with this research. The first concern was therapists revealing patients' identifying information during the interviews. While physiotherapists were asked to give examples of how they included clients' finance in their clinical reasoning, the discussion focused on the physiotherapist's clinical reasoning and did not identify the clients specifically. Thus, the clients' identifiable characteristics were not requested or collected during the interview, and where a physiotherapist mentioned a clients' identifying information, that portion was removed during the data transcription.

The second concern was protecting participants' identifying information. All participants' identifying information, including informed consent forms, were stored in a secure folder separate from other research information on the University of Manitoba's research (R:) server. Only I, the student researcher, and my supervisor (Dr. Engel) had access to the password-protected files containing participants' identifying information, contact information, and raw demographic data. Also, all participants were assigned a random code to de-identify collected data in line with Canadian privacy regulations (Office of the Privacy Commissioner of Canada, 2016).

Finally, protecting collected data (audio recording) and transcripts was of utmost ethical importance. No identifying information was included in the transcripts; participants were referred to by their assigned codes. The audio recordings and de-identified transcripts were uploaded to a folder on the University of Manitoba Teams for short-term storage and analysis. Only I, the student principal investigator and my research team, approved by the University of Manitoba Bannatyne research ethics board, could access this University of Manitoba Teams account. After data analysis, the recording and transcribed data were moved to the University's research (R:) server for long-term storage, where only me and my research supervisor had access to the document. I prevented potential data breaches during the research by following these steps.

Chapter IV: Result

Participants' Demography

Nine physiotherapists practicing in the province of Manitoba participated in this study. Participants had somewhat varied educational backgrounds ranging from diploma to master's level physiotherapy-related education. Most were advanced-level physiotherapy practitioners, with 7 of the 9 participants having over ten years of experience. The general demographic characteristics of participants are presented in Table 3 below.

Table 3

Participants' Demographic Information

Demographic Characteristic	Number of Participants (n=9)
Self-identified gender	
Man	2
Woman	7
Highest level of education	
Diploma in Physiotherapy	1
Bachelor of Science in Physical Therapy	1
Bachelor of Medical Rehabilitation in Physical Therapy	6
Master of Science in Physical Therapy	1
Years of clinical practice	
0-10	2
11-20	3
>20 years	4
Current practice role related to physiotherapy	
Clinician	3
Clinician and Instructor	2
Clinician and Manager	2
Clinician and Business owner	2
% of caseload over the last 5 years that makes up older adults	
0-25%	2
26-50%	3

51-75%	2
76-100%	2
Number of physiotherapists that have attended to older adults with dementia within the 5 years	9
The approximate number of older adults with dementia physiotherapists attended to in their clinical practice within the last 5 years	
0-50	7
51-100	1
>100	1
Duration since physiotherapist last treated an older adult with dementia	
0-1 year	7
2-5 years	2

Please note: the demographic questions were open-ended. Responses from the participants were then categorized and presented in the table above.

Themes

After analyzing the qualitative data from this study, I developed two overall themes, each with sub-themes. These themes and sub-themes describe if and how physiotherapists consider older adult clients' finances in their clinical reasoning and the effect of dementia or age-related cognitive impairment on physiotherapist reasoning related to older adult clients' finances. In the following paragraphs, I will explain each theme and subtheme in detail, with relevant quotes from participants. Each participant was assigned a random identifier (i.e., PT1 to PT9). The themes are summarized in Table 4 and the relationship between the themes is presented in Figure 4.

Table 4

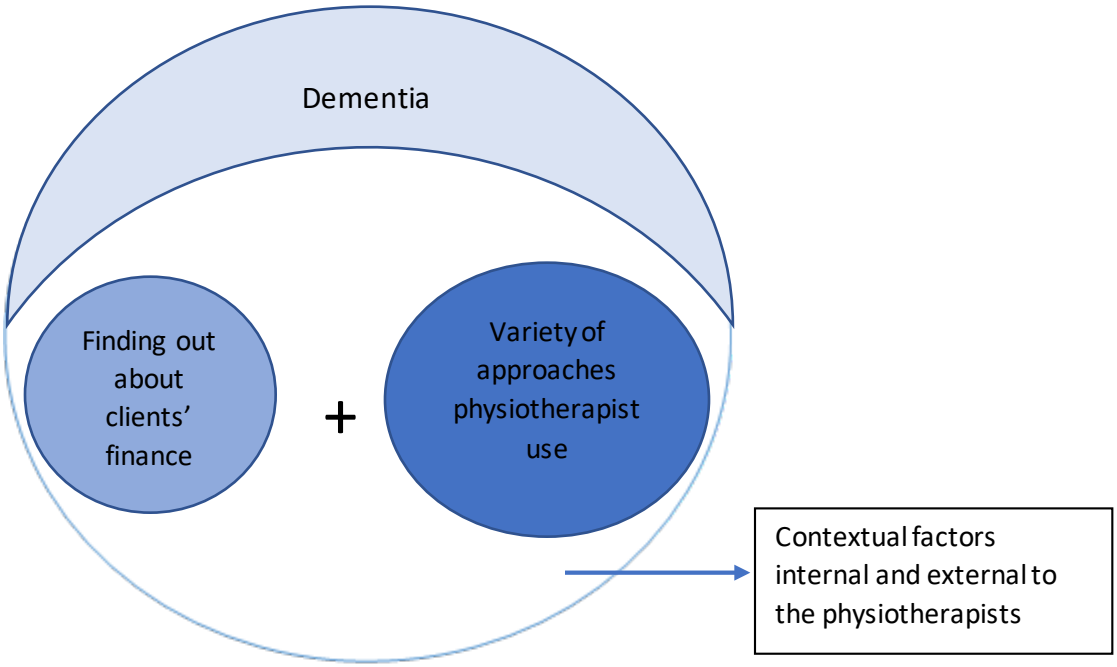
Themes Developed From the Analysis of the Qualitative Data

Themes

Theme 1: Considering older adult clients' finances in clinical reasoning depends on contextual factors internal and external to the physiotherapists.
Sub-theme 1.1: Finding out about older adult clients' finances is important in physiotherapists considering finances in their clinical reasoning.
Sub-theme 1.2: Physiotherapists use a variety of approaches to address the needs of clients with limited finances if they include clients' finances in their clinical reasoning.
Theme 2: Diagnosis of dementia adds another layer to the contextual factors and clinical reasoning related to older adult clients' finances.
Sub-theme 2.1: Diagnosis of dementia leads to physiotherapists involving clients' caregivers or family members in care plan.

Figure 4

Relationship Between Themes



Theme 1: Considering older adult clients' finances in clinical reasoning depends on contextual factors internal and external to the physiotherapists.

Considering older adult clients' finance in clinical reasoning and care planning was not a linear process nor consistent per the participants' description. Only seven out of nine participants in this study noted the need to address or include older adult clients' finance in their clinical reasoning or care plans. Also, not all participants who included clients' finance in their clinical reasoning did so all the time. The decision to include or not include clients' finance in clinical reasoning depended on contextual factors internal and external to physiotherapists. Participants in this study can be classified into four groups based on their clinical reasoning related to older adult clients' finance: (1) participant who did not consider clients' finance in their clinical reasoning, (2) participant who always considered clients' finance in their clinical reasoning and care plan as part of their standard practice, (3) participants who sometimes included clients' finance in clinical reasoning and care plans but not part of standard practice, and (4) participant who presented conflicting descriptions of perceptions and past experiences, or behaviours related to if they considered or did not consider clients' finance in their clinical reasoning and care plan. I will explain each of these categories in more depth below.

The first category was the participant who did not include clients' finance in their clinical reasoning and care plan. They did not do so due to factors internal to the physiotherapists, physiotherapists' perceptions. This group consisted of one participant, Participant 2, a physiotherapy business owner with 25 years of practice. Participant 2 did not include clients' finance in their clinical reasoning due to their perception that people in the location of their clinic had good finances: "It [finance] is usually pretty good in this (mild stutter) in this area, it's pretty good. The average (mild stutter) the average household income in our area is about $170,000. For the majority of them, it's not a barrier to seeking care" (PT2). In addition, this

same participant had a perception that the regulatory body guideline did not permit physiotherapists to include clients' finance in clinical reasoning:

> College of Physiotherapists Manitoba also very much doesn't want you to sort of give a break to people that have financial issues and stuff right there. They're very much about bring your A-game and that's what you do and everybody gets charged the same and everybody gets treated the same. (PT2)

The second category was the participant who always considered clients' finance in their clinical reasoning and care plan as part of their standard practice. This group also consisted of one participant, Participant 4, who had 26 years of experience as a physiotherapist and was a physiotherapy manager in a private setting during the interview. Participant 4 included older adult clients' finance in their clinical reasoning for reasons such as their perception that older adults experience financial challenges: "I always consider my patients' financial well-being and obviously just with older adults, it [finance] is way more of an issue" (PT4). Participant 4 also included clients' finance in clinical reasoning due to their experience as the sole income provider in their family:

> The other thing is that I used a donor to have my son, so it's just him and I and I'm the primary income. I'm the only income provider, so I'm very well aware of, you know, financial stress and financial resources and things like that. (PT4)

The third category were the participants who sometimes included clients' finance in clinical reasoning and care plans but including clients' finance was not part of their standard practice. This group comprised of six participants: Participants 1, 5, 6, 7, 8, and 9. Participant 1

had seven years of experience and worked as a manager in the public care system during the interview. Participant 5 had five years of experience and worked in private practice during the interview. Participant 6 had 17 years of experience and worked in a public care system during the interview. Participant 7 had 18 years of experience and worked as an instructor and physiotherapist in the public care system. Participant 8 had 35 years of experience and worked as a trainer for support workers during the interview. Finally, participant 9 had 19 years of experience and worked as a physiotherapist in the public care system at the time of the interview. The participants in this group described various reasons why considering clients' finance in clinical reasoning was not always part of their standard practice. The first reason five participants in this group described was not knowing how or wanting to bring up older adult clients' finance for various reasons. For example, Participant 6 described having difficulty with asking clients about their finance due to a lack of education about discussing finance with clients: "I don't know how to ask about it [finance], to be honest. It's not something we are taught at university" (PT6). Another participant, Participant 8, described having ethical concerns about asking about clients' finance: "I don't know that I have specific barriers other than you know the time and also you know just ensuring I guess ethically is (mild stutter) is it relevant like if I discuss their finances?" (PT8). Participant 5 also described not having a conversation about finance because they did not want to offend people: "I guess you don't wanna (sic), like, offend people and think you know that (mild stutter) that they may not be able to afford physio, so I typically act as if someone can" (PT5). Another reason clients' finance was not part of standard practice, as described by one of the participants in this group was that clients did not always volunteer information about their finances to the physiotherapists:

> A barrier could be them just agreeing to what you say, even when you don't know their financial situation. They're like okay, I'll come, but then they don't come back at all because they don't wanna (sic) say they can't do the treatment that you're prescribing. (PT5)

The last category was the participant who presented conflicting views on if clients' finance influenced their clinical reasoning and care plan. Participant 3 had 49 years of experience and was a private clinic owner during the interview. Participant 3 described having a perception that older adults as a population have good finances:

> I think this is probably a little different perspective from what you've had is the fact that I do treat a lot of elderly people cause of my age, etc. And actually, most elderly people have a significant amount of money. (PT3)

Participant 3's noted perception of older adult clients' finance as a sub-population did not consistently influence their clinical reasoning related to clients' finance. For example, Participant 3 described how they considered clients' finance in clinical reasoning multiple times in their interview despite their stated perception about the finance of older adults; for example, they noted; :-"I've never turned someone down because they don't have the money" (PT3). However, Participant 3 also expressed their belief that older adult clients could afford to pay for physiotherapy services if they believed physiotherapy service was a priority irrespective of the finances of the older adult in question. In addition, Participant 3 submitted that physiotherapists needed to educate their clients about the importance of physiotherapy to make them pay for physiotherapy services (quote below). These varied views from participant 3

gave conflicting views of if and how they considered clients' finance in their clinical reasoning and care plan:

> The person with no money, you know, it has to come out of their pocket. Might come out of housekeeping budget, or whatever it is. I think they should be presented with the information in an unbiased fashion that says, this is what I can do. This is what I think will happen in your life. You'll have to make the decision whether it's worth it. (PT3)

As discussed in the first paragraph of this theme, contextual factors could be internal or external to a physiotherapist. In addition to being an internal or external factor, these factors could also be a barrier that made it difficult for participants to include clients' finance in their clinical reasoning; or a facilitator that encouraged or allowed participants to include clients' finance in their clinical reasoning and care plan. In the tables 5 and 6 below, I presented a list of contextual factors classified into internal and external factors, barriers, and facilitators.

