

CHAPTER 2. LITERATURE REVIEW

Meaning of Home

Home is more than a just “a territorial core” and not just “an ordering principle in space” (Dovey, 1978), but also a complex entity that defines and is defined by cultural, socio-demographic, psychological, political, and economic factors. Home is a place where our identity continually evolves through connections with the past. Our experiences in the world carry their own meanings, and the places in which these experiences occur become ingrained with those meanings (Blank, 1988). The physical environment plays a very important role because it enables us to materialize our memory through association with places. Memories reflected in the home environment help to create our experiences of home, and those experiences serve in turn to preserve, evoke, and even revise the memory. This theme of connection is fundamental within the conception of home as a focus of self-identity (Brummett, 1997). Home environment may be a repository of memories and provide a link with the past, either through meaning accumulated from the recollection of events that took place within the physical setting or through the memories and sense of self that evolved through personal possessions and artifacts maintained within the home (Rowles, 1987). Our past belongs to us, and personal possessions are tangible parts of the past. These items serve to remind the person who she or he is and they carry with them the giver’s tangible presence into the future (Pastalan et al., 1993).

A considerable volume of research has explored the meaning of home to the general population as an experimental phenomenon (Altman & Werner, 1985; Dovey, 1978; Lawrence, 1987). Expectations concerning home appear to be important to everyone. Especially for old people, this is generally expressed as the wish to stay put. This suggests that for older people, home has a psychological and metaphysical significance over and above being a shelter in which to conduct everyday life (Blank, 1988).

Much of the research has suggested that the need for a home is a fundamental human imperative, providing a locus of order and control in a world of chaos. Home imparts a sense of identity, security, and belonging (Rowles, 1987). It is space differentiated from a world outside that is often viewed as hostile. Home is a place of protection, a refuge. To be at home is to know where we are; it means to inhabit a secure center and to be oriented in space. Home, as territory, can include a room inside a house, a house within a neighborhood, a neighborhood within a city, and a city within a country. At each level the meaning of home gains in intensity and depth from the interaction between the experience of the place and its context in a larger scale. Home in the sense of territory is a place where one can be independent, be in charge and take control, even if it is only perceived control, which means the extent to which one believes that what happens is a matter of fate, luck or one's own powerlessness, versus a belief that one is the master of one's own destiny (Howell, 1985).

Home includes a meaning of origin. People go "back home." We inhabit our home day after day until we develop a sense of familiarity with the environment to the degree that it becomes predictable and taken for granted (Dovey, 1978). Home has strong

roots in the experiences of childhood. Altman and Werner (1985) suggested that there are connections between the visual images of the childhood home and the environmental attitudes towards home expressed in adult life. Home has symbolic properties which refer to the meaning and the logic that gives property its cultural significance (Duncan, 1985). The physical environment also plays a very important role because it enables us to materialize our memory through association with places. The memories reflected in the home environment help to create our experiences of home. This theme of connection is fundamental within the conception of home as a focus of self-identity.

Importance of Housing for the Older Persons

Issues related to housing are closely connected with other aspects of the lives and lifestyles of the elderly. Research (Campbell, Converse, & Rodgers, 1976; Golant, 1985) has revealed that housing satisfaction is a strong predictor of total life satisfaction. Elderly people report higher levels of housing satisfaction than do other age groups though they may live in dwellings which are considered to be unsuitable in terms of objective standards of quality and dwellings which may even be detrimental to their health (Kwon, 1991).

Preference is based on a variety of needs including independence, privacy, security, and an appropriate social milieu. In order to increase elderly consumers' acceptance of alternative housing, some balance between consumers' needs and preferences, price, and quality must be achieved (Bland, 1999).

Age-related limitations and needs have prompted many to propose ways for optimizing the environment for the elderly. For example, Rowles (1987) proposes that housing can be aligned along a continuum of independence to dependence. At the

independent end of Rowles' continuum, where one lives in standard community housing, such as single-family homes, the resident has high independence but must be able to function with that independence. As the need for support increases, autonomy is sacrificed through housing options that make help more convenient but remove choices.

The interpersonal elements of living arrangements are substantial, and often contribute to the environment's functional adequacy and satisfaction level. For example, Dean, Kolody, Wood, and Matt (1992) found that older persons who live alone experience greater depressive symptomatology, even after controlling for support from friends, life events, disability, and financial strain. Further, those living alone seemed more negatively affected by the onset of substantial health problems than did those living with others. In a study of 725 elderly persons, LaGory and Fitzpatrick (1992) also found that environmental factors, including the availability of social support and the degree to which neighbors are also elderly, were associated with depression.

Attributes of Housing for the Older Persons

Wilson (1990) recognizes six attributes of the physical and operational environment and identifies four concepts that underlie her management philosophy for housing for the frail elderly. The attributes include privacy, dignity, choice, independence, individuality, and homelike surroundings.

Cohen and Weisman (1991) have identified nine therapeutic goals that form the basis for operational policies, physical design solutions, and social interaction. These nine goals are established for the mentally frail, but are also equally relevant for the physically frail. They include:

- Ensure safety and security
- Support functional ability through meaningful activity

- Heighten awareness and orientation
- Provide appropriate environmental stimulation and challenge
- Develop a positive social milieu
- Maximize autonomy and control
- Adapt to changing needs
- Establish links to the healthy and familiar
- Protect the need for privacy

Regnier (1994) expanded the categories in the above list and suggested the following composite list of twelve environmental behavior principles. All of these are relevant to older frail people living in housing and service arrangements including assisted living facilities:

- Privacy: Provide opportunities for a place of seclusion from company or observation where one can be free from unauthorized intrusion.
- Social interaction: Provide opportunities for social interaction and exchange.
- Control/Choice/Autonomy: Promote opportunities for residents to make choices and to control events that influence outcomes.
- Orientation/Wayfinding: Foster a sense of orientation within the environment that reduces confusion and facilitates wayfinding.
- Safety/Security: Provide an environment that ensures each will sustain no harm, injury, or undue risk.
- Accessibility and functioning: Consider manipulation and accessibility as basic requirements for any functional environment.
- Stimulation/Challenge: Provide a stimulating environment which is safe but challenging.
- Sensory aspects: Changes in visual, auditory, and olfactory senses should be accounted for in the environment.
- Familiarity: Environments that use historical reference and solutions influenced by local tradition provide a sense of the familiar and enhance continuity.

