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An Examination of Admission and Discharge Policy and Practice in Assisted Living Facilities in Calgary, Alberta

by

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ABSTRACT

This study explored the emerging assisted living industry in Alberta through qualitative, semi-structured interviews with 10 staff members from the former Calgary Health Region and assisted living facilities in Calgary, Alberta. Participants' definitions of assisted living made reference to assisted living philosophy, the social model of care, an option within a larger continuum of care, and distinctions between different types of assisted living in Calgary. Definitions of the concept of aging in place varied considerably; however, participants generally agreed that assisted living supports aging in place. While participants identified criteria used in resident admission and discharge decisions, they also indicated that these criteria are influenced by characteristics of the resident, the resident's family, the facility, and the health and political policy context.

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LIST OF TERMS AND ABBREVIATIONS

Activities of daily living (ADLs): Includes bathing, personal hygiene, grooming, dressing, toileting, and incontinence management. Assistance with activities of daily living is one aspect of personal care services available in Supportive Living settings in Alberta (Alberta Seniors and Community Supports, 2007b).

Aging in place: "Individuals are encouraged to remain in their community as they grow older. Aging in place refers to people living as independently as possible, using products and services to enable them to stay in their communities as their needs change. Aging in place is especially applicable to the home and supportive living streams of the continuing care system" (Alberta Seniors and Community Supports, n.d.b).

Alberta Health Services: "Alberta Health Services is a new organization that was officially launched on April 1, 2009. The Alberta Health Services Board became the common governance board responsible for the delivery of health services previously provided by 9 regional health authorities, the Alberta Cancer Board, Alberta Alcohol and Drug Abuse Commission (AADAC) and Alberta Mental Health Board. The provision of Emergency Medical Services (Ground Ambulance Service) has also transitioned from current municipal responsibility, to become a part of this provincial health care service. Alberta Health Services is responsible for the delivery of health programs throughout Alberta. The responsibilities of Alberta Health Services can be broken into two broad groups: regional health system governance and service delivery" (Alberta Health Services Board, 2009, p. 4).

Assisted living:

- Assisted living is a residential housing option that provides supportive services and recreational services. Supportive services include 24-hour access to care staff for residents who need help with activities of daily living (Butler, Lewis, & Sunderland, 1998).
- "A supportive living facility that provides the managed delivery of health and personal care services within a residential environment or setting. Higher staffing levels in assisted living facilities enable health care and social support to be provided to residents with higher care needs offering an alternative to traditional long-term care" (Alberta Seniors and Community Supports, n.d.b).
- "There are many definitions of 'assisted living' and 'supportive housing'. Neither of these terms is protected in Alberta and can be used by housing operators at their own discretion. In the broadest sense, they both refer to the combination of housing and services in a residential setting. The services that are included in the rent or are otherwise available for purchase vary from building to building" (Alberta Seniors and Community Supports, 2007b, p. 9).

Calgary Health Region: One of nine regional health authorities in Alberta before the creation of Alberta Health Services on April 1, 2009 (Alberta Health Services Board, 2009).

Continuing care: "A system of service delivery that provides individuals who have health conditions or special needs with access to services they need to experience independent and quality living. These services include professional services, personal care services and a range of

other services. These services may be provided in a home setting, supportive living setting or facility setting" (Alberta Seniors and Community Supports, n.d.b).

Continuing care health services: "means publicly-funded health care services and personal care services provided through community and home care programs or in long-term care facilities, where it is anticipated the client shall require health services for a period *exceeding three months*" (Alberta Health and Wellness, 2008a, p. 6).

Designated assisted living (DAL):

- "Refers to a facility where there is a contract between a regional health authority and an operator for a certain number of spaces within the facility. Under the contract, the operator provides health and support services based on assessed need. The regional health authority, in collaboration with the operator, makes decisions regarding admission and discharge. *Regional health authorities differ in terms of their target populations for these spaces, type and availability of health care staff, and the services that the operator must provide as part of the contract"* (Alberta Seniors and Community Supports, 2007a, p. 4). Words in italics were removed after the creation of Alberta Health Services.
- "A facility that typically serves residents with higher health needs, but who do not need the level of care provided in a long-term care facility. As a result, there may be more professional staff on site and special physical design features may be needed to better serve special populations. To address the higher care needs of their residents, designated assisted living operators will assume greater responsibility for supervising client safety, protecting clients, and providing personal care services. These responsibilities are met

through a contractual arrangement with Alberta Health Services. Alberta Health Services makes decisions on whether people can be admitted to or discharged from a designated assisted living space, depending on their assessed needs" (Alberta Seniors and Community Supports, n.d.b).