Table 5

Factors Internal to the Physiotherapist

	Quotes Demonstrating Internal Contextual Factors that Facilitated Including Clients' Finance in Clinical Reasoning	Quotes Demonstrating Internal Contextual Factors That Were Barriers to Including Cients' Finance in Clinical Reasoning
Physiotherapists' ethical concerns	"Being a reasonable human being. … That's just I just feel like that's just what you should do is take into consideration what your clients sitting in front of you is telling you, and then try to give them the most help that you can, but also taking into consideration	"I don't know that I have specific barriers other than, you know the time and also, you know just ensuring, I guess, ethically is it relevant like if I discuss their finances" (PT8) "You know, there's a fear of crossing boundaries of personal

	what are these other factors that are going to affect that" (PT1)	information, you know, like, OK, I'm a physio. Why am I asking about this? ... The legalities of consent would (mild stutter) would be there, I guess" (PT6)
Physiotherapists' own financial situation and need to make a living	"I've always had a practice where you know, I make good money. I've never turned someone down because they don't have the money" (PT3)	"So it's that ongoing balance between we need fees to be higher to be able to run our business, but we don't want to outprice ourselves" (PT9)
Physiotherapists' concerns about physiotherapy accessibility and engagement.	"Physiotherapy is that it's not uhm, it's not a publicly funded, or it is a very small piece of it is publicly funded. So it's kind of a luxury. It's for people that have the financial stability to use the service because they have jobs that provide them benefits or jobs that provide them financial means that they have extra to spend on these services… In this position, like I had said, we do have the stipulation that if you do have a financial barrier, that is what meets the criteria to have a referral sent to our programs. So we're trying to get those people that have the financial barriers to access this service" (PT1)	
Physiotherapists' perception of the cost or value of intervention and whether there are less costly but equally valued ways to provide a certain intervention.	"But honestly, if somebody needed to come in and see me, and they couldn't pay. It didn't bother me that much. It's not like I've spent a lot of money to do a treatment, anyway" (PT3)	"So, if you want to achieve those goals with the help of a physio to guide you through those, then you'll pay. Then you must pay for that" (PT6) "I find physiotherapists in general just from the history of me working in Canada especially that we devalue our time all the time, right and it's (mild stutter) it's difficult because we are talking about healthcare" (PT4)
Physiotherapists' perception of older adults as a group	"I always consider my patients' financial well-being and obviously, just with older adults,	"The biggest thing I've learned, and I think this is a probably a little different perspective from

having either generally poorer or good finance	it [finance] is way more of an issue" (PT4) "I definitely know older adults, kind of if they're not working, they're going to be on a strict budget. Whether that's from their pension, If they're lucky enough to have one, or they don't have a pension" (PT1)	what you've had, is the fact that I do treat a lot of elderly people cause of my age, etc. And actually most elderly people have a significant amount of money" (PT3)
Physiotherapists' personal experience with finance	"I think about it more than I ever did like as a new grad ... I was like, Oh, you just come for Physio, and it's fine, like I never really thought about it so much. But now you get older and you have a mortgage, and you have kids, and just all of these other expenses that you like, maybe didn't really realize when you were a new grad that, like all of these things that you need to consider so I think just yeah, with time, you realize like how much people really need to pay outside of just coming to a service like this" (PT1)	"I listen there was a CBC interview a number of years ago about looking at Canadians who are aging … The two guests they had, which are supposed to be opposite in their perspectives, were agreeing with each other… People who have, you know, struggled along … they're typically used to living with poverty, or, you know, not a lot of money. So, in fact, they're fine because they know how to manage it" (PT3)
Physiotherapists' perception of the regulatory body's guidance on if they can or cannot include client finance as part of clinical reasoning or care planning	"Obviously, I'm following the Manitoba College of (mild stutter) of regulations, so … I feel you know, confident with taking one's financial well-being into my clinical reasoning" (PT9)	"College of Physiotherapists Manitoba also very much doesn't want you to sort of give a break to people that have financial issues and stuff right there. They're very much about bring you're A-game and that's what you do and everybody gets charged the same and everybody gets treated the same" (PT2)
Physiotherapists' past clinical, professional, and educational experience	"I remember I got lectured by this one farmer. He said, 'stop that, you know. If I do Blue Cross or do a health insurance, it's going to cost me 20 bucks a month. And it's gonna *(sic)* be $240 a year. I'm reasonably well. I don't need this very often, like make the damn	"I think just knowing how to ask the questions. Because, again, as a physio, there's maybe a bit of a gap in terms of knowing about older adults' financial well-being. It's not something we are taught. It's not really part of our education" (PT7)

	orthosis. If it costs $300, then treat me. The foot problem is my problem. Don't (mild stutter) don't try and protect me from spending money' and I remembered it because I realized I was biased to thinking that my obligation in our free health care system is to keep them protected from spending money. I learned my lesson. I started asking people how important it was and changed my (mild stutter) my attitude to the idea that, being it's their decision, not mine" (PT3)	
Physiotherapists' personality	"I'm a emotionally based person, so I tend to overshare. Not in a, you know, not in a way that's against, you know, college guidelines and things like that. But you know, at a first assessment, you're really creating a relationship with your patient. And so I always feel comfortable asking them if that [finance] is an issue" PT4.	

Table 6

Factors External to the Physiotherapists

	Quotes Demonstrating External Contextual Factors that Facilitated Including Client Finance in Clinical Reasoning	Quotes Demonstrating External Contextual Factors That Were Barriers to Including Client Finance in Clinical Reasoning
Client's stated preference on if physiotherapists should include their	"She's like, 'my doctor wants me to come'. She's like, 'this is quite an expensive service. I can't afford it to do this regularly'" (PT1)	"I mean I have had folks that say 'yeah, I don't need the public. I got lots of money. I can do my thing'" (PT4)

finance in clinical reasoning		
Clients' discussing or not discussing their finance with physiotherapists	"'I have been to three other physios. I've now been referred to you because you specialize in shoulders and I've exhausted my benefits and I don't have the financial ability to'. And what I did is I just end up having a conversation with them" (PT4)	"A barrier could be them just agreeing to what you say even when you don't know about their financial situation. They're like, 'okay, I will come', but they don't come back at all because they don't wanna *(sic),* they can't do the treatment that you're prescribing" (PT5)
Workplace resources available to address affordability	"The hospital I worked at would often store older, just donated equipment. I know folks that have expressed that they weren't able to get, say, a walker. I've gone down into basements before and I've dug out and found an old piece of equipment that you know was safe enough and worked well enough for these folks" (PT8)	
The caseload assigned to a physiotherapist		"My caseload is complicated. Depending on how many patients I saw and how long I spent with them … in that part too, is considering someone's financial abilities. I do feel restricted in what I can give patients" (PT4)
Healthcare programs that pay for private physiotherapy services for people with poor finances	"Within this program, we do take into consideration financial needs because we are just essentially using up extra money that we have, that we haven't used for positions because of vacancies and stuff we've contracted out this physiotherapy service, and then there is a criteria that if you don't have the financial means to access physiotherapy, you would qualify, or if you don't have third-party insurance to	

	help cover the cost privately" (PT1)	
Physiotherapy clinic design		"It is also in a clinic where you've got curtains, and people can hear through the walls. People aren't always all that happy to discuss financial stuff either" (PT2)
Remuneration method for physiotherapists		"With respect to the fact that we get paid on commission, I think the way we get paid negatively impacts our ability to fully (slight stutter) fully commit and realize you know what's best for ultimately for patients' outcome" (PT9)
Having social workers in the clinic	"So, it can be social workers, especially social worker… The social workers might help them find avenues to access maybe some funds… that department is very much versed in knowing all of the options to maximize someone's finances." (PT8)	

Sub-theme 1.1: Finding out about older adult clients' finance is important in physiotherapists considering finance in their clinical reasoning.

As discussed earlier, while classifying participants who participated in this study, some participants did not at all or did not always consider older adult clients' finances in their clinical reasoning and care plans. Participants who sometimes or consistently considered finances described four ways they found out about it. The ways participants found out about older adult clients' finance are: (1) physiotherapists making an assumption about older adult clients' finance based on information not directly related to finance or their observations of clients; (2) physiotherapists leading a conversation with the client related to their finance and economic

accessibility to physiotherapy care; (3) clients leading a conversation about their finance as related to their economic accessibility to physiotherapy care; and (4) workplace system that provides information about clients' finance.

The first way participants found out about older adult clients' finance was by making assumptions about the financial status of older adult clients based on different reasons such as insurance status, housing conditions, physical appearance, and leisure activities. Physiotherapists' assumptions about clients' finance, a factor internal to a physiotherapist, could be a barrier or facilitator to participants including finance in clinical reasoning. Assumptions about clients' finance were based on the information that the physiotherapist may have gathered from discussions or assessments, clients' health information, or observations about the clients. Examples of assumptions and supporting quotes are presented in Table 7.

Table 7

Reasons Physiotherapists Make Assumptions About Clients' Finance

Assumption	Exemplary Quotes
Clients' living conditions, whether stated by the clients or observed by the physiotherapist	"Trust me, wealth is not a problem with this one. I visited a home visit because it was easier for me to do that. This was in the fall. The woman struggled with a foot problem, didn't find any help, but it got to me. I went to see her. She had ten bathrooms, ten bathrooms in the one house, so you can't. This house was majestic in its size" (PT3)
Physiotherapists' observations of the clients' physical appearance	"Okay, as a human being, I'm gonna *(sic)* note footwear people are wearing. If you're walking around on shoes that have been worn by every member of your family, maybe because that's all you had. That's going to be in my brain. I'm gonna *(sic)* like think they need support" (PT9)
Chronicity of a client's pain	"I would say, as a generalization, people with financial hardships tend to have more chronic pain, or it just seems like a lot of people

	with chronic pain have other biosocial stressors in their lives as well as this chronic pain" (PT1)
Client's mode of payment	"If they're paying out of pocket, I would suspect you know they may not be able to have as many sessions" (PT5) "So I would say to them, you know. Do you have Blue Cross? Do you have coverage? They'd say no, and I started to take care of that by trying to figure out how I could do less treatment" (PT3)
Client's geo-political or cultural context	"I mean, in Canada, it's pretty obvious that certain (mild stutter) certain folks of certain cultures have through, whether it's racism or whether it's Indigenous folks, so their culture growing up has sometimes affected whether or not they have access to all that they need or everything which finance is part of everything" (PT8)
Client's area of residence	"It [finance] is usually pretty good in this (mild stutter) in this area, it's pretty good. The average (mild stutter) the average household income in our area is about $170,000" (PT2)

The second way participants found out about clients' finance was by having a direct conversation with the clients about finance. Participants asked questions about clients' finance for reasons such as the physiotherapists' perception about the cost attached to treatment, physiotherapists' assumptions about older adult clients' finance, and past client experience. Below is a list of why physiotherapists asked questions about clients' finance and supporting quotes (Table 8).

Table 8

Why Participants Asked Clients About Finance and Supporting Quotes

Reason Why	Exemplary Quotes
Physiotherapists' perception about the cost attached to treatment	"Unless the care that I'm trying to provide requires (mild stutter) requires them to be, requires money, I guess, like I don't. It [finance] is not something I would talk about on a regular basis, unless it impact their, unless it was a direct impact on the things that I was trying to, the goals that I had set" (PT8)

Physiotherapists' assumption about older adult clients' finance	"We look at the goals of the goals of the session. And we look at all aspects, including financial. For most clients, this is part of the goal setting and looking at the resources available to the participants. Some people, I don't ask [about finance] … If you're going to want to look into bias as a human being, I mean, I haven't really thought about it. I'm not consciously, you know, this is why it's a bias. I may be aware when the person's telling me about their occupation… I may decide to have that conversation because it [finance] is going to really impact the rehab" (PT9)
Past client experience	If I asked them, do you have Blue Cross, or do you have, you know, something? My assumption was if they didn't, I would change my treatment program, and I realized that that was a unjust bias on my part, and therefore, I needed to change my approach… I needed to say to them, you know, is this a concern? (PT3)
Personality of the therapist	I'm a emotionally based person, so I tend to overshare. Not in a, you know, not in a way that's against, you know, college guidelines and things like that. But you know, at a first assessment, you're really creating a relationship with your patient. And so I always feel comfortable asking them if that [finance] is an issue" (PT4)
Physiotherapists' perception about clients' reactions in the clinic	She came to her session because she hadn't cancelled it, and she seemed super nervous and anxious at the beginning of the session. And I asked, and I was like, you know, 'what's going on?' And she just kind of said like 'I'm just, you know', she just explained her situation. 'I'm not sure if that I'm going to be able to, you know, make this work and just, you know, work. It is really tight'. And I was like you know what, we do not have to continue with this session. We will cancel today" (PT5)

As discussed earlier in this result section, some physiotherapists did not include clients' finance in clinical reasoning due to not knowing how to discuss finance with their clients or not wanting to have a conversation around finance for various reasons. These reasons included not wanting to offend people, lack of education about discussing finance, and physiotherapists' perception that discussing finance was an uncomfortable topic for the physiotherapist to discuss. When I, as the interviewer, probed participants about what could be a facilitator to

asking questions about finance, participants suggested educating physiotherapists on how to discuss finance with clients: “Yeah, just having the education and then knowing how to ask the question in the right way, like I don’t think I know exactly what I should be asking” (PT7). Another participant discussed the need for a standardized method to find out information about clients’ finance: “I think maybe that maybe just needs to be a like a trigger question to have a conversation about finances with the client in the first session” (PT1).