- Aesthetics/appearance: Design environments which appear attractive, provoking, and noninstitutional.
- Personalization: Provide opportunities to make the environment personal and to mark it as the property of a unique single individual.
- Adaptability: An adaptable or flexible environment can be made to fit changing personal characteristics.

Resident Satisfaction

Concept of Satisfaction

The term satisfaction implies an emotional or affective response. Satisfaction is a widely used concept in many areas of social sciences and is defined variously by researchers of different areas (Campbell et al., 1976; Pascoe, 1983; Smith, 2000).

Reporting on the demand for information on consumers' experiences and satisfaction with health and social services system, Smith (2000) says that satisfaction is assumed to be an attitude. It combines cognition and affect but excludes behavior. According to him, measures of satisfaction should be distinguished from measures of quality of life, life satisfaction, and preferences for care.

In a study of quality of life, Campbell et al. (1976) concluded that housing satisfaction was significantly related to overall satisfaction with quality of life. They said that the measure of life satisfaction was primarily cognitive in nature. Six domains such as standard of living, spare time, family life, friendships, health, and education were found to be significant in explaining overall life satisfaction in this study. They suggested that researchers should conduct qualitative studies where observation and in-depth interviews are the dominant methods of data collection and respondents are given the freedom to discuss aspects of their lives that contribute to their overall satisfaction to

explain the relationships between housing satisfaction and overall satisfaction with quality of life.

Focusing on the satisfaction of patients in nursing homes, Pascoe (1983) defines patient satisfaction as “a health care reaction to salient aspects of the context, process, and result of their service experience” (p. 190). According to this definition, patients evaluate a directly received service by comparing their personal experience to a subjective standard, which is closely related to their expectations regarding their health care. He asserts that understanding older adults’ expectations is crucial to assessing and interpreting measures of patient satisfaction (Pascoe, 1983).

Satisfaction appears to be simultaneously a unidimensional and a multidimensional construct (Smith, 2000). Campbell et al. (1976) asserted that “the level of satisfaction can be precisely defined as the perceived discrepancy between aspiration and achievement, ranging from the perception of fulfillment to that of deprivation” (p.8). They examined satisfaction with 17 life domains to determine how well that set could explain differences in individual responses on the composite measure of overall life satisfaction. The most important domains were family life, marriage, financial situation, housing, job, friendships, and community.

Factors Related to Satisfaction

Recognizing the importance of satisfaction in diverse fields, many researchers have conducted studies to identify factors that contribute to satisfaction. Numerous factors have been related to resident satisfaction such as socio-demographic factors, housing and neighborhood characteristics, structure of care, maintenance, management, and health status.

Socio-demographic factors

Socio-demographic factors were the most frequently mentioned factors that would affect resident satisfaction. People who perceive themselves as having a higher social and economic status apparently also set high standards for their material belongings, such as their dwellings. In the study of American life in the 1970s, Campbell et al. (1976) examined people's satisfaction with their living environment. They found that older adults with higher economic status were less satisfied with their housing environments. They speculated that, compared with lower status older people, higher status adults are more likely to perceive a gap between their high standards and the perceived reality of their dwellings' quality. Among socio-demographic characteristics of patients in nursing homes, patient age and gender are most consistently associated with patient satisfaction, with both female and older patients being more satisfied (Smith, 2000).

Housing and Neighborhood Characteristics

Recognizing the importance of housing satisfaction to a person's overall evaluation of his or her life, Campbell et al. (1976) also found that attributes of the dwelling unit were related to overall assessment of satisfaction with housing. Of the five objective housing characteristics found to be significant contributors to housing satisfaction, person-per-rooms had the strongest relationship followed by ownership, value or rent, structure type, and age of the structure. In another study (O'Bryant & Wolf, 1983), housing satisfaction was found to be related to space, tenure type, structure type, structural quality, housing and utility costs, neighborhood satisfaction as well as socioeconomic and demographic characteristics of the residents.

The importance of neighborhood satisfaction as a contributing factor to residential satisfaction has been determined by several researchers (Golant, 1985; Lee, Brandt, & McFadden, 1994). Lee et al. (1994), in looking at a causal relationship between constraints, conditions, satisfactions related to housing, and propensity to move at retirement, found that propensity to move was directly influenced by neighborhood satisfaction with other constraints such as age, gender, marital status, tenure, and housing satisfaction.

The findings of a nationwide survey relating to housing arrangements and housing concerns of older adults by the American Association of Retired Persons showed that the majority of older people were satisfied with their housing arrangements (AARP, 1990). According to this survey, over 70% of older respondents were “very satisfied” with their neighborhood or location of home, physical condition of the home, personal safety in the home, type of home, and general comfort of home. For general high satisfaction with housing by older people, Kart and Kinney (2001) explained that it might be the strong attachment they have to their homes and neighborhood; that is, a great proportion of the elderly have spent the most of their adult lives in their present homes and neighborhoods.

Subjective Factors

O’Bryant (1982) investigated the housing satisfaction of elderly people living in a large Midwestern metropolitan area to find out whether subjective or objective factors better explained satisfaction with housing. The results indicated that subjective factors such as feelings of competence and emotional security that can be derived from a home, explained more of the variation in housing satisfaction than did demographic characteristics of residents or objective housing characteristics.

Structure of Care

In long-term care facilities, the structure of care influences the residents' satisfaction. The structure of care includes both the organization and financing arrangements, as well as issues of accessibility and continuity of care (Smith, 2000). In a study identifying patients' satisfaction in nursing home, patients were more satisfied with organizations that had greater autonomy and communication with other organizations (Pascoe, 1983). Patients were also less satisfied as the cost of care rose, and health maintenance organization patients tended to be more satisfied with their financial arrangements for care (Cleary & McNeil, 1988). Provider characteristics that influence satisfaction include nursing care, medical care, food quality, noise levels, and physical surroundings, with nursing and physical care generally being the most important determinants (Smith, 2000). Studies have suggested that greater accessibility, availability, and continuity of care are positively related to satisfaction (Cleary & McNeil, 1988).