Home Care: "The single largest component of community-based services is home care. Home care offers professional support services like nursing and rehabilitation, and personal support services like homemaking and care-giving practices, including assistance with meal preparation and bathing" (Alberta Health and Wellness, n.d.).

Nursing home: In Alberta, nursing homes and auxiliary hospitals are together referred to as long-term care facilities. Long-term care facilities are "reserved for those with unpredictable and complex health needs who require 24-hour nursing care… Specialized services such as respite, palliative care, as well as services for advanced Alzheimer's and dementia are available at these facilities. Personal care and life-enrichment activities are also provided" (Alberta Health and Wellness, 2008b, p. 19).

Personal care services: "means services that assist clients with the activities of daily living, therapeutic regimes, and other aspects of general care. This may include but is not limited to assistance with bathing, personal hygiene, grooming, dressing, toileting, incontinence management, medication assistance and reminders, basic wound care, respiratory equipment management, ostomy care, mouth care, turning, and behaviour management" (Alberta Health and Wellness, 2008a, p. 6).

Private assisted living: Assisted living that is not provided under contract through the health authority. "Personal assistance and/or professional services may be provided to residents by: the RHA [Regional Health Authority] directly, the operator on contract to the RHA, the operator privately, or private-pay by an alternate vendor" (Alberta Seniors and Community Supports, 2007b, p. 6).

Resident: "an adult who may be mentally or physically challenged or is elderly" who lives in a supportive living setting or a nursing home (Alberta Seniors and Community Supports, 2007a, p. 5).

Seniors Lodge: "A congregate living setting that provides a private room, meals, housekeeping, linen laundry and life enrichment services for senior citizens who are functionally independent but are not capable of maintaining or do not desire to maintain their own home, including services that may be provided to them because of their circumstances. Services beyond these basic offerings may vary depending on the lodge and the community. Typically, lodges are administered by management bodies and operate under the *Alberta Housing Act*" (Alberta Seniors and Community Supports, n.d.b).

Supportive Living: "means a philosophy and an approach for providing services within a housing environment. It provides a home-like setting where people can maintain control over their lives while also receiving the support they need. Examples of Supportive Living arrangements now in place in Alberta include lodges, enhanced lodges, designated assisted living, group homes, and adult family living/family care homes. The building is specifically

designed with common areas and features to allow individuals to 'age in place.' Building features include private space and a safe, secure and barrier-free environment. Supportive Living promotes residents' independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life enrichment activities. Publicly-funded personal care and health services are provided to residents based their assessed unmet needs" (Alberta Seniors and Community Supports, 2007a, p. 6).

Transition Services (Community Team): "Community Transition Coordinators work in the Calgary community to screen, assess and evaluate the needs of patients and families in the community. Duties may include:

- Screening and assessing individuals living in the community who may require admission to a Supported Living facility (Care Centre, Designated Assisted Living or Personal Care Home);
- Reviewing and reassessing residents of Supported Living facilities that are waiting transfer to another facility, setting or care stream;
- Reviewing and assessing residents of Supported Living facilities whose care needs can no longer be managed at their present facility;
- Process referrals from Calgary Health Regions clients who wish to transfer to a facility in another Health Region;
- Process referrals from out of region clients who wish to be admitted to the Calgary Health Region; and,
- Assessing and wait listing residents who required facility respite"

(Alberta Health Services, n.d.).