While some physiotherapists experienced challenges in discussing finance with clients, some participants described how they were willing to discuss finance if the client brought it up first, which was the third way physiotherapists found out about clients’ finance: “I don’t routinely ask only if they bring it up actually… And so, if they bring that up, then I can have conversation … I don’t openly ask it unless they bring it up” (PT6). Another participant described an example of their recollection of a client leading a conversation around finance with the therapist: “‘I have been to three other physios. I’ve now been referred to you because you specialize in shoulders, and I’ve exhausted my benefits and I don’t have the financial ability to’. And what I did is I just end up having a conversation with them” (PT4).

The last way physiotherapists learned about clients' finance was through workplace systems. This included access to electronic clients’ information that showed clients insurance information: “So I mean we have like a pretty, with like technological system, so I’m able, to like, see their insurance and you know see all that stuff” (PT5). Another participant found out about clients’ finances through conversations at team meetings: “There’s a lot of team meetings … So, if we are discussing that, there are concerns about maybe not being able to financially, you know, follow through on kind of what we are what we are suggesting” (PT8).

Subtheme 1.2: Physiotherapists use various approaches to address the needs of clients with limited finance.

In situations where physiotherapists included clients' finance in their clinical reasoning, contextual factors also influenced physiotherapists' clients' care plans. Participants described using a variety of approaches to adjust their care plan to promote physiotherapy participation and engagement when clients' finance or economic barriers to physiotherapy care were discovered. For example, participants described modifying the client's treatment plan if the client explained to the physiotherapist that they could not afford the prescribed treatment plan:

> I try to suggest what I think they really need and then if they say, 'Oh no, I can't come back that often', then I'll kind of say, okay, well, let me adapt … We can do once a month instead of you know see you twice next week. (PT5)

Another physiotherapist, Participant 1, described how they modified the treatment plan to fit what was affordable for their clients: "I have had a couple of conversations with people like what is affordable for you and then make a plan of something that can work for them" (PT1).

In addition to modifying treatment plans, participants described suggesting self-management activities to clients or a home program to manage their condition until the next treatment session: "It's more kind of home exercises or self-management things to kind of get them from appointment to appointment" (PT1). Participant 9 described teaching clients' skills to self-manage their conditions:

> The client and I have to have a conversation. You know, hey, you work on this, you know, kind of get a sense of things. I really want you to kind of, you know, get connected with some different muscles of your body. Once you feel like you kind of got that skill down, you know, you can decide when you come back. (PT9)

Another way participants included clients' finances in their clinical reasoning was by offering the clients free treatment sessions or changing their billing method so that clients attended more physiotherapy sessions than they paid for. Participant 3 described how they changed their billing method to ensure the clients could come for more treatments: "So, if it's something that I needed to see them 25 times, but they only had a certain amount, I would say well, I'll do a quick treatment but I'll charge you every three times or something" (PT3). While Participant 3, the participant who offered conflicting views on including finance in clinical reasoning, offered clients multiple free sessions with their change in billing method, Participant 6 offered one of their clients one free treatment session due to the recovery rate:

> I actually ended up seeing her one extra time for free. And that was purely because she'd been recovering, she was improving, and I just couldn't face the thought of just dropping her when she was sort of at that point where one more time would really, really help her. (PT6)

Other ways participants addressed the needs of clients with poor finances included involving a social worker where available, sourcing cheap equipment for clients, offering clients previously used and donated equipment, writing appeal letters so clients' physiotherapy could be covered by the government, and cancelling clients' appointment for the day they say they

could not afford physiotherapy services without charging cancellation fee or financial implication to the client.

Theme 2: Diagnosis of dementia adds another layer to the contextual factors and clinical reasoning related to older adult clients' finance.

As per the interview guide, I explicitly asked participants to describe if at all how a diagnosis of dementia influences their practices. In response, eight out of nine participants described that a client's diagnosis of dementia or age-related cognitive impairment added another layer to the contextual factors and clinical reasoning related to older adult clients' finance. Dementia influenced if participants included clients' finances in their care plan. For example, physiotherapists' perception about clients' finances, a factor internal to the physiotherapist, was discussed in theme one. In theme one, these perceptions were due to various reasons, such as clients' assets or insurance status. In this current theme, participants' perception about older adult clients' finances was due to the diagnosis of dementia. Several participants had a perception that older adult clients with dementia did not have good finances. This perception was due to factors such as physiotherapists' personal experience, concern about the clients' ability to manage their finances, and perception that people with dementia were at risk of financial abuse. For example, Participant 8 had the perception that older adult with dementia could not effectively manage their finance due to the clients' cognitive decline: "I mean financial wellness does, I believe it does require effective cognition to be able to, to manage kind of funds coming in, going out, ongoing planning for the future" (PT8). Similarly, Participant 1 had the perception that older adults with dementia were at risk of financial abuse, which could influence their finances: "They might be financially abused like so definitely

dementia could affect people's financial wellbeing" (PT1). Participant 7's perception about older adults with dementia's finance stemmed from a recent personal experience. Their loved one with dementia was defrauded and this made them aware of the impact dementia had on not just the nuclear family but also the extended family's finance:

> Just thinking personally right now and my father-in-law has dementia. He used to be an accountant. His wife has had to take over all the finances and they got scammed yesterday hugely. So, it's pretty painful, and that's why I think just this topic in general right now for me makes me realize that dementia patients must impact the whole family like it must really influence everybody that surrounds them. (PT7)

Sub-theme 2.1: Diagnosis of dementia leads to physiotherapists involving clients' caregivers or family members in care plans.

In addition to participants' perception about the finances of older adults with dementia, participants also described involving older adults' caregivers, family members, or those who held the power of attorney in the treatment of older adult clients with dementia. Participant 1 described the importance of involving a caregiver in the care plan of older adults with dementia:

> I think in that case it's just important to make sure there is a caregiver with them, someone that you can make sure that they are kind of like taken care of in a responsible way, that they do someone kind of overseeing things. If that's something that they need in that there's someone there to kind of agree to in private practice say, pay for the session, or whatever it might be, or agree that yes, this particular client will bring him

> back next week, because we can drive him, and we can make sure that he can pay for the appointment. (PT1)

Similarly, Participant 4 described the negative effect lack of caregivers for clients with dementia could have on the clients' ability to participate in physiotherapy services:

> And if they [clients' with dementia] can't be a good advocate for themselves. Typically, in our healthcare environment, if you don't have someone who is kind of rallying for you, I just tend to see you know, a lot more impact on their health, their financial well-being, and their ability to function. (PT4)

Participants described various ways they included family members or caregivers in the care plans of older adults with dementia. For example, Participant 3 had a perception, a factor internal to a physiotherapist, that the cost of physiotherapy was not worth it for that client. However, instead of the physiotherapist discussing with the client, the added layer of dementia made the physiotherapist to discuss care plan and client finance related to care plans with the client's daughter:

> I thought that it was, you know, the spending the money on physical therapy was not really worth it … He certainly had cognitive issues, but because his daughter was there. Her (sic) [His] daughter, you know, quietly discussed it with me, and said, 'there are no financial issues. Get on'. In fact, I was biased against treatment because, you know, his age, and I didn't think the treatment was worth it. (PT3)

Similar to Participant 3, Participant 9 sought the consent of the client to speak to their daughter when they suspected the client had dementia:

> I was treating a client that it took about 3 to 4, nah, 3 sessions. And I was really being like, hmm, there's something going on here like with this individual from a cognitive perspective. And it turns out actually there was. For that individual, it was the start, starting of dementia. So, I recognized that and had a conversation with the client's daughter, who I happen to know, and the person gave consent for me [to speak to their daughter]. (PT9)

The result from this study have demonstrated that finance is not always considered in clinical reasoning and care plans of participants in this study. In the next section of this thesis, I will discuss some important points from the result and compare the result of my study to other studies.

Chapter V: Discussion

This study explored if and how physiotherapists consider older adult clients' finances in their clinical reasoning and care plan in general and specific to older clients diagnosed with dementia. To my knowledge and after a specific literature search for this topic, this is the first study in the published literature to examine if and how physiotherapists in Canada include older adult clients' finances in clinical reasoning. Other studies have looked broadly at if physiotherapists consider clients' finances in clinical reasoning, but this study is specific to an important population group, older adults, and a provincially administered healthcare system, the Canadian healthcare system, which contrasts to other healthcare systems and how healthcare and physiotherapy care is funded in other countries. Based on the in-depth individual interviews of nine physiotherapists in Manitoba who worked with older adults, with most participants having at least ten years of practice, the research findings demonstrated that including older adult clients' finances in clinical reasoning is influenced by many factors. In the paragraphs below, I will discuss some of this study's findings and compare the study's results to existing literature. Specifically, I will look at: (1) how personal and professional experience influences clinical reasoning; (2) the need for education and professional development regarding regulatory practice guidelines about including older adult finance in clinical reasoning; (3) the current taboo around discussing finance and how that can relate to decreased open discussions with clients about financial access to care; and (4) how a diagnosis of dementia led to participants involving caregivers or family in the care planning of older adults with dementia. Last, I will discuss how the results of my study compare and contrast to the guiding frameworks for this study (i.e., access to care framework and the financial capability

and well-being model) and then return to my positionality, briefly relating how my own experiences and positionality compare and contrast to the results.

The first discussion point is on the role of personal and professional experience in clinical reasoning. Higgs and Jones (2008) described personal and professional experience as non-propositional knowledge, that is, knowledge acquired through experience, and one of the components of clinical reasoning. Participants in my study described how their professional and personal experiences influenced their clinical reasoning related to finance, or the relationship between affordability of physiotherapy care and clients' ability to pay. Specific to personal experience, some participants in my own study spoke of how their personal finances or financial situation influenced if they considered or did not consider clients' finances in their clinical reasoning. The influence of physiotherapists' personal financial experiences on clinical reasoning was also described by Sturm and colleagues (2024) after the analysis of 200 responses from 72 different countries. Sturm and colleagues (2024) reported that while some physiotherapists considered clients' finances in their clinical reasoning, some physiotherapists who were struggling financially were more likely to make clinical decisions that will benefit the physiotherapists' finances such as engaging in fraud (e.g., prescribing more appointment than needed and billing clients fraudulently for their own financial gain; Sturm et al., 2023). In contrast, participants in my own study tended to include clients' finances in clinical reasoning, in a way that would decrease potential costs of care to the client, if they (the physiotherapist) had had personal or family experiences related to decreased financial well-being for various reasons (e.g. relatives being victims of fraud after dementia, being a sole income earner in the family, or change in expenses over time). Specific to professional experience, participants

discussed how their experience with clients in clinical settings made them change their clinical reasoning related to finance (e.g., asking about what clients can afford rather than assuming the financial situation of their clients).

The prevalence of personal and professional experience in clinical reasoning has also been documented in various studies. Sturm and colleagues (2024) reported that individual factors, which include personal and professional experience and the physiotherapist's experience as a patient, were the most reported factors that influenced the clinical reasoning of physiotherapists in their study. In addition to the financial status of physiotherapists discussed in the paragraph above, other factors reported by Sturm and colleagues (2024) include: relation factors (e.g., characteristics of clients or physiotherapists' relationships with clients), and organizational factors (ethics of the organization and structure of the organization). Similarly, Schumacher and colleagues (2023) and Carrier and colleagues (2010) also reported that personal and professional factors played a role in occupational therapists' clinical reasoning and care plans. For example, Schumacher and colleagues (2023) reported in their study that occupational therapists have learned through their professional experience that clients prefer different types of activities, so therapists recommended different types of activities to clients. Also, the therapists also recommend activities that they, the therapists, enjoyed to clients during treatment sessions. Further, Carrier and colleagues' (2010) study found in their own study that occupational therapists' clinical reasoning are influenced by internal and external factors. Examples of external factors included clients and practice context. Examples of the internal factors included past personal and professional experiences, and personal context of the therapists.