Maintenance

Maintenance of an environment is important. Butterfield and Weidemann (1987) examined factors that were related to older residents (N=120) in a mixed-age housing site in Illinois. An important predictor of residential satisfaction for older residents was "attractiveness," a term that included a non-institutional exterior, home-like appearance, ability to find one's way around the site easily, and suitable interior units. These researchers commented that: "A well-maintained housing site gives the impression that residents care about their home and is, therefore, more likely to encourage residents to respect the environment and contribute to the continuation of a high level of maintenance" (p.34). They commented that an aesthetically pleasing environment

indicates to residents that they are assets to society and promotes the perception that the environment is a safe place to live.

Real or perceived deviations in the maintenance of the physical environment could easily contribute to residential dissatisfaction by not meeting residents' initial expectations. Golant (1992) also addressed the stability of retirement facilities. He commented that retirement facilities offer residents a relatively ordered and predictable setting and lifestyle, with considerable assurance that the social environment and the facilities that presently exist will not significantly change in the near future.

Along with the physical maintenance of housing, subjective appraisal of what is comfortable in a dwelling is also important. Although measures of the aesthetics of housing and neighborhood environments may be difficult to define, they are a reflection of one's perception of the environment (Reynolds, 1997).

Management

Many residents in independent living facilities move from traditional single-family homes in the community that they have managed themselves. As such, these in-movers give up control of important aspects of their housing environments. Managers and management policies become important influences on the day-to-day lives of the residents.

Butterfield and Weidemann (1987), in examining 37 housing sites for variables that contributed to residential satisfaction, found that for people over 65, management was among the top four predictors of residential satisfaction. The others were privacy, facilities provided, and access to people and the community.

For some movers, relinquishing control can be a source of relief from burdensome responsibilities. Formal retirement living gave these older adults the excuse to grant others the responsibility for portions of some areas of their lives. This attitude justified a dimension of dependence without loss of perceived autonomy, control, or self esteem. Residents of a retirement facility may experience advanced self-confidence in their competencies, and maintain a satisfying amount of power. Perceived autonomy may actually be unrecognized loss of control, particularly if management turns out to be lacking in the qualities important to residents.

In a study that examined satisfaction of elderly residents in subsidized housing, Johnson, Lovingood, and Goss (1993) found that the leadership style of the apartment manager had a significant direct effect on the residential satisfaction of the respondents. Francescato, Weidemann, Anderson, and Chenoweth (1979) evaluated the management qualities important to tenants in 37 HUD-assisted housing sites in a study on residential satisfaction. Management was considered satisfactory if staff was accessible for conversations, friendly and cooperative; if complaints were followed upon quickly; and if residents perceived that rules met their needs and were fairly and consistently enforced.

Health Status

Health status may also be related to satisfaction separately from the outcomes of care, suggesting that controlling for pre-existing differences in health may be important when examining the relationships between outcomes and satisfaction (Smith, 2000). The results of AARP survey relating to housing arrangements and housing concerns of older adults showed that 61 % of the respondents were very concerned about their failing health as the most significant housing concerns (AARP, 1990). In the same survey,

keeping the home in good condition (59%) and losing independence (56%) were included as significant housing concerns.

Assisted Living Facilities

Assisted living facilities are a recent addition to a semi-independent living category of housing and include a higher level of services, such as at least one meal a day, transportation, activities, and often an alarm system. The concept emerged out of a desire to provide services in a residential setting.

Definition of Assisted Living

One of the big problems in looking at ALFs today is that there is no clear definition (Kalymun, 1990). Although assisted living is the most common term used for housing for older persons, assisted living settings may be known by as many as 26 different names, including residential care, personal care, adult congregate care, boarding home, and domiciliary care. Common to all these terms, however, is the understanding that an assisted living setting:

- Provides or coordinates personal services, 24 hour supervision and assistance (scheduled and unscheduled), activities, and health-related services
- Minimizes the need to move;
- Accommodates individual residents' changing needs and preferences
- Maximizes residents' dignity, autonomy, privacy, independence, choice and safety; and
- Encourages family and community involvement (NCAL, 1998).

Assisted living is often defined as a housing type for both the physically and mentally frail. Assisted living has become the most common term in the United States for describing housing with services that fits between skilled nursing care and congregate

housing. The character, organization, and management philosophy of assisted living must reinforce its identity as a housing type and not an institutional building type (Brummett, 1997). Kane and Wilson (1993) defined assisted living as “any group residential program that is not licensed as a nursing home, that provides personal care to persons with need for assistance in the activities of daily living (ADLs), and that can respond to unscheduled needs for assistance that might arise ” (p. xi).

A number of research and policy organizations have developed formal definitions of assisted living (Regnier, 1994; RTI, 1996). According to Coopers and Lybrand (1993), assisted living is defined as a special combination of housing, supportive services, personalized assistance, and health care designed to respond to the individual needs of those who need help in activities of daily living. Supportive services are available 24 hours a day to meet scheduled and unscheduled needs, in a way that promotes maximum independence and dignity for each resident and encourages the involvement of a residents’ family, neighbors, and friends. American Association of Retired Persons (AARP, 1993) used the following operational definition: “group or congregate living arrangements that provide room and board as well as social and recreational opportunities; assistance to residents who need help with personal needs and medications; availability of protective oversight or monitoring; and help around the clock and on an unscheduled basis.”

Most of the definitions refer to the “aging-in-place” philosophy of assisted living. The central tenet of that philosophy, the notion that the resident’s dignity and autonomy are paramount, is made clear in most of these definitions. For example, the AARP definition emphasizes that the “aim of assisted living is to enhance the capabilities of frail

older persons so that they can live as independently as possible in a home-like atmosphere. Assisted Living accomplishes this through both building design and care practices that facilitate independent functioning and reinforce residents' autonomy, dignity, privacy, and right to make choices" (RTI, 1996).