CHAPTER ONE: CONTEXT OF THE STUDY

Assisted living is a residential care option for older adults and people with disabilities that provides services such as meals, housekeeping, and some degree of personal care or nursing. A wide variety of terms exist for assisted living and similar types of care settings, including supportive living, community living, seniors' lodges, group homes, and residential care. Assisted living is a housing and care option that emerged in the 1990s in Canada and has grown to become popular among the general public and promoted by provincial policy. As Alberta's population ages, there is an increasing need to define the place of assisted living on the current continuum of care, and explore its potential to meet the needs of an older adult population that is increasing in numbers and becoming more diverse in needs and preferences. Although there is inconsistency in the use of the term "assisted living", I will use the term throughout the study to refer to "a supportive living facility that provides the managed delivery of health and personal care services within a residential environment or setting. Higher staffing levels in assisted living facilities enable health care and social support to be provided to residents with higher care needs offering an alternative to traditional long-term care" (Alberta Seniors and Community Supports, n.d.b).

Researcher's Experience with Assisted Living

I came to recognize the importance of understanding the place of assisted living in the continuum of care services for older adults in Alberta when I was working as a social worker at the Alzheimer Society of Calgary. My work involved providing education, support, and referral services to people with dementia and their family members. Through

this experience, I became aware of the impact of progressive illness on individuals and their families, and the need for increasing assistance as needs change. I also recognized that the preferences of many individuals with dementia and their family caregivers was to allow the person to age in place in their current place of residence for as long as possible. While in most cases a move to facility-based care was inevitable, moves to supportive living environments were frequently avoided for several reasons. First, the cognitive losses of dementia can make moves and adjustments to new environments difficult, so minimizing the number of moves was a priority. Secondly, due to the progressive nature of dementia, there may be a short window between requiring supportive living and requiring nursing home care, which would require another move. Third, many individuals with dementia and their families preferred to manage care at home for as long as possible, which was frequently to the point of nursing home eligibility. Finally, private supportive living options, both in-home and residential, are often beyond the financial means of low to middle income Albertans. Within this context, I was interested in investigating the role of assisted living as a care option for older adults with dementia or other health or functional limitations.

As a social worker, I place a high value on self-determination, and I have an ethical obligation to protect and promote my clients' rights to self-determination. While the philosophy of assisted living promotes the independence and autonomy of residents, and assisted living has been a popular consumer choice for frail older adults with financial means in the United States and Canada partly due to this philosophy, assisted living may not be a financially accessible choice for many older Albertans. My particular interest in assisted living arose out of my impression that it may not be a feasible care

option for those with progressive illnesses such as dementia, and for those with low to moderate income levels, within a policy context in Alberta that increasingly promotes supportive living options as alternatives to nursing home care.

As a social worker, I have been able to promote and preserve the value of self-determination among clients through ethical decision-making. For example, as a social worker at the Alzheimer Society, my assessment of the needs of family caregiver clients and my decisions to provide information and referrals had an influence on the clients' range of choices for services. The social work Code of Ethics (Canadian Association of Social Workers, 2005) recognizes that ethical decision-making can be complex, and that decisions may involve personal values, professional values, agency policies, and local legislation. Ethical practice can not be prescribed by a set of regulations, but rather enabled through using regulations to understand the context of the decision as the basis for judgement. Multifaceted decisions, such as those concerning the admission and discharge of residents from assisted living, do not necessarily have a single, simple, predictable, prescribed ethical response. For this reason, social work ethics is concerned with both expressed values, and the process by which those values are upheld through professional decision-making.

Background

Alberta's Aging Population

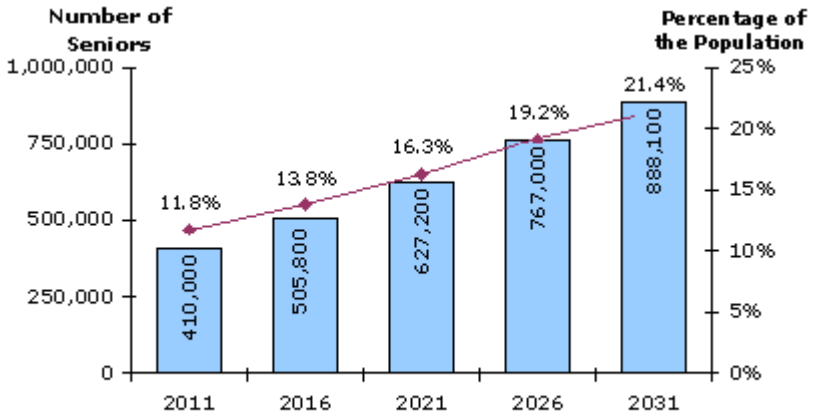
The importance of studying assisted living as a care option in Alberta is increasing because the population of Alberta is aging. Populations are said to be aging when the proportion of people over age 65 increases relative to other age groups (Hodge,

2008). In 2008, approximately 10% of Alberta's population was over age 65. This percentage is expected to increase to 11.8% in 2011, and continue to increase to 21.4% in 2031 (see Figure 1).