While personal and professional experience is prevalent in clinical reasoning, use of personal and professional experience in clinical reasoning may not always benefit the clients. For example, in my own study, a participant explained how their experience, watching a program about older adults' wealth in Canada and their own comfortable financial status as an older adult, influenced their perception that most older adults have good finances in Canada. This perception about finances could potentially create a bias related to including older adults' finances in their clinical reasoning and consequently influence older adults' access to and participation in physiotherapy services. Bias about including older adults' finances in clinical reasoning described by participants in my study included: (1) the perception that all older adults can afford physiotherapy services and they only need to be informed of the important of accessing physiotherapy services and (2) older adults in the location of the clinic have good finances, so clients' finances is not needed in clinical reasoning. The negative effect of personal and professional experience on clinical reasoning has also been documented in various studies related to healthcare practitioners. Choudhry and colleagues (2005) completed a systematic review of 62 research related to professional experience (measured in years of practice and age) of physicians and quality of care provided to clients; in this study quality of care was assessed by knowledge of conditions and adherence to standards of practice for diagnosis, prevention, screening, and intervention. Thirty-two of the 62 included articles reported that participants provided decreased quality of care with more experience while 13 more articles reported poor quality of care in some of the examined factors with increased experience. Choudhry and colleagues (2005) attributed this inverse relationship between physicians' experience and quality of care to the physicians possessing and relying on less formal

knowledge with more experience gained. This reliance on less formal knowledge reduced the likelihood of the physicians following current standards of practice advocated for in their area of practice.

Personal and professional experience can also lead to implicit bias towards clients (Adegboye & Adeyoye., 2021). Implicit bias is unintentional bias that influences clinical reasoning. Making clinical decisions based on implicit bias rather than regulatory guidelines or standard of practice could affect the quality of healthcare services offered to clients (Adegboye & Adeyoye., 2021; Gopal et al., 2021). Bullock (2004) reported that class bias, a type of implicit bias affects clinical reasoning of clinicians where clinicians expect that everyone belongs to the middle or upper class, due to the clinicians themselves being in middle or upper class—people tend to think people around them are in similar economic class or of a higher economic class or financial well-being status, with similar financial abilities to pay for or challenges to afford services. According to Bullock (2004), such projection about finances of clients can lead to wrong diagnosis or lead clinicians to ignore that the clients might need help accessing, vis-à-vis affording, healthcare services. The risk of implicit bias was also noted in this current study when a participant described how their bias made them assume people who dress a certain way have poor finances. Practitioners may be able to reduce the risk of bias if they utilized regulatory guidelines rather than solely relying on their personal or professional experience and by engaging in reflection and reflexivity about their own experience contrasted to that of their past, current, and future clients, who all come with varied financial past, present, and future well-being positions, experiences, values, and goals (McDonald et al., 2005).

However, it can be difficult for regulatory guidelines to provide direction on clinical reasoning and care plans when there is confusion about such guidelines. My findings in this study indicated that there was confusion among participants on if physiotherapists could include clients' finances in their clinical reasoning. While some participants had the perception that regulatory guidelines allow for the inclusion of finance in clinical reasoning, other participants asserted that including finance in clinical reasoning was against the regulatory guidelines. Other studies have also reported that healthcare practitioners have conflicting views on regulatory guidelines (Balneaves & Alraja, 2019; MacDonald et al., 2022). MacDonalds and colleagues (2022) conducted a descriptive qualitative study with 876 dental hygienists. Part of their findings was that dental hygienists expressed conflicting views about regulatory guidelines regarding Covid-19. Similarly, Balneaves & Alraja (2019) also reported that nursing practitioners in Canada had different views on if they can authorize cannabis use for clients. Conflicting views about regulatory guidelines can be addressed by regulatory bodies providing clearer guidance on regulations, as not doing so will continue to cause confusion among practitioners (Largent & Lynch, 2017).

However, the confusion among practitioners in my study on if they can include clients' finances in clinical reasoning cannot solely be attributed to the failure of the regulatory body to communicate guidelines regarding the inclusion of finance in clinical reasoning. As noted in the results, several participants in my studies expressed conflicting views on if they can include clients' finances in their clinical reasoning. The regulatory body for participants in this study, the College of Physiotherapy of Manitoba (CPM) and the examining body for physiotherapists, Canadian Alliance of Physiotherapy Regulators (CAPR) both have published guidance, available

online for physiotherapists and the public, on if and how physiotherapists in Manitoba can include finances in clinical reasoning (CPM, 2017; NPAG, 2017). Policy 5.2 Fees Schedules and Billing Practice (i.e., under the Ethics heading on the regulatory body's website) states that physiotherapists can provide free treatment sessions or reduce the price of treatment sessions (CPM, 2017). In addition, CAPR also stated in their practice competency module that physiotherapists should and are encouraged to include clients' context, which includes financial status, in their clinical reasoning (CAPR, 2017; NPAG, 2017). However, while both of these either permit (i.e., CPM) or encourage (i.e., CAPR) incorporating client financial status and ability to pay into clinical reasoning, neither provide in-depth guidance on the appropriateness of when to do so or how to assess or address client financial status related to physiotherapy care access.

From the questioning I used, I cannot ascertain for sure why participants in this study had conflicting views on the regulatory agency's guidelines regarding older adult clients' finances and clinical reasoning. However, literature has identified possible reasons for this confusion or different views: (1) different regulatory guidelines for different healthcare professionals in the same workplace, such as those reported about dental hygienists having different COVID-19 guidelines from dentists despite working in the same facilities (MacDonald et al., 2023); (2) changes or overlap in terminology used in guidelines (Zollman & Vickers., 1999); and (3) regulatory agencies using outdated methods to create guidelines rather than using current evidence (Reid., 2016). In addition to those reasons mentioned above, another potential reason for this confusion might be the current method the information is store or shared, or the impetus for physiotherapists to find and access this information. Having this

information about including finance in clinical reasoning in texts or websites may not be enough; the regulatory agency may need to pursue other methods of knowledge dissemination, such as seminars or workshops to educate practitioners about their regulatory guidelines.

Participants in my study discussed the need for education and professional development around including clients' finance in clinical reasoning. Participating in Continuing Professional Development programs (CPDS) or Continuing Medical Education (CMEs) is the norm for many healthcare professionals (French et al., 2008; Giri et al., 2012; VanNieuwenborg et al., 2016). These educational programs can help healthcare practitioners, including physiotherapists, keep up to date with current guidelines, improve confidence, clarify roles in addressing client goals, and improve the quality of care offered to patients (French et al., 2008; Cleland et al., 2009; Gunn & Goding, 2009; Li et al., 2010; Filipe et al., 2014; Giri et al., 2012; VanNieuwenborg et al., 2016). According to VanNieuwenborg and colleagues (2016), for the educational and professional development program to be successful, organizers should audit the knowledge of practitioners through health records, patients' satisfaction, and research works, such as this study, to design programs to meet the educational needs of practitioners.

Another reason described by participants in this study on why they did not include older adults' finances in their clinical reasoning is the sensitive nature of the topic – clients finances are often considered taboo to talk about for many cultures and social groups (Kingsbury, 2017), including within the Canadian context (Fortin et al., 2022). Like Fortin and colleagues (2022), my study highlighted the taboo around discussing finance with clients. The taboo around discussing finance is due to factors such as the perception that discussing finance is often against acceptable social norms, personal conflicts about what money means to individuals, and the

perception that talking about finance is uncomfortable (Kingsbury, 2017). In Canada, Fortin and colleagues (2022) reported in their article about financial toxicity that although cancer care practitioners are aware that cancer care can be a financial burden to clients, they do not discuss finances with their clients. They do not discuss finances because: (1) they lack the time to address finances and (2) they feel ill-equipped to discuss finance with clients. Schrag & Hanger (2007) in their survey study with 167 oncologists also reported that one in three oncologists reported that they felt uncomfortable discussing finance with their clients. The results from Schrag and colleagues (2007), Kingsbury (2017), and Fortin and colleagues (2022) all align with the result of my study. Participants in my study described being ill-equipped to discuss finance with clients due to a lack of education and perceptions that discussing clients' finance was rude or uncomfortable. Treating discussion around finance as a taboo was a barrier to considering clients' finance in clinical reasoning in this study which could influence access and participation in physiotherapy services.

However, to address access and engagement in care needs, as noted in the access to care model used for this study (Levesque, et al., 2013), physiotherapists, like other healthcare practitioners, should be open to discussing and including clients' finance in clinical reasoning as finance can influence access and participation in healthcare services. Further, practitioners and the system need to work on various ways to improve the alignment of affordability of needed care to the ability of the client to pay to optimize access to adequate care. Federman (2004) wrote in his editorial that discussing and utilizing clients' finance in clinical reasoning, especially for uninsured elderly clients with poor finances, is the responsibility of healthcare practitioners. Federman (2004) continued that healthcare practitioners should refer clients to available

resources such as drug discount services and refer clients to social workers to improve access to health services. Similarly, Piette and colleagues (2004) conducted a national survey of 660 older adults who underused their medication while living with chronic disease to determine how many discussed finances with healthcare practitioners. Piette and colleagues reported that 67% of the participants were not asked by clinicians if they could afford the medications which resulted in underusage of the medication. Other participants who had a discussion on finance with their clinicians reported getting free medication samples and information about payment plans for medication. This finding by Piette and colleagues (2004) is similar to findings in my own study where participants explained that clients agreed to come for treatment even though the clients knew they could not afford the treatment sessions. However, due to the lack of funds by the clients and the therapists not having a conversation around finance with clients, this resulted in missed appointments. Thus, when my own findings and past literature are synthesized, healthcare practitioners have an ethical obligation to discuss the cost of treatment and where needed, refer clients to services that can assist them in accessing needed services (Federman, 2004; Mirivel, 2010; Meluch, & Oglesby, 2015).

Another finding from my own study is the added complexity of clients' cognitive impairment or the diagnosis of dementia. In my study participants involved caregivers or family members in the care planning of older adults with dementia. Involving family or caregivers in the care plan of clients with dementia is recommended practice for healthcare providers (Bergman, 1986; Anderson et al., 2013; Kelly et al., 2013). Welch and colleagues' 2022 systematic review of 22 articles found that involving family members or relatives benefited older adults with dementia, the caregivers, and the healthcare practitioner. For clients with

dementia, involving family or caregivers led to improved health outcomes, satisfaction with care, improved psychosocial symptoms, and helped to identify treatment goals (Shega et al., 2003; Adams et al., 2005; Callahan et al., 2006; Judge et al., 2011). Families of older adults with dementia reported having less stress, increased satisfaction in the care their relative was getting, and better utilization of support groups and counselling available to help them cope with caregiving challenges when they were involved in the care of their relative with dementia (Shega et al., 2003; Callahan et al., 2006; Schmidt et al., 2009; Donath et al., 2010; D'Souza et al., 2015; Vick et al., 2018). Healthcare providers reported that having families involved in care of clients with dementia provided additional information to aid diagnosis, saved time during home visits, and improved adherence to treatment (Teel, 2004; Hansen et al., 2008; Donath et al., 2010; Vick et al., 2018).

Although family involvement is beneficial in the care of older adults with dementia, doing so could also put older adults at risk of financial abuse and decreased care (Yon et al., 2017; DeLiema, 2018). Bagshaw and colleagues (2013) in their survey study found that older adults depending on others for care is one of the three factors that predispose them to financial abuse from their family members. Older adults' financial abuse is the improper use of an older person's financial resources by family or trusted friends. Yon and colleagues (2017) conducted a systematic review of the prevalence of elder abuse in the community. They found 40 articles with a combined sample size of 45,915 older adults on financial abuse of the elderly. They estimated that one in fifteen older adults (6.8%) of the total sample size had experienced financial abuse. While all older adults are at risk of financial abuse, older adults with dementia have a higher risk of financial abuse. Samsi and colleagues (2014) surveyed staff of Alzheimer's

Societies across England, they reported that half of the 86 respondents encountered and reported cases of financial abuse of older adults with dementia in 2011. DeLiema and colleagues (2018) reported that 27 out of 45 cases of elder financial abuse reported to a forensic center were cases of financial abuse of older adults with cognitive impairment. In Canada, the Government of Canada (2021) estimated that 45% of older adults in Canada experience abuse, and financial abuse among older adults with dementia was the most reported form of abuse experienced.