Philosophy and Principles of Assisted Living

Although there is some recognition of the significance of the physical environment in an ALF, there is less indication in the literature of a general understanding of the assisted living philosophy (RTI, 1996). Regnier (1994) suggested the basic qualities and characteristics of the assisted living facility based on the fact that industry definitions are vague and often distorted by marketing descriptions that rarely clarify basic characteristics. He expected that these definitional qualities of an assisted living facility can be a loose normative definition and can provide appropriate targets for the development of highly supportive, humane residential housing for the mentally and physically frail:

- Appear residential in character: The character, appearance, precedent, imagery, and memory, of assisted living should be related to residential housing.
- Be perceived as small in size: Most settings will require more than forty units to offer competitive rental rates and provide reliable twenty-four-hour care.
- Provide residential privacy and completeness: A small kitchenette in a private room and a full bathroom make the dwelling unit complete. Privacy should be achieved through a combination of efforts, including leasing policies that encourage single occupancy, design features such as locks and doors, and management practices that require staff to identify themselves before entering.
- Recognize the uniqueness of each resident: Each older person who enters assisted living has lived life in a unique way. Each has a multiplicity of different

experiences, which have nurtured diverse interests, abilities, and values. Capturing that diversity within a group setting is important.

- Foster independence, interdependence, and individuality: Resident assessments should inventory the unique capabilities and competencies of each person and devise a treatment plan that treats each person as an individual, with respect and dignity.
- Focus on health maintenance, physical movement, and mental stimulation: Avoiding institutionalization as long as possible is a major motivation provided by assisted living. Monitoring health through preventive checks, good nutritional habits, and careful attention to pharmaceuticals constructs a safety net of assurance.
- Support family involvement: The purpose of family-based assessments is to develop a caregiving partnership that allows family members a more important role in making critical decisions and in managing care. The building should also provide places for residents and family members to gather and share activities.
- Maintain connections with the surrounding community: Encouraging residents to visit their old neighborhood to attend church or have their hair styled maintains linkages and connections with old friends and familiar places. This allows residents to draw on a wider range of interaction rather than narrowing their choices.
- Serve the frail: Facilities should conform to the 40/40 rule, which suggests that 40 percent of the population could be experiencing some problem with incontinence and 40 percent some confusion or memory impairment (p.15).

An ALF is described in most provider trade publications as a residential option for the elderly who need some help with activities of daily living (ADLs) and possibly some minimal nursing care. Most definitions from the literature refer to the provision of supportive personal care services and many explicitly mention either that assisted living residents do not require the intensity of care found in nursing homes or that residents have “limited medical needs” or require “minimal medical care” (RTI, 1996).

There are two key components of the better models of ALFs (Regnier, 1994). First is that of a service-rich, comprehensive, flexible, and individually assessed and delivered assistance and care provider. Crucial to this component is the ability for residents to choose those services they require from a range of methods in which these services are delivered, representing a continuum of service delivery from independency to dependency. The second component of assisted living is that these services are offered within a physical and operational environment that provide as much of the normalcy, autonomy, comfort, and stimulation as experienced at home. Not only should the environment present a physical and spatial experience throughout that is homelike, it should also provide and afford the same opportunities for normal, homelike and community-like social interaction and ADLs as experienced at home living (Brummett, 1997).

With the same perspective of Regnier (1994) who provides the assisted living industry a normative definition of assisted living, Brummett (1997) also suggested nine principles that are fundamental to the better models of ALFs:

- Choice/Control/Autonomy. The ability to make choices and decisions, and develop and consider options that carry responsibility and influence meaningful outcomes.
- The need to feel in control of one's life is especially important in old age. The ability to take care of a home is perceived as evidence of continued personal capabilities. Homeownership may better buttress older persons from the sense of loss they experience after retirement or the death of a spouse. By the same token, homeownership can accentuate one's sense of vulnerability.
- Independence and control are likely to be very high in single-family homes but so are the possibilities for loneliness, isolation, and a lack of safety and security.

- Privacy. The ability to reach a place of retreat or seclusion and be free of unwanted intrusion. This applies to both a place and private behavior or activity, including the ability to receive treatment without intrusion by, or the knowledge of, others.
- Dignity. The acknowledgement and respect of one as an individual with abilities, freedoms, and rights as extended to all people, and as capable of enrichment of both self and others.
- Independence. The affordance of opportunities to contribute to, and carry out, tasks of one's own maintenance of well-being. The ability to perform meaningful, useful, and enjoyable tasks and activities and make worthwhile decisions as an individual and valued person. The ability to act as a unique person, including identifying with, and personalizing of, one's own space.
- Familiarity and Attachment with One's Environment. The ability to understand, identify, and occupy the imageful, spatial, and material qualities of the place as a familiar comfortable home.
- Safety/Security. The ability to live in the comfort of a controllable and responsive environment, reasonably free of undue or unaccepted risk or hazard.
- Accessibility. The accommodation of all spaces, elements, and routes for easy access for those with mobility, sensory, and cognitive impairments.
- Adaptability. One's ability to reasonably adjust the activities, therapies, behaviors, and physical environment to respond to one's changing needs, desire, and competencies.
- Stimulation/Challenge. The opportunity to yield physical, intellectual, and emotional reward from one's activities and environment while maintaining safe and acceptable levels of risk (p.16).

Types of Assisted Living Facilities

Assisted living facilities can be classified into three types: subsidized public housing for poor elderly, units in continuing care retirement communities (CCRCs), and freestanding facilities (RTI, 1996). McDonald, Remus, and Laing (1994) explained

another typology by research with a small sample of elderly: “constant” and “accommodating” models of health and housing that can be used with assisted living (McDonald et al., 1994). The constant model entails admission and discharge policies and procedures developed by management personnel. In this model, the environment facilitates resident independence, but does not change over time. The accommodation model is similar to an “aging in place” model, where the environment changes over time and residents stay in the facility until they need 24 hour nursing care. McDonald et al. (1994) conducted focus group interviews with 29 subjects from a random stratified sample to determine the subjects’ attitude toward housing. All subjects emphasized the importance of maintaining their independence and the importance of continuity of care. In attitudes toward housing, however, the researchers found that the subjects divided into two groups, based on health and disability. Those who were in poorer health and who were more disabled favored adding services and modifying the environment, or the accommodating model. Those in better health who were less disabled favored the constant model where services provided and the environment would remain constant over time.