The two main reasons for Canada's aging population have been a decrease in birthrates and increased life expectancy. In addition, the generation born between 1946 and 1965, commonly known as the Baby Boom generation, is the most populous generation in Canada. Starting in 2011, the first of the Baby Boom generation will reach age 65. In the following years, the percentage of the population over 65 will rise dramatically. In addition, improved life expectancy will continue to result in increases in the percentage of the population over age 80. Although immigration has had a minimal effect on population aging in Canada, changes to immigration patterns and increased immigration in mid to late life has led to increased cultural diversity among the older population. In 2001, 25% of Canadians age 65 and over were born in other countries, although most had immigrated as younger adults (McPherson, 2004).

As the population ages and individuals live longer, the prevalence of people with long-term chronic illness and progressive cognitive decline is expected to increase. The most common chronic illnesses among people over age 65 in the United States are arthritis, hypertension, hearing impairments, orthopaedic impairments, heart disease, and cataracts (Nathanson & Tirrito, 1998; Spitzer, Neuman, & Holden, 2004). The physical declines associated with these chronic conditions and the cognitive declines resulting from Alzheimer Disease and other types of dementia can diminish an individual's ability to provide self-care, thereby increasing his or her needs for caregiving support. Although

FIGURE 1: ALBERTA SENIORS' POPULATION PROJECTIONS



(Alberta Seniors and Community Supports, 2009, p. 6).

age is not a good predictor of health and ability, and many older adults remain very active and in good health, the risk of physical and cognitive illness increases after age 65 and rises quickly after age 80 (Spitzer et al., 2004; Hodge, 2008). Advances in disease prevention and treatment, pharmaceuticals, and technological aids may mitigate potential increases to age-related disability. However, it is expected that such advances will not be sufficient to address the sheer increases in numbers of older adults in the coming years (Golant, 2008). While disability rates among older adults fell in the 1980s and 1990s, the decline has been offset by increases in chronic illness that result in increased care needs, including osteoporosis, cancer, and diabetes (Wolf & Jenkins, 2008).

In addition, the capacity of family members to be available to provide care has changed. As birth rates have declined, fewer adult children are available to be caregivers. Increased migration within Canada has resulted in fewer older adults living in the same community as their adult children. Golant (2008) notes that increases in the divorce rate may result in fewer spousal caregivers. The participation of women in the labour force,

which increased sharply starting with the Baby Boom generation, has caused many women to be less available to provide care for older family members. The trend to start having children later in life has resulted in more middle-aged adults, predominantly women, in the "sandwich generation", providing care for both young children and older parents. These factors may result in less availability of care for older adults by family members, and increased caregiver stress for family members who may be juggling with distance, other responsibilities including work and child care, and lack of support from other family members. While it is expected that family members, especially spouses, daughters, and daughters-in-law will continue to provide care for older family members, the availability of family members to provide care and the increasing demands placed on family caregivers may result in increased caregiver stress and interest in different community care options. Since more women than men tend to assume the role of family caregiver, Golant (2008) suggests that the availability of family caregivers will "depend on how future generations of women view their family obligations" (p. 20).

Given that provincial policy in Alberta has promoted more care to be provided in the home and by family caregivers, the appeal of assisted living as a community care option may increase as older adults and their family members seek out community care options that suit their needs. Although assisted living care does not substitute for family caregiving, and frequently family involvement in care is required to retain a resident in an assisted living facility (Hawes, Phillips, Rose, Holan, & Sherman, 2003), the services and residential environment of assisted living may serve as a supplement to family caregiving and result in reduced caregiver stress. According to Golant (2008), many family members want to remain involved in caregiving and the monitoring of care when an older family

member moves to assisted living. As the population ages, it is important to recognize the essential contributions of and impacts on family caregivers. The continuum of care services in Alberta will need to adapt not only to increasing numbers and diversity of older adults, but also to the increasing and diverse needs of family caregivers, who play a significant and pivotal role in both community-based and institutional care.