While involving family members in the care of older adults can be beneficial, it is crucial that healthcare professionals, including physiotherapists, are aware of the risk of financial abuse and report suspected cases of financial abuse to relevant legal authorities (Manthorpe et al., 2012). Although participants in my own study expressed concerns about older adults with dementia being at risk of financial abuse, they did not discuss the need to assess for financial abuse or report suspected cases of financial abuse. The reason participants may not have discussed the need to assess or report suspected cases may be due to the interview not including questions about screening for signs of financial abuse or need to report financial abuse to relevant authorities. However, it is important to note that two laws in Manitoba mandates that healthcare professional including physiotherapists report suspected cases of abuse including financial abuse, but this only applies but this only applies to some clients who may be recipients of their care (CancerCare Manitoba, 2016): 1) the Vulnerable Person Living with a Mental Disability Act would apply to older adult clients who received a mental disability related diagnosis prior to the age of 18 (Government of Manitoba, 2022) and 2) the Protection for Persons in care Act would apply to an older adult receiving care in a health facility

(Government of Manitoba, 2000). Failure to report such cases of abuse related to these to provincial laws could lead to the healthcare professional being reported to their professional body (Government of Manitoba, 2000). However, these two acts would not necessarily apply to all older adults receiving physiotherapy care in Manitoba (e.g., older adult with cognitive-related disability but onset and diagnosis is after the age of 18, or receiving physiotherapy not in a healthcare facility under the law). These laws do not provide protection and mandatory reporting of abuse for all older adults, such as two failed past Manitoba bills advocated for (i.e., the unpassed Bill 213, The Seniors' Rights and Elder Abuse Protection Act, and Bill 205, The Seniors' Rights and Elder Abuse Protection Act; Manitoba Law Reform Commission, 2021).

Another possible reason participants in this study did not discuss the need to look for signs and report suspected cases might be due to lack of training on signs of financial abuse, although this was not explored in my interview questioning. Arguably, this potential lack of awareness about signs of financial abuse is why healthcare workers including physiotherapists should be trained on signs to look out for and how to report suspected cases of elder abuse, including financial abuse to the appropriate authorities (Manthrope et al., 2012; Schuessler, 2022). Harries and colleagues (2014) reported in their randomized control trial with 187 healthcare professionals that educational training on financial abuse led to more consistency in the detection of fraud and improved the professionals' confidence in detecting financial abuse. Training physiotherapists to identify financial abuse can help eliminate bias, make it easier to spot financial abuse, and safeguard older adults' finance, especially older adults living with dementia (Harries et al., 2014; Schuessler, 2022).

In addition to older adults being at risk of financial abuse by involving families and caregivers in the care planning of older adults with dementia, including family and caregivers can also lead to paternalism. Paternalistic care or paternalism comes from the word "father", and it means having someone else make decisions that they believe best suit the needs of the client (Thompson 2017), but paternalistic care can be in direct conflict with an individual's autonomy to decide what they want for themselves (Smeby et al., 2015). Smebye and colleagues (2015) conducted a qualitative study in 2015 with 27 individuals (i.e., nine older adults with dementia, nine family carer and nine professional caregiver). They reported that the autonomy of the older adults was often in conflict with paternalistic caregivers' right to make decisions on behalf of the older adults with dementia. Other studies also reported that families of individuals with dementia often had difficulties knowing what the client wanted in some cases and the individuals with dementia were not allowed to make decisions on their own health. When older adults with dementia are included in the decision making, the caregiver still makes the final decisions (Hovenga et al., 2024; Mortensen et al., 2023). In summary, including caregivers in the care of older adults with dementia can be helpful but we should be mindful of the effect it can have on clients' autonomy.

Revisiting Foundational Models and Frameworks in Relation to Study Results

In reflecting on my results in relation to other literature, it is also important to reflect on how the results of my study relate to the guiding frameworks and models for the study. First, the access to care framework (Levesque et al., 2013) was one of the two frameworks I discussed in the methods section of this thesis. I explained how abilities of clients to pay for healthcare services (i.e., demand side of the Levesque model) and the affordability of

physiotherapy services and recommended care (i.e., supply side of the Levesque model) interact to determine access to and utilization of physiotherapy services (i.e., the processes or actions of accessing care). Specifically, in my methods section, I explained how, within the Access to Care Framework proposed by Levesque and colleagues, access to services are determined in part by affordability, which is contained within the dimensions of supply. Affordability in turn interacts with the ability to pay for services, which is contained within demand (abilities of client). According to the framework, utilization of healthcare services depends on the clients' ability to pay for the direct, indirect, and opportunity cost of accessing healthcare services. In alignment with the description of Levesque and colleagues, participants in my study described how the actions of the physiotherapists (i.e., supply side) could make physiotherapy services more affordable. A more affordable physiotherapy services can improve clients' (i.e., demand side) ability to pay for physiotherapy services which could in turn improve access to care (i.e., "care utilization" (Leveque and colleagues 2013 p.5)). Participants in my study discussed how they improved access to physiotherapy services for clients they perceived or found out had less finances (i.e., ability to pay) to access physiotherapy services by reducing the direct and indirect costs (i.e., affordability) of physiotherapy services. For example, some participants were able to reduce the direct cost of accessing physiotherapy services by offering clients used and safe to use equipment and offering free treatment sessions. Other participants discussed how the indirect cost of accessing physiotherapy services such as transportation to appointments and opportunity cost to attend physiotherapy services, such as having to choose between physiotherapy services and other services made them consider clients' finances in clinical reasoning.

However, my results also highlighted how the relationship between affordability (i.e., supply) and ability to pay (i.e., demand) is related to "the operationalization of access to health care all along the process of obtaining care and benefiting from the services" (Levesque et al., 2013, p. 1). According to Levesque and colleagues (2013), the framework is not as linear as it appears in the framework diagram provided by Levesque and colleagues (i.e., Figure 2, p. 5). Instead, the different abilities of demand and dimensions of supply are interrelated or interact to determine access to healthcare services. "The various dimensions of access identified are not completely independent constructs… They often influence each other and act at different times during an episode of illness and care" (2013, p.6). This interrelatedness of the dimensions of supply and abilities of demand were supported by the findings in my study. I found that participants' considering or not considering older adult clients' finances in clinical reasoning depended on more than just the affordability of physiotherapy services (i.e., supply) interacting with ability to pay (i.e., demand) to access physiotherapy services. For example, participants in my study discussed how having a caregiver (ability to engage; i.e., demand) can influence clients' ability to pay (also included in abilities of demand) the direct cost and indirect cost of physiotherapy services (i.e., affordability; dimension of supply). Specifically, participants discussed how clients with dementia might have difficulties managing their finances and paying for the cost of physiotherapy services if they do not have caregivers' supports. The clients' ability to seek (contained within demand side) the needed physiotherapy services is another ability on the demand side noted by participants in my study as influencing the affordability (i.e., supply side) and clients' ability to pay (i.e., demand side) for physiotherapy services. Specifically, participants in my study discussed how a clients' personal or cultural values,

delineated by Levesque and colleagues as related to "ability to seek" might make the client reluctant to discuss finance with their physiotherapists. Client not discussing finance with the physiotherapists can be a barrier to physiotherapists deploying strategies to reduce the cost of accessing physiotherapy services (i.e., making physiotherapy services more affordable) and improve access to care.

Participants in my study also described how other dimensions of supply can influence the cost of accessing physiotherapy services (affordability, i.e., supply) and clients' ability to pay (i.e., demand) to access healthcare services. For example, amount of time spent with clients and adequacy of the treatment are both under appropriateness (i.e., supply in the Leveseque model), yet it influences affordability (also supply) of physiotherapy services and clients' ability to pay (i.e., demand) for physiotherapy services. Specifically, participants in this study described how the more clients they have, the less time they have to spend with each client which can make it difficult for the physiotherapists to ask questions about finance or include finance in their clinical reasoning. Physiotherapists not having time to discuss finance with clients can be a barrier to the physiotherapists deploying strategies to reduce the direct or indirect costs of physiotherapy services (affordability), thus, interfering with the physiotherapists' ability to provide adequate care to the clients. Acceptability, a dimension within supply which includes professional values, norms and culture, was also discussed by participants in my study as influencing if they included or did not include clients' finance in their clinical reasoning. For example, participants in my study were less likely to discuss finance with clients if they had the perception that discussing finance was against the cultural beliefs or norms (i.e., discussing finance is a taboo). Not discussing finance with clients leads to missed opportunities to explore

ways of making physiotherapy services more affordable to clients. Finally, participants also discussed how professional values and norms influenced if they included finance in clinical reasoning. A participant's norm and professional value in this study was that finance must always be discussed and included in their own clinical reasoning. This participant was able to explore ways of making physiotherapy services more affordable to clients by having these conversations about finance with their clients. In summary, result from this study showed that any of the ability of demand and dimension of supply cannot be looked at in isolation. In alignment with the discussion of their own access to care framework given by Levesque and colleagues, abilities of demand and dimensions of supply interact in various ways at various proposed processes or stages of access to care to determine the overall access and utilization of healthcare services, this includes a interrelatedness with affordability and ability to pay with multiple other accessibility dimensions (i.e., supply) and client abilities (i.e., demand).

The financial well-being and capability model delineated by Kempson and Poppe (2018a) was the second framework I described in the methods section of this study. In this framework delineated by Kempson and Poppe (2018a), socioeconomic environment was one of the direct determinants of financial well-being. Socioeconomic environment includes all the expenditures an individual incurs and an increase or decrease in expenditure may influence financial well-being. In the context of my own study, physiotherapy services could be viewed as an expenditure with variable costs. Older adults with good financial well-being will potentially be able to afford to participate while older adults with poor financial well-being may have difficulties paying for physiotherapy service. Further, an increase in expenditure may have a negative effect on financial well-being while a decrease in expenditure, such as physiotherapists

including finance in clinical reasoning, may not only make physiotherapy services more accessible but also prevent a negative effect on overall financial well-being. Participants in this study described how they included older adults' finances in clinical reasoning by modifying treatment plans and offering free services, doing this could potentially protect older adults from having poor financial well-being.

Financial confidence and control is another factor related to financial well-being that was discussed in this study. Financial confidence and control refers to the ability of individuals to manage their daily finances and plan for the future (Kempson & Poppe, 2018a). As discussed by the participants in this current study, they considered the finance of older adults with dementia in clinical reasoning because older adults with dementia might have difficulties managing their own finances which could negatively influence financial well-being. Finally, Kempson and Poppe (2018a) also delineate that personality traits are also an indirect determinant of financial well-being. Personality traits related to financial behaviours, as delineated by Kempson and Poppe (2018a), includes spending restraints, such as not spending more than you have to do (Kempson & Poppe, 2018a). Participants in my study described how some clients do not exercise spending restraints and ask physiotherapists not to consider their finances in clinical reasoning even when physiotherapists wanted to include finance in clinical reasoning. Clients asking physiotherapists not to include their finances in clinical reasoning can potentially have a negative effect on the finances of the older adults in question. Therefore, in my study it seemed that in some cases the personality traits of clients, as discussed by Kempson and Poppe (2018a), also influenced the relationship of client finance to the clinical reasoning of physiotherapists.

In contrast, my study results highlighted an area that was not explicit or delineated by Kempson and Poppe's (2018) financial well-being framework. That is, how having someone else manage an individual's finance can influence the individual's financial well-being. The Kempson and Poppe's framework was conceptualized without consideration for people who have cognitive impairments or diagnoses such as dementia which can influence their ability to manage their own finances and how that can influence the individual's finance. The importance of the effect of having someone else manage clients' finance was discussed by a participant in this study. The participant narrated how their father-in-law who was an accountant could no longer manage their finance due to dementia and how their mother-in-law had to take over. Despite the mother-in-law taking over the management of the finance, they still got scammed out of a huge amount of money which negatively influenced the family's financial well-being. From the questioning used, I was unable to determine why the participant's father-in-law was scammed despite their mother-in-law taking over the finance.

Revisiting My Positionality Related to Study Results

In reaching a conclusion to my discussion is to return to my reflections on my positionality and how the study results relate to my practice experience. I come from a country with a vastly different healthcare system compared to Canada, where the cost of public or private healthcare services is not usually covered by the government. Lack of healthcare coverage and widespread poverty made finance an important consideration in clinical reasoning and care plans in my home country, Nigeria. The importance of finance in access and participation in physiotherapy services in Nigeria made me want to investigate if physiotherapists in Canada also considered older adults' finances in clinical reasoning and

compare the similarities and differences between how physiotherapists in Canada and Nigeria considered older adult clients' finance in clinical reasoning. However, after beginning my studies in Canada, I realized a cross-country and cross-continental study will be a difficult undertaking within the confines of the duration of my study. This led to me studying only if physiotherapists in Canada consider or do not consider older adults' finance in clinical reasoning and care planning.