The Growth of the Assisted Living Industry

In 1995, assisted living facilities were estimated to be between 30,000 and 40,000 in number, serving between 600,000 and 1 million residents, and earning \$10 to \$12 billion in revenues, and were expected to double in revenues in the next four to five years (Wood, 1995). More recently, the National Center for Assisted Living (NCAL, 1998) reported that the number of ALFs is nearly 29,000 in the United States, and there are approximately 1.15 million people living in those residences. The assisted living target

population is expected to increase six-fold over the next 25 years, when a large portion of the baby boom generation enters their seventies. According to the NCAL (1998), more than seven million frail elderly persons will be candidates for assisted living by the year 2020. This industry is expected to grow to serve three times that number of older people within the next ten years (RTI, 1996).

Spaces provided in an ALF usually include some larger, more active spaces for group gatherings and events, as well as smaller, more intimate shared spaces; dining room and service kitchen; a number of small assistance spaces, such as a bathing room and a medicine storage location; a few smaller staff work spaces; and a reception/oversight area. According to Evans (1994), most developments built specifically as assisted living communities are small, with few having more than 70 units. Between 12 and 130 resident apartments are usually provided. Typically, 25-60 units are most preferred and viable (NCAL, 1998). Additional social and service spaces, such as a small market or store, library, activity kitchen, beauty parlor, food service entity, or chapel, may be provided, depending on the size of the facility and availability of such services nearby in the community (NCAL, 2000).

Residents typically can choose furnished or unfurnished studio or one-bedroom units with a private bathroom, although shared bathrooms are common. Accommodations include private and semi-private units, based on availability. Assisted living residences can range from a high-rise apartment building to a residential home. The average size of an ALF is 43 units. A survey of NCAL (1998) found that 36 % of facilities had kitchenettes and another 21 % offered full kitchens.

Factors Affecting the Growth of Assisted Living Facilities

One of the major influences on the growth of assisted living is the enormous increase in the number of people over the age of 85 or the “old-old.” Projections show that these numbers will continue to grow during this century. According to the U.S. Census, the number of people over the age of 85 will double between 1990 and 2010 and then more than double between 2010 and 2040. Many of the old-old, though not acutely ill, are very frail. In order to maintain personal independence, they require a range of supportive personal and health care services (NRPC, 1996).

Changing preference of consumers and their advocates can be another factor that can affect the growth of ALFs. Older consumers, many of whose parents were in nursing homes, are increasingly reluctant to accept institutional settings. The high cost and institutional lifestyle associated with conventional nursing home facilities is unappealing to most people. Many older people see themselves aging in place until they can no longer care for themselves. At that point, an assisted living environment is often preferred over a nursing home as a better fit for individuals needing medical care and monitoring. Furthermore, adult children who are increasingly making decisions about placement for their parents, are seeking value and responsiveness from providers, an environment that is residential in character, and a friendly and appealing place to visit. In addition, many adult children are now demanding flexible housing alternatives that provide supportive care, yet allow them to stay involved with their elders.

A number of key factors have led to the need and consumer demand for assisted living. Advances in medical knowledge and practice are enabling people to live

significantly longer and healthier lives (Kane, 1990). Many who reach their upper 80s and older are relatively healthy, needing some assistance but not intense care.

Average Size and Age of Structure

The average size of an assisted living residence is 43 units and ranges from three units to 200 units. The average number of residents in a facility is 40, with a range of one to 175 residents (NCAL, 1998). The average ALF has been in operation for seven years and the physical structure that houses the assisted living residence has existed for 11 years (NCAL, 2000).

Services

Services provided by assisted living facilities varied widely across facilities. The numbers and kinds of services available may be dependent on residents' ability to pay (Kalymun, 1990). Assisted living facilities typically provide or coordinate 24 hour supervision, three meals a day in a group dining room, and a range of services that promote residents' quality of life and independence, including personal care services such as help with eating, bathing, dressing, etc., various health care services, social services, supervision of persons with cognitive disabilities, social and religious activities, exercise and educational activities, arrangements for transportation, laundry and linen service, and housekeeping and maintenance (NCAL, 1999). Additional popular amenities such as recreation rooms, exercise rooms, outdoor gardens, libraries or chapels may be available depending on the facility.

In a national study of 63 providers for AARP, Kane and Wilson (1993) examined services provided in ALFs. When they were asked to name the services provided, respondents typically listed meals, housekeeping, transportation, laundry and linen

service, activities, medication monitoring, and assistance with bathing and dressing. Many settings also mentioned having add-on levels of care that could be purchased separately. They categorized facility responses into three levels of services: 1) relatively heavy services provided; 2) relatively light services provided; and 3) graduated services provided. Heavy services involve 24 hour supervision, emergency call system, nursing supervision around the clock, assistance with ADLs, medication supervision, personal care staff, weekly beautician-extra charge, daily exercise program, daily social activities (i.e., recreation, rides, shopping), transportation program, housekeeping services, three meals a day, special diets, safely equipped bathrooms, and laundry service.

Kane and Wilson (1993) also found that a number of ALFs provided services to residents at an additional charge or on a fee-for-service basis, called amenities. According to a survey conducted by Coopers and Lybrand (1993), the most common amenities offered by a large number of assisted living providers were emergency response system (100%), personal laundry (99%), social programs (99%), transportation (95%), beauty/barber services (95%), exercise room (79%), electronic security (75%), nighttime security guards (58%), and chapel/meditation room (41%).

Most residents, however, do not necessarily require all services. Some residents may require some at more intensive or dependent levels and other residents at more independent levels. Service needs are dynamic and may develop temporarily or over time. The ability for residents to choose desired services, the level of need, and manner of delivery is definitive to assisted living. Monitoring and evaluation of service needs is considered a shared responsibility among the resident, the resident's family, and the caregiving staff (Brummett, 1997).