The aging of the population raises the question of the role of assisted living within the continuum of care options for older adults in Alberta, and the extent to which it will be accessible and be able to meet the care needs of the increasing older adult population. Since assisted living is still a relatively new model of care in Alberta, it remains to be seen how it will continue to respond to a rapidly aging and increasingly diverse population. According to Hyde, Perez, and Reed (2008), the Baby Boom population born 1945 to 1964 is likely to show a preference for assisted living as a care option because of the values of independence and consumer choice that are associated with the assisted living industry.

The impact of the aging population on programs and services for older adults will likely be an increased demand for services and options to meet individual needs. It is anticipated that the increasing numbers of adults in the oldest cohort will lead to an increased demand for assisted living services, since the average age of assisted living residents in the United States is currently 85.3 (Hyde, Perez, & Forester, 2007), and averages 83.7 in studies of assisted living in the United States published from 1993 to 2004 (Kane, Chan, & Kane, 2007). In addition, the increasing diversity of resident culture, language, values, and preferences of older adults in the United States and Canada will test the ability of assisted living as an industry or care option to meet diverse needs

and promote individuality and autonomy while providing care as health and functional abilities decline.

Aging in Place

"Aging in place" is a concept that is frequently referred to in assisted living policy and literature. Although there have been many interpretations, definitions include "enabling older adults to remain in their current or preferred environment, with necessary adaptations and support services, to the end of their lives" (Eckert, Carder, Morgan, Frankowski, & Roth, 2009, p. 167), and supporting the preference that many older adults express to remain in their own home as they age (Chappell, Gee, McDonald, & Stones, 2003). The advantage to aging in place is that it allows older adults to retain connections to the people and physical environments that they have established over time. By preserving these connections, older adults also maintain a sense of autonomy and security due to the familiarity of surroundings and sense of belonging in the community (Hodge, 2004). These benefits are frequently lost through institutionalization, or even a move to an unfamiliar community (McPherson, 2004).

Although the singular "place" implies that individuals would remain at the same precise location until the end of their lives, "the assisted living sector has adopted and adapted this concept, so, once an older adult moves into assisted living, the assumption is that he or she should be able to remain their with growing support to meet changing needs" (Eckert et al., 2009, p. 167). In other words, when it is not possible or preferable for a person to continue to live in their current residence, aging in place can begin after a person moves into an assisted living environment. Alberta Health and Wellness (2008b) adapted the concept of aging in place in their Continuing Care Strategy, titled *Aging in*

the Right Place. The concept of aging in the right place emphasizes improved assessment methods "so that the right level of service is provided in the right setting, supporting Albertans' preference to choose their own accommodations" (p. 5).

The concept of "place" could also be interpreted as a facility or community rather than the more particular ideas of a suite within a facility or a private home within a community (Black, 2008). Using this definition, an individual could still be considered to be aging in place if they move from their home to an assisted living facility in their community, and if they move from one room to another within the same facility as their care needs increase. More broadly, for those with changing care needs, aging occurs in places along the continuum of care, including home, assisted living, hospital, and/or nursing home. Black (2008) defines aging in place functionally, as "the fit between the person and their residential setting and includes programs and policies that help maintain that fit" (p. 80).When characteristics of a resident or facility can no longer support aging in place in an assisted living setting, the goal is to find the best available place to continue to age, or to create a new care option to meet the need.

There is disagreement about whether aging in place is possible in assisted living, and whether it should be an expected or desired outcome (Chapin & Dobbs-Kepper, 2001). For some, the ideal scenario is that residents age in assisted living until end of life. For others, assisted living is understood as one element in a continuum of care that includes nursing home care (Eckert et al., 2009). As assisted living has grown as an option for housing and care for older adults in the United States, it is increasingly recognized that as a resident's care needs increase, assisted living may not be the best place for that person to stay (Eckert et al., 2009). In reality, two-thirds of assisted living

residents in the United States are discharged from assisted living facilities before end of life (Sloane et al., 2003). In this context, it is possible to plan for the outcome of "prolonged residence" rather than aging in place in assisted living, and in fact many providers interpret the concept of aging in place as prolonged residence rather than care to end of life (Frank, 2002).