Much of the result of this current study was a surprise to me, especially after learning about the cost-related barriers older adults in Canada face in accessing healthcare services. My bias going into this study was that physiotherapists have a duty to encourage access to and participation in physiotherapy services by including clients' finance in clinical reasoning. I had to routinely reflect on my bias during the interviews and data analysis process to ensure I was representing the data from this study and not what I think should be the practice in Canada. The result from this study showed some similarities and differences between my practice experience in Nigeria and the experience of physiotherapists practicing in Canada.

One major difference I noted between my own experiences as a physiotherapist in Nigeria compared to the discussions presented by the participants in my study related to Canadian practice is the ease of discussing finance with clients. Participants in this study indicated that they had difficulties initiating conversation about finance. In contrast, asking about finance is an important part of documentation in my practice in Nigeria. While participants in this current study in Canada noted the need for more practice guidance (e.g., "trigger questions" as noted in the results) to discuss finance, practitioners in Nigeria already developed trigger questions that facilitate discussion around the financial status of clients.

Questions related to income and financial well-being were much more common in Nigerian physiotherapy education and practice; questions such as asking the type of water clients drank (i.e., factory-packaged indicating higher income versus well-water indicating lower income), the client's job or their spouses' job, the type of dwelling they live in (e.g., owned versus rented; house versus apartment; apartment style and size). For instance, living in a "face me I slap you" apartment, which is a common Nigerian slang term for a multi-family dwelling unit where sometimes up to ten families share the same washroom and kitchen, was often an indication of the financial status of the clients and could lead to a conversation around the affordability of physiotherapy services and influenced my own clinical reasoning. Physiotherapists in Canada may be able to discuss finance more openly if they can develop questions that can lead to conversation about affordability, similar to what is practiced in Nigeria.

However, it is important to note that while there are "trigger questions" as noted by a participant in my study that can start the conversation around finance, as a physiotherapist in Nigeria, I did not always have the liberty to use such questions. For instance, while practicing in Nigeria, I ran a private practice during the weekend, and I would often be called to provide home service for some clients in their homes. In such cases, the clients always wanted a price for each visit during the initial phone conversation to determine if home service was something they would want to continue with. Like participants in this study, I sometimes made assumptions about the financial status of the client based on the location of their house. The perception that the client lives in a location with poor finances influenced my clinical reasoning and led to a reduction in fees while those who live in affluent neighborhoods got higher fees, compared to what I usually charged (note: in Nigeria, as a physiotherapist there were no

guidance to what I could charge clients, and I was free to choose fees for clients as I saw fit—which is in contrast to fee guidance provided by different provincial associations to physiotherapists in Canada).

This research has changed my own positionality. Prior to conducting this study, I had an incorrect view about the Canadian healthcare system. I assumed all healthcare services were covered by the government. Through literature review, I found this was not the case. The realization that older adults' participation in physiotherapy services may be influenced by their finances made the result of this study surprising to me. I expected finance to be an important discussion between therapists and clients, like my practice experience in Nigeria, to promote access to and participation in physiotherapy services but this was not the case. Most importantly, this study has made me aware of how my assumption about certain clients' finance was wrong and could have influenced those clients' access to physiotherapy services. Specifically, I have learnt from literature that having good finances does not always mean you are able to afford physiotherapy services as each individual has different expenditures that can influence their ability to afford services. I look forward to changing my clinical practice and having conversations with all clients about finance rather than making assumptions about what is affordable to clients.

Study Strengths and Limitations

This study, like any other, has strengths and limitations. The first strength of this study is that it is the first study to examine how finance influences physiotherapists' clinical reasoning in an important demographic, older adults, and within a unique healthcare system, Canada

(specifically the province of Manitoba). The second strength of this study is the data collection method. I used in-depth semi-structured interviews to collect data. An individual in-depth semi-structured interview allowed me to capture the individual opinions and experiences of the participants. Capturing participants' individual experiences helped create in-depth descriptions of the contextual factors that influenced physiotherapists' clinical reasoning. The third strength of this study is the data analysis method. I used an inductive approach to reflexive thematic in analyzing this result. This approach not only allowed me to capture and present the participants' views in relation to the available data but also influenced me to constantly reflect on my role in the research. By regularly reflecting on how I could influence this study and keeping a journal about my reflections, I was able to be more transparent about my influence on the research process, including the analysis and findings. Lastly, I used multiple strategies for data analysis trustworthiness and rigor, namely triangulation of perspectives during analysis. As discussed in the data analysis portion of this thesis, I coded a transcript with my research supervisor, Dr Engel, and Sarah Conci. This triangulation supported the creation of the themes from multiple perspectives and gave multi-perspective meaning to the findings described in the result portion of this thesis.

Despite the strengths of this study, there are also limitations. The first limitation is the small sample size. While twelve physiotherapists answered the recruitment call to participate in this study, only 10 met the eligibility criteria and nine participants completed the informed consent and interview process. This sample size although small can be acceptable for a qualitative study with homogenous participants (in this case, physiotherapists practicing in Manitoba) as the goal of qualitative study is to get depth rather than breadth (Boddy, 2016;

Malterad et al., 2016). While data saturation was reached in identifying contextual factors related to the themes, it could be that other physiotherapists may have different experiences or people who were not interested in the study have different perspectives on client finance related to clinical reasoning or possibly that they consider it less often than those interested in the study. The second limitation is in the sampling method used. This study used a sample of convenience rather than the initially planned purposeful sampling to improve the diversity of recruited participants. However, due to the decreased response to the recruitment email, everyone who signified interest in participating, met the eligibility criteria, and completed the informed consent process took part in this study. This led to a sample that may have been somewhat self-selected and homogenous; for example, seven participants were female, and seven of the participants had over 10 years of practice. This lack of diversity might have affected the results. Finally, it is important to note that the result of this study may not be generalizable across provinces in Canada due to differences in healthcare system and access inter-provincially, as Canada's healthcare system, while supported by federal transfer funds, is delineated pragmatically at a provincial level of government.

Recommendations for Future Research

This current study has explored if and how physiotherapists in Manitoba include older adult clients' finance in clinical reasoning and care plans. However, this study has raised some new questions and areas for future research. The first is the conflicting views of participants on regulatory guidelines on including older adult clients' finance in clinical reasoning and care plans. More studies are needed to understand if physiotherapists have conflicting views about other parts of the regulatory guidelines and the potential causes of the different views on

regulatory guidelines. Further, the diagnosis of dementia was an important factor in including older adult clients' finance in clinical reasoning and care plans in this study. More findings need to be made on if any other chronic condition will influence the inclusion of older adult clients' finance in clinical reasoning. In addition, I found in my study that personal and professional experience influenced if physiotherapists considered or did not consider older adult clients' finances in their clinical reasoning. However, due to the questions used, I was unable to explore why personal and professional experience impacted clinical reasoning the way they did. More studies need to be conducted to examine why personal and professional experience influence clinical reasoning and the various ways personal and professional experience influence clinical reasoning. Finally, different provinces have different access to publicly funded physiotherapy services. Investigating similarities and differences in if and how physiotherapists in other provinces include older adult clients' finances in clinical reasoning and care plans is vital to fully understanding physiotherapy clinical reasoning related to client finance across Canada's different provincial healthcare systems and provincial physiotherapy regulatory bodies.

Conclusion

The findings from this study demonstrated that physiotherapists including clients' finances in clinical reasoning is not a straightforward process. It depends on contextual factors internal and external to the physiotherapists. Also, there were conflicts within each participant and across participants on if and how to consider clients' finances in their clinical reasoning. In addition, diagnosis of dementia influenced how participants considered older adult clients' finance in their clinical reasoning and care planning.

This study showed that having regulatory guidelines around physiotherapists including older adult clients' finances in clinical reasoning does not guarantee that such guideline will be taken into consideration during clinical reasoning. Instead, in my study I found that participants were confused about regulatory guidelines. Practitioners relied on various factors such as assumptions about finance to determine if and how they will consider clients' finances in clinical reasoning. Leaving a critical part of client centred care (i.e., clients' finances) to assumption should be concerning to physiotherapists and regulators as other parts of practice and client care are not based on assumptions.

For physiotherapists to move from biomechanical approach (i.e., treating the body like a machine) to client-centred approach (i.e., considering clients' contextual factors, including finance, in clinical reasoning), it may be important that physiotherapy regulators and educators critically reflect on how to disseminate practice guidelines around inclusion of clients' finances in clinical reasoning to physiotherapists. One of the methods that can be employed in the dissemination as suggested by a participant is education and professional development opportunities for physiotherapists related to the importance of including and how to include client finance into clinical reasoning, which could help clarify some of the confusion or concerns participants in this study expressed about if they are permitted to incorporated client finance in their clinical reasoning and how they might do so.

However, while education can sensitize clinicians to include clients' finances in clinical reasoning, it is also important to consider the influence of factors external to the physiotherapists, specifically workplace factor and healthcare systems. According to my study, workplace factor and healthcare systems can influence if and how physiotherapists include

finance in clinical reasoning. As described by participants, having a access to previously used and access to previously used and donated equipment one can provide free, having social workers on the teams to refer clients to, and working in the public healthcare system where there were funds physiotherapist units could use to pay for private physiotherapy of clients (i.e., through unused public hiring budget) facilitated the inclusion of clients' finances in clinical reasoning. Creating workplace environments and systems that support physiotherapists to include clients finance in their clinical reasoning can make more physiotherapists ask and include finance in their clinical reasoning and care plan. Which could improve older adults' access and participation in physiotherapy services.

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Appendices

Appendix A: Permission to Include Diagrams

Kafayat Adedotun

From: Christian Poppe <chripo@oslomet.no>
Sent: Tuesday, October 17, 2023 2:57 PM
To: Kafayat Adedotun
Subject: Re: Permission to include figures from SIFO published report (Kempson & Poppe, 2018)

Hi there,

Go ahead, use the figure with reference to us.

Christian Poppe
Senior Researcher
OsloMet/SIFO

------ Original melding ------
Fra "Kafayat Adedotun" <adedotuo@myumanitoba.ca>
Til "Christian Poppe" <Chripo@oslomet.no>
Dato 17.10.2023 18:34:34
Emne Permission to include figures from SIFO published report (Kempson & Poppe, 2018)

Det er ikke ofte du mottar e-post fra adedotuo@myumanitoba.ca. Finn ut hvorfor dette er viktig.

Hello,

How are you doing today? I am emailing to request your permission to use one figure that I will fully cite in my master's thesis.

The figure I want to use is Figure 8-2: The revised conceptual model (page 74) and the reference is

Kempson, E., & Poppe, C. (2018). Understanding financial well-being and capability - A revised model and comprehensive analysis. ©Consumption Research Norway - SIFO. https://oda.oslomet.no/oda-xmlui/handle/20.500.12199/5357

My thesis will be published on the University of Manitoba thesis repository, Mspace https://mspace.lib.umanitoba.ca/home

Is it possible to get approval from SIFO to use the figure (listed above) in my thesis?

Thank you for considering my request.

sincerely,
Kafayat Adedotun (B.M.R.P.T, PT Reg (Nigeria)
Graduate student,
College of Rehabilitation Science,
Rady Faculty of Health Sciences, University of Manitoba

1

Kafayat Adedotun

From: Jean-Frederic Levesque (Agency for Clinical Innovation) <JeanFrederic.Levesque@health.nsw.gov.au>
Sent: Wednesday, October 18, 2023 8:19 PM
To: Kafayat Adedotun
Subject: RE: Permission to include a figure (A conceptual framework of access to health care) in my Master's thesis

Thank you Kafayat

I am happy to approve the use of the figure. All the best in your studies.

Jean-Frederic

From: Kafayat Adedotun <adedotuo@myumanitoba.ca>
Sent: Wednesday, 18 October 2023 3:51 AM
To: Jean-Frederic Levesque (Agency for Clinical Innovation) <JeanFrederic.Levesque@health.nsw.gov.au>
Subject: Permission to include a figure (A conceptual framework of access to health care) in my Master's thesis

> You don't often get e mail from adedotuo@myumanitoba.ca. Learn why this is important

Hello,

How are you doing today? I am emailing to request your permission to use one figure that I will fully cite in my master's thesis.

The figure I want to use is Figure 2: A Conceptual Framework of Access to Health Care (Page 5 of 9). The reference for this article is:

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 12(1), 18–18. https://doi.org/10.1186/1475-9276-12-18

My thesis will be published on the University of Manitoba thesis repository,
Mspace: https://mspace.lib.umanitoba.ca/home

Is it possible to get your approval to use the figure (listed above) in my thesis?