Location

Urban, rural, and suburban locales provide distinctively different advantages and threaten significantly different problems. Assisted living facilities are typically situated in semi-urban (dense housing and commercial mix), suburban, or small community settings (Zimmer & Chappell, 1997). Freestanding facilities represent 51 % of existing ALFs. Location of an assisted living level within a Continuing Care Retirement Community (CCRC) campus is another typical application. Many residents and family members prefer low-rise freestanding models rather than mid-rise or high-rise building in appearance because it provides a more homelike feeling. The smaller size of a stand-alone facility may also foster more direct and meaningful staff-resident interactions, and better integrate within the surrounding community. The benefits of belonging to a larger CCRC campus often include more in-house social services, commodities, and opportunities, and the security of nearby higher levels of care within the campus (RTI, 1996).

Elderly living in rural areas differ in a number of important ways from their urban counterpart. There are differences in income and health status, as well as in the quality and quantity of social interaction. In addition, rural and urban neighborhood environments tend to differ. Rural seniors are more isolated, hence transportation and accessibility to amenities becomes an issue. These differences suggest that the environmental needs of rural and urban seniors may differ. The rural elderly usually experience a relative shortage of services in their communities (Kwon, 1991). Thus, rural elderly are especially dependent upon their neighborhood and their dwelling. Previous research has indicated that, in terms of subjective measures of well-being and life

satisfaction, rural elders tend to score better than urbanites (Conrad, Hultman, Hughes, & Hanrahan, 1993). Rural seniors more often satisfy daily living functions rather than providing only emotional support.

Case Management Staff

Case management refers to “coordinating and managing a group of services on behalf of a group of people” (Kane, 2000, p. 438). Since the early 1970s, case management has been steadily evolving as a feature of long-term care programs for elderly people. A case manager acts as a technical consultant and expert to identify and compensate for functional problems and marshal resources on behalf of people needing long-term care. Case managers are often social workers, sometimes because of formal training at the masters or bachelors level or sometimes because of job title. They may also be nurses. Usually, case managers hold at least a college degree. In addition, however, they usually have had no specific education about case management before assuming the role, although some may be highly trained nurses, social workers, or others with advanced degrees (Kane, 2000).

Case management varies substantially at the individual level, the level at which the case manager meets the client. Case management also varies in intensity, from a minimal presence in the consumer’s life to a highly involved relationship, with regard to the intervals of routine monitoring (weekly, monthly, or less frequently), the form of routine monitoring (by phone or in person), and the amount of systematic effort incorporated into determining the quality of service providers and the satisfaction of clients (Wacker et al., 1998). Related to all of the above, case management programs also vary in their relationships with service providers.

Case managers may be generalists or specialists working with a case load of consumers who share particular diagnoses or problems, and caseloads may vary from fewer than 20 to more than 200. The results long-term care case managers expect to accomplish can be addressed at the level of the individual consumers and their families and at the level of the system of care in the community. At the individual level, some case management programs seek to maximize the choices and the personal autonomy of the consumers of care. At the system level, case management may have any or all of the following goals: reduce the public and /or private costs of Home and Community Based Services (HCBS) care in the community; improve access to services; allocate services equitably; assure quality of services; develop a broader range of services in the community; stimulate volunteer activities; and reduce unit price of services (Kane, 2000).

Because the services provided in ALFs and the care plans that are developed for residents are created by people, it is important to explore the role of staffing in assisted living (RTI, 1996). There is a lack of systematic, comparable information on the topic of staffing due to the wide range of staffing patterns. This wide range of staffing patterns may reflect, in part, the diversity of residents served by ALFs. The number of staff employed by ALFs varies based on several factors including state regulations, the number of people living in the facilities, and their needs. Staff may be employed directly by the facility or from an outside agency. Typical staff may include administrators, nurses, certified nurse assistants, personal care attendants, health/wellness directors, activity directors, food service managers, and maintenance personnel. Contract services frequently include physicians, podiatrists, dieticians, nutritionists, physical therapists, and beauticians (NCAL, 1999). Kane and Wilson (1993) found that “staffing patterns related

to whether the setting was freestanding, part of a nursing home or CCRC, or a housing complex; whether the setting was large or small; how the state regulated assisted living; and so forth” (p.30).

Like staffing patterns, ratios and professionalism also vary widely across ALFs. A 1992 American Health Care Association (AHCA) study found that the average members of residential care facility which typically had 50 beds employed 3 management personnel, 5 nurses, 13 aides, 9 dietary staff, and 4 housekeepers. The AHCA member facilities also reported employing a number of other types of staff: an activities director (82%), a pharmacy consultant (70%), a RN consultant (60%), a dietitian (45%), a physical therapist (36%), and a social worker (46%). Kane and Wilson (1993) found that the median staff for the national study of 63 settings was 20.5 (range 3 to 60). Staffing ratios may be related to the level of care and time of day. A mean staffing ratio of residents per staff member in the seven states studied was 3.2 (range 2.8 to 4.7). Cutler (2000) asserted the importance of manager’s periodic assessment of assisted living need to determine how well their facility is achieving its purpose, because this assessment provides quantitative measurements of resident and family satisfaction.

Regulations/Cost/Sponsorship

Assisted living residences are not defined or regulated by the federal government. In the absence of federal regulations, most providers are subject to state and local laws (NCAL, 1999). States vary significantly in their licensing requirements, quality standards, and monitoring and enforcement activities. The NCAL (1998) survey found that 94 % of assisted living residences were licensed by the states in which they operate. Regulations among states vary. As a result, competition among providers has become the catalyst for

establishing levels of service, controlling costs, and maintaining a high quality of care.

Assisted living can be 20 to 30 percent less expensive than conventional nursing home care (Nordheimer, 1996). A 1993 study of American Association of Homes for the Aging ([AAHA], 1993) found residents with a median daily rate of \$33 for a single occupancy unit. The fees usually cover three meals a day and private or semi-private accommodations, and transportation to doctors and social activities within the complex (Gelfand, 1999). Gordon (1998) stated that average costs of typical ALFs are \$35 to \$45 per day. Costs for assisted living residences vary greatly and depend on the size of units, services provided, and location. Rents for assisted living vary from approximately \$1,000 to \$3,000 per person per month (Evans, 1994). The NCAL (1999) survey found that 49 % of all ALFs charge between \$1,000 and \$2,000 in average monthly rent fees. Another 26 % charge between \$2,000 and \$3,000 and 7 % charge more than \$3,000 each month. A full 18 % of ALFs charge less than \$1,000.