The understanding of aging in place as remaining in a single residence or health care setting may be too limited. The reality is that many older adults age in several places, and adapt to transitions between places such as private residence, assisted living, hospital, and nursing homes as needs change over time. Movement between settings within a continuum of care is "neither linear nor predictable" (Kissam, Gifford, Mor, & Patry, 2003, p. 1652). While it is possible for some residents to remain in assisted living until end of life, such a scenario relies on a tenuous balance of fit between the changing needs of the resident and the ability of the physical, social, and care environment of the assisted living facility to meet those needs (Eckert et al., 2009). The possibility of residents aging in place in assisted living is influenced by a number of factors, including the medical and care needs of the resident, facility staffing, the financial situation of the resident, the physical and social environment of the facility, and the policy context and management philosophy of the facility. If there is not a good fit between resident and facility, the possibility that a resident will age in place in that setting will be affected (Eckert et al., 2009).

Assisted living facilities in Canada have been providing care for an increasingly impaired population of residents (Aminzadeh, Dalziel, Molnar, & Alie, 2004). The trend toward increasing levels of care in assisted living facilities may be seen as the result of

the under-funding of home care and nursing home programs, which has created a market for assisted living as a private-pay option for care for those older adults who have the financial resources to pay for their own care. Aminzadeh, Dalziel, Molnar, and Alie (2004) claim that assisted living facilities are tending towards becoming "unlicensed pseudo-nursing homes" (p. 282). On the other hand, Chapin and Dobbs-Kepper (2001), writing about the American context of assisted living, claim that assisted living facilities should be offering higher levels of care if they are to truly carry out the philosophy of aging in place. Assisted living facilities operationally define the level of care they provide through admission and discharge criteria. Since admission and discharge criteria are not uniform among assisted living facilities, the profile of resident care needs varies among facilities (Golant, 2004).

Among the range of definitions of the concept of aging in place, the most literal definition is an older adult to living in his or her chosen residence, potentially until end of life (Chappell et al., 2003). However, continued home living is not possible for many older adults who experience increasing needs for care. Assisted living has emerged as a residential and care option between independent living and nursing home care. As a whole, care services for older adults exist on a continuum of care from occasional in-home services to 24-hour residential nursing care. The continuum of care can be understood from a medical model as a range of services that a resident will progress through as care needs increase (Frank, 2002). It may also be viewed as a selection of services from which one may choose, and through which one's progression is not necessarily linear (Hodge, 2008). In the latter case, assisted living may be viewed not as just a precursor to nursing home care, but as a distinct care option and a nursing home

alternative, due to the philosophical differences between assisted living and nursing home environments and care.

Assisted Living Philosophy

Assisted living refers not only to a set of residential and care services, but also describes a philosophy or approach to how these services are provided. Elements of the philosophy include resident independence, privacy, dignity, autonomy, choice, and a sense of community (Assisted Living Federation of America, 2009; Frank, 2002; Chapin & Dobbs-Kepper, 2001). Hyde et al. (2008) claim that the assisted living philosophy arose in the United States due to the same historical and social influences that led to the cultural characteristics of the Baby Boom generation, including the civil rights movement, changing gender roles, changes to immigration patterns, and technological innovation.

Assisted living philosophy is consistent with a social model of care. Hyde et al. (2008) identify four elements in a social model of care: 1) that residents define what quality of life means to them and care providers recognize and respect their choices; 2) that residents and their family members are capable of making decisions about their place of residence and care; 3) that positive social interactions and meaningful activities can be therapeutic; and 4) that residents retain their connections with the community, including family members, friends, and other service providers. The social model of care can be contrasted with a medical model of care, which is frequently associated with nursing home and hospital care. Characteristics of a medical model of care include a focus on "the incidence, causes, and treatment of disease" (McPherson, 2004, p. 406). Assisted living facilities are a distinct care option from nursing homes, although some assisted

living facilities that have high percentages of residents with high care needs provide care that is consistent with the medical model. Likewise, some nursing homes are experiencing culture changes that bring them more in line with a social model of care (Calkins & Keane, 2008; Eckert et al., 2009).