Thank you for considering my request.

sincerely,
Kafayat Adedotun (B.M.R.PT, PT Reg (Nigeria)
Graduate student,
College of Rehabilitation Science,
Rady Faculty of Health Sciences, University of Manitoba

1

Appendix B: Recruitment Email

Study Title: Physiotherapists' Clinical Reasoning Related to Older Adult Clients' Finance and Economics

Procedure: CPM, MPA, working groups, and collectives will send out this email to their members list

Subject Line: invitation to participate in a research about physiotherapist clinical reasoning related to older adult clients' finances.

Study Title: Physiotherapists' Clinical Reasoning Related to Older Adult Clients' Finance and Economics

Hello,

I am excited to invite you to be a part of a study on physiotherapists' clinical reasoning related to older adult clients' finance and economics.

Previous research has identified the need for physiotherapists to include clients' finance in their clinical reasoning to promote access and participation of clients in physiotherapy services. I am a Nigeria licensed physiotherapist and I will like to interview you for 60 to 90 minutes about your experiences and thoughts on inclusion of older adult clients' finance in your clinical reasoning.

I am looking for physiotherapists to take part in this study who:

- have practiced for at least two years
- are practicing or have practiced in a clinical setting within the last five years
- self-report to have worked with older adults in private or public care practice
- have some client practice experience in Manitoba province

If you take part in this study, you will receive a gift card for your time.

If you would like to learn more about this study or have questions about the study or would like to participate in the study, please contact

Kafayat Adedotun

Email: adedotuo@myumanitoba.ca

Phone voicemail: 204-789-3419 (please leave a message)

Thank you for your interest, I look forward to hearing from you!

Sincerely,

Kafayat Adedotun

BMR (PT), PT reg (Nigeria)

MSc: Rehabilitation science student,

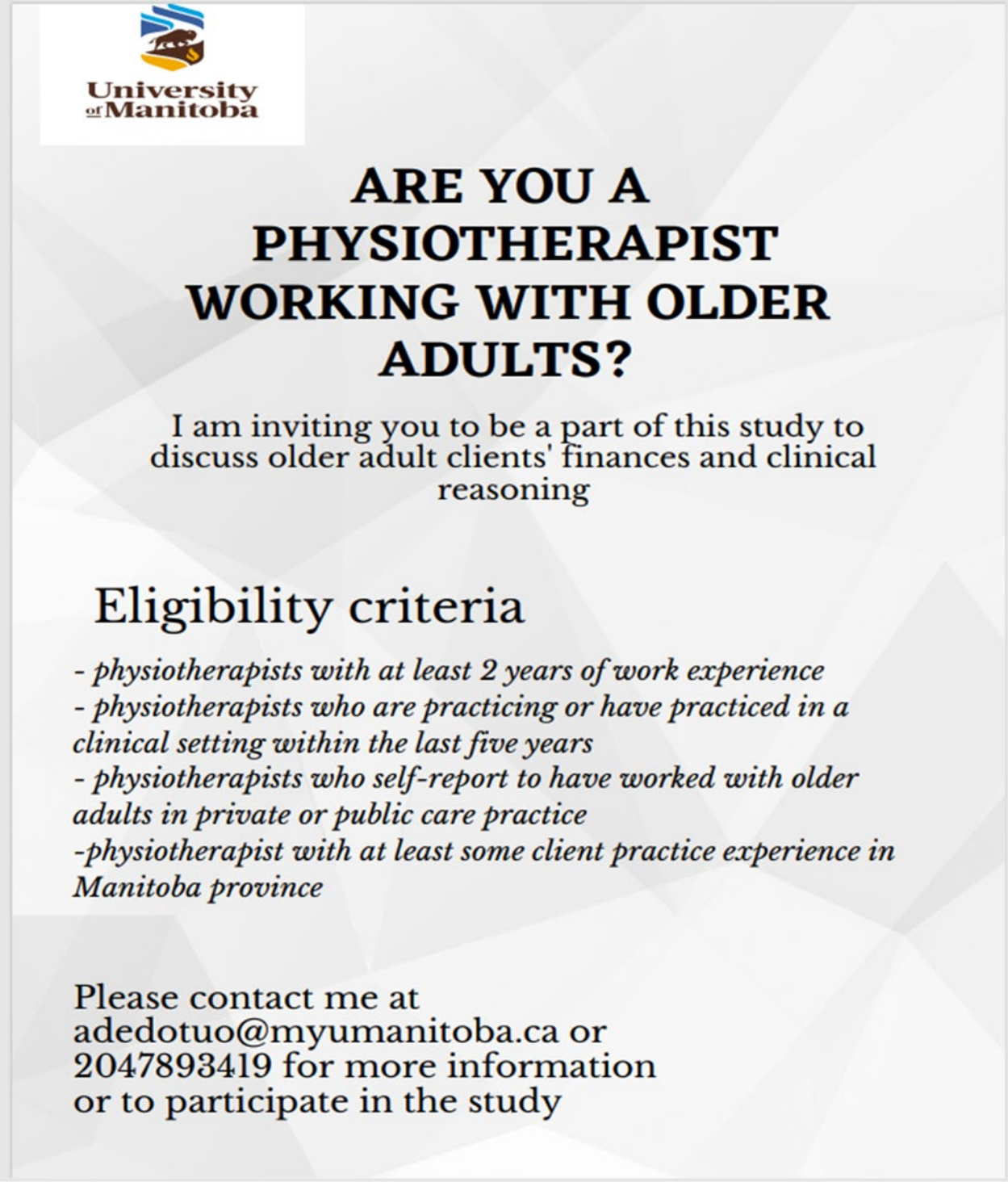
Department of Rehabilitation science,

Rady Faculty of Health Sciences,

University of Manitoba

This study has been approved by the University of Manitoba Health Research Ethics Board. This study is funded by the personally held research fund of Dr Lisa Engel, the researcher's supervisor.

Appendix C: Recruitment Poster



Appendix D: Informed Consent

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: Physiotherapists' Clinical Reasoning Related to Older Adult Clients' Finance and Economics

Study Health Research Ethics Board Approval Number: HSW25918 (H2023:087)

Student Principal Investigator: Kafayat Adedotun
MSc: Rehabilitation science student, Faculty of Rehabilitation Sciences, University of Manitoba.
Email: adedotuo@myumanitoba.ca
Phone: 204-789-3419 (please leave a message on voicemail of Dr. Lisa Engel)

Study Supervisor & Co-Investigator: Dr Lisa Engel
Assistant Professor, Department of Occupational Therapy, Rady Faculty of Health Sciences, University of Manitoba.
R129 – 771 McDermot Avenue, Winnipeg MB, R3E 0T6
Phone: 204-789-3419Email: Lisa.Engel@umanitoba.ca

Other Co-investigators:

- Dr Patty Thille (Patty.Thille@umanitoba.ca) (Department of Physical Therapy, College of Rehabilitation Science, University of Manitoba)
- Dr Stephanie Chesser (Stephanie.Chesser@umanitoba.ca) (Faculty of Kinesiology and Recreation Management, University of Manitoba
- Sarah Conci (Sarah.Conci@umanitoba.ca) (Department of Physical Therapy, College of Rehabilitation Science, University of Manitoba)

Funding: The funding for this project is through Dr Lisa Engel's research fund.

You are being asked to participate in this study. Please take your time to review this consent form and contact the student principal investigator to discuss any questions you may have over the phone or teleconferencing meeting. You may take your time to make your decision about participating in this study and you may discuss with your friends, family, or colleague before you make your decision. Please ask the student principal investigator to explain words or information you do not clearly understand.

Purpose of Study

The purpose of this study is to explore if and how physiotherapists in Manitoba consider older adults' financial well-being in their clinical reasoning and care plan.

Participant Selection

Up to 15 participants will participate in this study. You will be asked to participate in this study if you are a physiotherapist who:

- has practiced for at least two years,

- is practicing or have practiced in a clinical setting within the last five years,
- has worked with older adults in private or public care practice in the last five years,
- has some client practice experience meeting the above three inclusion criteria within the province of Manitoba,
- can communicate in English language,
- consent to being recorded (audio or video recording) during interview, and
- do not have workplace guidelines or policies that will not permit you to be a part of this research.

Study Procedures

If you take part in this study, you will have the following procedures:

- You will be scheduled for an in-depth semi structured interview conducted by the student principal investigator.
- Demographic information will be collected at the end of this interview as part of the interview process.
- The interview will be conducted over the phone, University of Manitoba Zoom, or University of Manitoba Teams, according to your preference.
- Phone interviews will be audio recorded with an external recorder
- The interview will be recorded using video and audio recording options with audio transcription if the interview is completed via a University of Manitoba Zoom or Teams account. You can turn off your camera during the interview in the teleconferencing options if you do not wish for your face to be recorded or an external audio recorder can be used to record the interview according to your choice.

Study time

The total amount of time you will give to this study is 90 minutes to complete the semi-structed interview and collection of demographic data.

Data analysis & knowledge sharing

- If the interview is recorded via the University of Manitoba Zoom or Teams account, the transcription files will be downloaded from the University of Manitoba Teams or Zoom account and checked for accuracy and corrected by the student principal investigator.
- If the interview was recorded via an external recorder, the student principal researcher will transcribe the audio recording verbatim into a written form. The de-identified transcripts will be shared with all investigators listed on page 1 of this document, who will analyze the data from this study using Microsoft word, Excel, and Nvivo. The Nvivo is a software that can help with theme creation and categorization Nvivo.
- The student principal investigator and the study supervisor/co-investigator will share the results of this study in presentations, conferences, seminars, meetings, and publications, where they will quote some of the things you said during the interview, but your name and other identifying information will not be used or shared.

Data Management

- The student principal investigator and the research supervisor are required to keep any information from this study that can identify you confidential.

- All identifying information (name, contact information) will be input in a password protected document ("master list") and you will be assigned randomly generated ID code to identify you with. This information will be kept in a separate folder from other non-identifying information on the study's University of Manitoba's Research Drive (R-Drive). All study information you share with us will not have your name; all study documents, other than the master list, will only have a random ID assigned to you.
- Only the student principal investigator (Kafayat Adedotun) and the research supervisor (Dr Engel) will have access to the password protected master list document.
- All data collected (demographics, video and audio recordings, informed consents, and transcripts) will be de-identified and uploaded on the University of Manitoba's research servers (R: drive) from the data sources. The data at the sources will then be deleted (e.g., audio recordings on the external audio recorder, video and audio recordings on UM Teams or Zoom).
- To enable analysis, some of the research data will be stored for short-term analysis purposes on a University of Manitoba Teams account created by the study Supervisor (Dr Engel) for this study. Only the investigators listed on the first page of this document will have access to this study's University of Manitoba Teams account.
- The demographics information collected as part of the interview will be input into a password-protected excel sheet. Only the student principal investigator and her research supervisor will have access to this password protected document and the demographic of individual participants. Only aggregated data across participants will be shared external to the student principal investigator or the research supervisor.
- The written interview transcripts will be de-identified.
- After the completion of this study, all the research data stored on the University of Manitoba Teams account will be moved to the University of Manitoba research server (R-Drive) for storage and then any copies on Teams will be deleted
- After the completion of this study, the information collected from you during this study will remain on the University of Manitoba Research drive for 7 years. After 7 years, all study information kept on the University of Manitoba Research Drive (R-Drive) will be permanently deleted.
- The investigators would share your information with the University of Manitoba Bannatyne Health Research Ethics Board if requested for research audit purposes,. Like the other people involved in this study, the people completing the research audit will keep any of your personal information confidential.

Participant rights & voluntary participation

- Participating in this study is voluntary and you can refuse to participate in this study
- You can ask questions about this study at any time.
- You can withdraw your consent at any point during this research.

Study risks

- There are a few risks associated with participating in this study.

- It is possible that thinking and answering questions about your experience related to clients' finances make you uncomfortable. During the study, you do not have to answer any questions that make you feel uncomfortable.
- The is also a risk that you might reveal past patients' identifying information during the interviews. While you will be asked to give examples of how you might have included clients' finance in your clinical reasoning, the focus of the interview is your clinical reasoning and not on identifying clients specifically. If you do start to discuss clients' identifying information, the student principal investigator will stop the interview and point this out to you. During the transcription process, the clients' identifying information will be removed.
- If you are feeling uncomfortable, you can talk with the student principal investigator about your concern.
- If during the study you say that you wish to harm yourself or other people, under the duty to report laws of Manitoba we will contact emergency services and stay with you until emergency services arrive to help you.
- If during the study you say that you have participated in child abuse or neglect, under the duty to report laws of Manitoba we will contact the police and child protective services to disclose what you have said and your identity.