Coopers and Lybrand (1993) conducted a survey of assisted living providers for 201 facilities, representing 6,119 units in 25 states. Among these facilities, for-profit ALFs represented 75 % of the sample, 4 % were publicly-held, and 21 % were nonprofit. Kane and Wilson's (1993) national study of assisted living showed similar patterns with the above. This study included interviews with a national sample of administrators of 63 ALFs; 65 % of the facilities were for-profit and 35 % were nonprofit programs.

Comparing ownership types, Elwell (1984) found that nonprofit and government facilities allocated more financial resources to personnel costs and provided more staff hours. According to Greene and Monahan (1981), for-profit ownership was related to fewer professional nursing hours and lower expenditures on patient care, dietary services,

and professional nursing care. Similarly, Ullmann (1987) found that expenditures for patient care were lower in for-profit than in nonprofit or government facilities; nonprofit facilities were also rated as somewhat higher on the quality of rehabilitation services.

Moos and Lemke (1994) compared 147 proprietary, 91 nonprofit facilities, and 81 veterans facilities to examine the influence of ownership to facility quality. Overall, nonprofit facilities were better than proprietary facilities in every aspect. The results showed that the residents in nonprofit facilities are about 5 years older on average than residents of proprietary settings. For physical environment, nonprofit settings provided their residents with a more comfortable atmosphere and had more physical features that add convenience and comfort, more features that provide a safe and secure environment, and more space for resident and staff functions. The residents of nonprofit settings developed a greater sense of community and self-direction than did proprietary facilities. Moreover, the residents of nonprofit facilities had somewhat greater residential stability. In policies and services, nonprofit facilities made more provisions for communicating with residents and staff and for giving residents a formal voice in running the facility. Nonprofit facilities provide their residents with more privacy and somewhat more flexibility in scheduling.

As the main reason for the better quality of nonprofit facilities, the researchers suggested a difference in philosophy of care. In other words, nonprofit facilities place more emphasis on recognition of the older person's need for a sense of independence and mastery. Compared with residents in proprietary facilities, residents in nonprofit facilities reported more cohesion, less conflict, and better organization, as well as more independence and resident influence (Moos & Lemke, 1994). Some of the differences

between for-profit and nonprofit facilities can also be explained by the more flexible policies in nonprofit facilities and the more experienced staff who are more active and supportive of the residents (Barker, Mitteness, & Wood, 1988).

Resident Profiles in Assisted Living Facilities

The literature provides some general information about the residents of ALFs, but there is little information about who is eligible, how and by whom eligibility is determined, or who is excluded from assisted living (RTI, 1996). Under two categories of Lower Intensity of Assistance Needs and Higher Intensity of Assistance Needs, Brummett (1997) classified seven types of resident profiles of ALFs based on variety of needs and problems of typical assisted living residents as following:

Lower Intensity of Assistance Needs

- Profile 1. A person of good physical and mental health who lives alone and, because of general frailties and slight sensory impairments, feels vulnerable to accidents and/or crime and thus seeks the security of group living and professional protective oversight. This person may also be less able to travel to social places and functions and, hence, may seek the camaraderie and companionship of group living.
- Profile 2. A person of fair health but with chronic physical frailty. The burdens of household chores such as cooking and cleaning may be too strenuous, difficult, or consuming for this person. He or she may also seek protective oversight.
- Profile 3. A person who is in good physical health but suffers from relatively consistent confusion and disorientation. This person may seek protective oversight, professionally delivered meals, medication and cleaning services, and occasional behavioral cueing and assistance.
- Profile 4. A person with a combination of the above physical and cognitive needs.

Higher Intensity of Assistance Needs

- Profile 5. A person who maintains most cognitive skills but has developed more intensive physical frailties and disabilities. These may include limiting mobility impairments requiring dependence on a wheelchair, scooter, or walker and some transfer assistance; severely decreased strength and coordination of his or her hands or arms requiring assistance with many activities of daily living; respiratory ailments causing shortness of breath and inability to perform many activities; sensory impairments causing some communication and orientation difficulty; and/or incontinence and a limited ability to self-manage this.
- Profile 6. A person who maintains most physical abilities but has a decreased cognitive ability, often the result of Alzheimer's disease or other organic brain dysfunctions. This person may have relatively regular or extended periods of moderate disorientation to time and place, and may require consistent and redundant behavioral cueing and assistance in order to appropriately carry out activities of daily living and any needed therapy. This person may also have a few brief episodes of disruptive behavior necessitating intervention.
- Profile 7. A person with a combination of the above physical and cognitive disabilities requiring regular and intensive assistance (pp.7-8).

Age/Gender/Marital Status/Health Status

Assisted living facilities generally serve a population of single females in their early 80s (NCAL, 1998). The ALFAA study provided a resident profile drawn from the assisted living facilities responding to their survey: 79 % of residents were female with an average age of 85; male residents average 83 years; nearly all (96.7%) are White and non-Hispanic (Coopers & Lybrand, 1993). In their national study, Kane and Wilson (1993) also found that the average age for residents was 83 years. In fact, only 19 % of assisted living residents were male, according to the findings of this study. Finally, the vast majority of residents (more than 97 %) in these facilities were unmarried or were not

living with their spouse. According to NCAL (1998), the average youngest age of residents was 64 and the average oldest age of residents was 97. The average male and female ratio in assisted living residences was 74 % women and 26 % men.

Nearly 26 % of all assisted living residents need no assistance with activities of daily living (ADLs). On average, residents need help with 1.7 ADLs and more specifically: 68 % of assisted living residents require assistance with bathing; 47 % of assisted living residents require assistance with dressing; 27 % of assisted living residents require assistance with toileting; 22 % of assisted living residents require assistance with transferring; and 13 % of assisted living residents require assistance with eating (NCAL, 1998).

Length of Stay

The typical assisted living resident stays in a residence an average of 35 months (NCAL, 1998). Kane and Wilson (1993) found that assisted living residents had an average length of stay of 26 months. The most frequently cited reasons for assisted living residents' leaving were: 1) the need for greater care; 2) behavioral problems; 3) improvement in functioning; 4) not enough funds; and 5) spouse died or moved. In contrast, other researchers have found a mean length of stay in seven CCRCs to be 7.5 years (Newcomer, Preston, & Roderick, 1995). It has also been reported that females average more than six months longer lengths of stay than males in both assisted living and nursing units (Newcomer et al., 1995).

Theories of Person-Environment Interactions

It is generally believed that the greater the health and or mobility problems, the more likely elderly individuals are to be affected by the environment. To explain the hypotheses about interactions between older individuals and their environment more logically, some ecological theories such as Lawton and Nahemow's (1973) Competence and Environmental Press Theory and Kahana's (1982) Congruence Model of Person Environment Interaction can be used. Both of these theories assumed that persons are influenced by levels of functional competence, or needs and preferences, and the demand characteristics of the physical environment. The extent to which interactions between older persons and the environment complement one another determines positive or negative outcome behaviors. The more vulnerable elderly people are, the more likely that their behaviors will be affected by the environment (Kalymun, 1990).

Lawton and Nahemow (1973) state that older adults must be properly matched with their housing environment. If people fit with their environment, it would be expected that they would be satisfied, and could use the environment in a productive way (Lawton & Nahemow, 1973). Therefore, knowledge about the group of adults should be preceded to plan a productive living environment for the elderly. In this theory, there are two important concepts: competence and environmental press. Competence is the upper limit on one's capacity to function. Environmental press reflects the demands placed on a person. One implication of this model is that the less competent a person, the more impact the environment has.

One way to express the person-environment interaction is by focusing on competence and environmental press. Lawton and Nahemow (1973) believe that competence involves five domains: biological health, sensory-perceptual functioning, motor skills, cognitive skills, and ego strength. Unfortunately, the components of competence are not easy to measure. The problem is that most measures of the components involve the environment in some way. Environments can be classified on the basis of the varying demands that they place on the individual, a notion termed 'environmental press.' They assert that behavior is a result of a particular competence level acting in an environment of a specific press level. Furthermore, behavior is placed on a continuum from positive to negative.

The adaptation level is where behavior and affect are normal, and we are usually unaware of them. Awareness increases as we move away from adaptation level. The less competent the individual is, the greater the impact of environmental factors. To the extent that individuals experience declines in health, sensory process, motor skills, cognitive skills, or ego strength, they will be less able to cope with environmental demands. This theoretical framework can be applied to the concept of appropriateness of assisted living facilities as a home. If the physical features and social interaction or services of the assisted living facility (environmental press) are not able to cope with the resident's demand (individual competence), the resident will not be satisfied with the facility, and he/she will evaluate the appropriateness of the facility as low.

Kahana's Congruence Model (1982) proposes that people search for environments that best meet their needs. The work of Kahana on person-environment fit deals almost exclusively with the person-environment component: the needs, perceptions,

and desires of residents and staff are priorities (Calkins & Weisman, 1999). Congruence between the person and the environment is especially important when either individual or environmental options are limited. The congruence model helps focus on individual differences and on understanding adaptation in nursing homes and other long-term care facilities.

Kahana's (1982) Congruence Model also includes the ideas of competence and environmental press, but it applies to them differently. In Kahana's view, people vary in their needs, and environments differ in their ability to satisfy them. According to the congruence model, people with particular needs search for the environments that will meet them best. To the extent a match exists, the individual feels content and satisfied; when a mismatch occurs, stress and discomfort result.

Limitations can occur for three reasons: 1) environmental characteristics are restricted, such as when public transportation is unavailable for going shopping; 2) an individual's freedom is limited, such as when he or she must always eat at the same time every day; and 3) one believes that one has limited freedom, such as when one thinks that there is no way to get around despite a reliable bus system. Restricted environments are exemplified most clearly by long-term care facilities such as nursing homes and hospitals. Limits on individual freedom can result from age-related declines in competence. Self-perceptions of limited freedom reflect the belief that one's life is controlled by external forces.

When applied specifically to the older adult, Kahana's (1982) Congruence Model shows that several points should be considered for optimizing the person-environment fit. One must consider not only the kind of situation, such as whether the person is in a

single-family, congregate, or institutional living arrangement, but personal factors as well. Personal factors are very important because people vary in their needs. Some of us value autonomy and independence highly, for example, whereas others place less importance on them. We must be careful when designing programs and interventions for adults to take these individual differences into account.

Based on Lawton and Nahemow's Competence and Environmental Press Theory and Kahana's Congruence Model, Calkin and Weisman (1999) proposed an Integrative Model of Place (IMP) to examine and define an appropriate framework for assessing assisted living facilities. The IMP posits that a setting is composed of a complex system of relationships among four distinct dimensions: individuals, social context, organizational context, and physical setting. Their model follows Lawton's earlier work that emphasized relationships between person and environment by distinguishing among the characteristics, needs, abilities, and behaviors of an individual in a setting and the various characteristics and actions of groups of people associated with that setting (Lawton, 1986). However, the IMP differs from Lawton's model by combining all aspects of groups of people into one category. The IMP recognizes the important role of the physical environment. One important difference between the IMP and the other models is that it is fundamentally interested not in the determinants of behavior but in the experience of place.

Based on the IMP model, I built a conceptual framework for this study; that is, the appropriateness of ALF that make residents feel "at home" could be comprehensively identified by examining several aspects including personal, physical, social, and organizational characteristics.

Summary

Home takes on added importance for the elderly because many older adults spend most of their time in the immediate home environment. Housing for the elderly should include basic attributes such as privacy, dignity, choice, independence, individuality, and homelike surroundings. Housing satisfaction is a strong predictor of total life satisfaction. Numerous factors including socio-demographic factors, housing and neighborhood characteristics, structure of care, maintenance, management, and health status are related to resident satisfaction. As a semi-independent housing type for both the physically and mentally frail elderly, the assisted living facility is the fastest growing type of long-term care. Not only should the assisted living facility present a physical and spatial experience throughout that is homelike, it should also provide and afford the same opportunities for normal, homelike and community-like social interaction and activities of daily living as experienced by living at home. Several factors such as size and age of structure, services, location, case management staff, regulations, cost, and sponsorship affect the growth of assisted living industry.