Potential benefits

There may be no direct benefits for you to participate in this study. Some participants may find it beneficial to provide their experiences and thoughts that can be used in improving access and participation of older adult clients in physiotherapy services.

Study Costs

There is no anticipated associated costs for being in this study. All interviews will be conducted over the phone or University of Manitoba Zoom or Teams teleconferencing platform.

Study Honorarium

You will receive a $25 honorarium in form of a gift-card to a store of your choice to appreciate the time you spent on this research.

Study Contact

If you have any questions during, or after the study, please contact the student principal investigator: Kafayat Adedotun at adedotuo@myumanitoba.ca or 204-789-3419

If you have any questions or concerns about the conduct of this research you can also contact the research study supervisor/co-investigator: Dr. Lisa Engel, lisa.engel@umanitoba.ca.

For questions or concerns about your rights about being in the study or the conduct of this study, you can contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at 204-789-3389

Consent & Non-Disclosure Statements

By signing below, you agree to the following statements:

- I have read all 5 pages of the consent form.
- I understand the activities included in this study.

- I have had the chance to ask questions and all my questions have been satisfactorily answered.
- I understand that by signing this consent form, I have not waived any of my legal rights as a participant in this study.
- I understand I can decide not to answer any question that I am asked and that I can quit this study at any time.
- I understand that I can ask to have any information I give to the study removed from knowledge sharing activities before the knowledge sharing activities happen.
- I understand that the information I give to this study may be shared with other people listed in the data & knowledge sharing section above.
- I have a copy of this consent form to keep.
- I agree to participate in the study.

□ I would like to be contacted by the student principal investigator (Kafayat Adedotun) about the ways the result of this study is being shared.

Signature Page

(1) Signature consent option

Participant signature_____

Participant printed name: _____

Date _____(day/month/year)

Witness

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Witness signature_____

Witness printed name: _____

Witness study role: _____

Date _____(day/month/year)

Appendix E: Interview Guide

Hello,

My name is Kafayat, and I am a master of rehabilitation science student at the University of Manitoba and I will be conducting this interview. This interview will take between 60 to 90 minutes.

The title of the study is "Physiotherapy Clinical Reasoning Related to Older Adult Clients' Financial Well-being." Thank you for your interest in the study. I will be conducting this interview to get your experience about the research questions.

This research is being supervised by my masters of rehabilitation sciences advisor, Dr. Lisa Engel, who is an assistant professor at the University of Manitoba's Department of Occupational Therapy, and her work focuses on client financial capability and financial well-being.

As a quick recap, the definition of key terms in this interview are:

Clinical reasoning (also known as practice decision making) is a context-dependent method of thinking and making decisions in professional practice that is used to guide practice. It entails the creation of narratives in order to make sense of the various circumstances and impairments clients present (Higgs, 2006).

Financial well-being is the extent to which anyone can fulfill their present financial needs and meet such obligations in the future (Kempson et al., 2017).

Older adults: people sixty years and over (WHO, 2020)

Please note that there are no right or wrong answers. This interview is to get your perspective and thought on physiotherapists' clinical reasoning related to older adult clients' financial well-being.

I hope to use this information to make recommendations on improving older adult clients' access and participation in physiotherapy services to promote healthy aging. The results will also be used for my masters of rehabilitation sciences thesis.

This interview will take about 1 hour to 1.5 hours. Are you comfortable responding to these interview questions included in the participation email sent to you? At any time, you can skip a question, take a break, or end the interview.

This interview will be recorded which you have consented to in the informed consent form. Do you have any questions before we proceed?

How are you doing today?

The recording will start now.

Question 1: I want to learn more about your physiotherapy practice and experience, can you please tell me about your physiotherapy practice and experience working with older adults?

Probes:

a) What type of practice do you work? (e.g. private/public/large/small/solo/multidisciplinary)
b) How long have you worked as a PT?
c) What is your current role (manager, supervisor, coordinator, instructor)?
d) What is your experience working with older adults (including those with dementia)?

Question 2: What are your thoughts on older adult clients' financial well-being?

Probes:

a) What does good older adult financial well-being look like in practice?
b) What do you think contributes to older adult clients' financial well-being?
c) If at all, what impact does older adult clients' financial well-being have on the ability to seek and participate in physiotherapy care?

Question 3: Can you think of a time you have considered older adult clients' financial well-being in your clinical reasoning (clinical assessment, decision making, and care plan)?

If participant answers yes, proceed to question 3.1.1. If participant answered No, proceed to page 3.2.1

Question 3.1.1: (Case Example 1) Can you describe that time or that example you thought of when you included older adult clients' financial well-being in your clinical reasoning?

Probes

a) Is older adult clients' finance something you routinely include in your clinical reasoning (assessment, decision making, and care plans) or what factors prompted you include clients finance in your clinical reasoning?
b) How did you gather information about older adult clients' finance?
c) How did you use the financial information?
d) What were facilitators (factors) that made it easy for you to consider this older adult clients' finance in your clinical reasoning?
e) If at all, what were the barriers (factors) that made it difficult for you to include older adult clients' finance in your clinical reasoning?

Question 3.1.2: Case Example 2: Thank you for describing that example. Can you think of and describe a different example of when you included older adult clients' financial well-being in your clinical reasoning?

Probes

a) How did you gather information about older adult clients' finance?
b) How did you use the financial information?

c) What were facilitators (factors) that made it easy for you to consider this older adult clients' finance in your clinical reasoning?
d) If at all, what were the barriers (factors) that made it difficult for you to include older adult clients' finance in your clinical reasoning?

Question 3.1.3: Apart from the (1 or 2) case examples you discussed, are there any other ways you consider older adult clients' finances in your clinical reasoning or care planning/decisions?

Question 3.1.4: You outlined some facilitators while describing the case example(s) previously, are there any other facilitators to considering older adult clients' financial well-being in your clinical reasoning?

Probes

a) If at all, what factors (e.g. years of practice, practice setting, personal factors) encourage you to ask/ include older adult clients' financial well-being in your clinical reasoning?
b) If at all, how did your perspective on including older adult clients' financial well-being in your clinical reasoning change over time?

Question 3.1.5: You outlined some of the barriers while describing the case example(s) previously; are there other barriers to considering older adult clients' financial well-being in your clinical reasoning?

Probes

a) What factors (e.g. practice setting, years of practice, or factors) made it difficult for you to consider older adult clients' financial well-being in your clinical reasoning?
b) If at all, how did your perspective on including older adult clients' financial well-being in your clinical reasoning change over time?

If participants answer NO to Question 3

Question 3.2.1: Is older adult clients' financial well-being important to your clinical reasoning (clinical assessment, decision making, and care plan)?

If YES to 3.2.1

Question 3.2.1.1: While you think it is important, can you give describe me some reasons why you might not consider older adult clients' financial well-being in your practice?

Probes

a) If at all, how has your perspective about not considering older adult clients' financial well-being changed over time?
b) If at all, what influence does your practice setting have on your not considering older adult clients' financial well-being in your clinical reasoning?
c) If at all, what impact does your personal factors (thoughts, not wanting to pry or appear rude, age difference between physiotherapists and patients) have on why physiotherapists should not consider older adult clients' financial well-being in their clinical reasoning?

d) If at all, what signs/ factors make you think of considering older adult clients' finance in your clinical reasoning?

If NO to 3.2.1

Question 3.2.2.2 Can you describe why you thing older adult clients' finance is not important to your clinical reasoning or care decisions or planning?

Probes for 3.2.2.2

a) If at all, how has your perspective on the importance of older adult clients' financial well-being in their clinical reasoning changed over time?
b) If at all, what impact does your workplace and personal factors (thoughts, not wanting to pry or appear rude, age difference between physiotherapists and patients) have on why physiotherapists should not consider older adult clients' financial well-being in their clinical reasoning?

All participants answer Question 4 and 5

Question 4: If at all, how do you think dementia would impact older adults' financial well-being?

Probes

a) How can dementia affect financial well-being?

Question 5: Based on what you have said earlier in question 3 (summarize key points), does a diagnosis of dementia influence your clinical reasoning as it relates to older adult client's finances?

If participant answers YES to question 5, proceed to 5.1.1; If Participant answered NO to question 5, proceed to 5.2.1

Question 5.1.1: Can you give an example of how older adult clients' diagnosis of age-related cognitive impairment or dementia influenced your inclusion of older adult clients' financial well-being in your clinical reasoning?

Probes for 5.1.1

a) What made you ask and consider older adult clients' dementia diagnosis in your clinical reasoning related to their financial well-being?
b) Can you explain why dementia diagnosis influence your clinical reasoning around older adult clients' financial well-being?
c) If at all, what impact does factors (e.g. your clinical experience, practice setting, personal context) have on dementia diagnosis influencing your inclusion of older adult clients' financial well-being in your clinical reasoning?

If Participant answered NO to question 5, proceed to 5.2.1

Question 5.2.1: Is older adult clients' dementia diagnosis important to your clinical reasoning (clinical assessment, decision making, and care plan) relating to financial well-being?

IF YES to 5.2.1

Question 5.2.1.1: Can you explains why older adult clients' diagnosis of dementia influence physiotherapists' decision to include older adult clients' financial well-being in clinical reasoning?

Probes for 5.2.1.1

a) if at all, how does older adult clients' diagnosis of dementia influence their financial well-being and ability to seek and participate in physiotherapy services?
b) how should older adult clients' diagnosis of dementia influence physiotherapists' decision to include older adult clients' financial well-being in clinical reasoning?

IF NO to 5.2.1

Question 5.2.2.1: Why might an older adult clients' diagnosis of dementia not influence physiotherapists' clinical reasoning relating to older adult clients' finance?

Probes/prompts for 5.2.2.1

a) if at all, how does older adult clients' diagnosis of dementia influence their financial well-being and ability to seek and participate in physiotherapy services?
b) if at all, what factors influenced your decision that older adult clients' diagnosis of dementia should not influence physiotherapists' clinical reasoning relating to older adult clients' finance?

That is all the formal interview questions I have for you. Thank you for sharing your thoughts and experiences. Do you have any questions or anything else you would like to add?

Is it okay that we now go through a few background/demographic questions? This information will be used to help me describe who takes part in this study, but without identifying you or any other participant.

Ask the demographic questions (i.e., demography questions appendix).

That concludes all of the formal questions I had for you. Is there something you would like to mention that I didn't think to ask?

Is there something you would like to add or questions for me?

Ends recording.

Thank you very much for your time today. You have provided a lot of great information. If you have any questions or concerns at any time, don't hesitate to get in touch with me via email at

adedotuo@myumanitoba.ca, which is also on the informed consent form and emails I sent to you previously. Do enjoy the rest of your day.

General probes/prompts for during the interview: These probes will be used as needed in the interview to get more information from the participants or clarify what was meant by the provided information.

i. Can you please tell me more about (insert what I need information about)?

ii. I'm not quite sure I understand …… point

iii. You mention …….. Can you tell me more about that?

iv. I thought I heard you say…….. Is that correct?

v. Why do you feel/think that way?

vi. Can you clarify what you meant by (insert relevant information)

vii. Do you have another example?

Appendix F: Demography Questions

1. Participant's Randomly generated ID: _____

Note: For all open-ended questions below (i.e., questions 2-9), participants will be reminded prior to starting question 2, that they are allowed to skip any question if they would prefer not to disclose that information.

2. What is your self-identified gender? _____

3. What is your highest level of education (e.g., diploma, bachelors, masters, or doctoral level, and what program/focus this degree was in]? _____

4. What is your highest-level degree related to practice (e.g., BSc/BPT; Msc/MPT; DPT)? _____

5. How long have you or did you practice clinical physiotherapy? _____

6. Approximately what percentage of your clients are older adults in your current physiotherapy practice (i.e., within the last five years) or your Physiotherapy practice prior to retiring or leaving clinical physiotherapy practice?_____

7. Have you ever treated an older adult with dementia in your physiotherapy practice?_____

8. Approximately how many older adult clients with dementia have you treated in your physiotherapy practice within the last five years?____

9. Approximately how long ago did you last treat an older adult client with dementia?_____

10. In general, what is your current practice role (choose all that apply):

a) Clinical professional/physiotherapy practitioner

b) Physiotherapy manager/administrator

c) Multidisciplinary manager/administrator

d) Physiotherapy educator or teacher (e.g., clinical educator, fieldwork supervisor; academic instructor)

e) prefer not to answer /disclose

Appendix G: Framework Categories After Initial Coding and Categorization