Two paradoxes exist regarding the philosophy of assisted living care. The first paradox is between the philosophy and services of assisted living, as residents are simultaneously viewed as exercising independence while being assessed as requiring assistance and living in a structured, if not institutional, environment (Frank, 2002). The other paradox in assisted living is the simultaneous value placed on autonomy and the reality that most residents are discharged before end of life. While it is possible that residents have exercised autonomy and made their own or a mutual choice to leave assisted living, it is also possible that facility discharge criteria or the belief by health care professionals and administration that death should occur elsewhere along the continuum of care may override resident autonomy (Frank, 2002).

The possibility that residents can exercise the choice to age in place in assisted living is affected by the admission and discharge policies of assisted living facilities, and the way that those policies are put into practice. The degree to which assisted living facilities in Alberta live up to the assisted living philosophy and provide services that allow residents to age in place has been shaped by the federal and provincial policy context of health care insurance and services.

Legislative and Policy Development of Residential Care for Older Adults in Canada

Although assisted living facilities have been part of the American continuum of care for older adults since the mid-1980's (Utz, 2003; Eckert et al, 2009), assisted living began to appear in Canada a decade later (Eales, Keating, & Damsma, 2001). For this reason, there is a greater body of research literature on assisted living in the United States. In the United States, assisted living facilities are privately owned, and the costs of residency and services are predominantly covered by the residents themselves. In recent years, up to 70% of assisted living residents paid for the full cost of their housing and care. Low-income residents may receive federal subsidies, state supplemental payments, and Medicaid (Newcomer, Fox, & Harrington, 2001). The Assisted Living Foundation of America is a national organization that formed in 1991 to promote the assisted living philosophy among member facilities and advocate for public policy that supports the growth of assisted living as an industry and the adherence to the assisted living philosophy within seniors housing and care (Assisted Living Federation of America, 2009). However, there are currently no national standards or regulations for assisted living facilities, and it is up to each state to license and regulate these facilities. This has resulted in a diversity of policies across the United States, and little consistency within the industry (Utz, 2003).

Assisted living developed in the United States through the emergence of four models: hospitality, housing, health care, and a hybrid of housing and services (Wilson, 2007). Elements of all four of these models survive in present-day assisted living settings and policies. The hospitality model has contributed to the unbundling of services and a

focus of resident satisfaction. The housing model emphasized the importance of a home-like environment, privacy, and legal rights as a tenant. The health care model led to increased focus on health care quality measurement and standards, staff training requirements, and the defining of assisted living as occupying a niche on the continuum of care between independent living and nursing homes. The health care model involved stricter admission and discharge criteria in order to discourage assisted living as an alternative to nursing home care. Finally, the hybrid model led to a greater emphasis on resident autonomy and choice (Wilson, 2007).

The assisted living policy landscape in Canada has a distinct history from that of the United States. Table 1 provides an overview of federal and provincial health and housing policy. The British North America Act of 1867 established the division of powers between the federal government and the provinces. Health care services, which at the time consisted of "hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals" (Department of Justice Canada, 2009, p. 8) became the responsibility of the provinces. The Medicare system of public health insurance for medical services came into being with the Hospital Insurance and Diagnostic Services Act of 1857 and the Medical Care Act of 1966. These acts together established the scope of Medicare as including hospital and physician services. The federal government did provide funding for the establishment of nursing homes in the 1970's, but by time of the introduction of the Canada Health Act of 1984, the federal government had almost completely removed itself from extended health services, which remained provincial jurisdiction (Chappell et al., 2003). The Government of Canada still provides limited assisted living services for Aboriginal people through the Indian and

TABLE 1: FEDERAL AND ALBERTA PROVINCIAL LEGISLATION

	Date	Jurisdiction	Implications
British North America Act	1867	Federal	Established the provincial responsibility for the provision of health services in Canada
Hospital Insurance and Diagnostic Services Act	1957	Federal	The federal government began to finance 50% of the cost of hospital and diagnostic care, with provinces financing the remainder.
Medical Care Act	1966	Federal	The federal government began to insure 50% of physician services, with provinces financing the remainder.
Federal-Provincial Fiscal Arrangements and Established Programs Financing (EPF) Act	1977	Federal	The federal government contribution to provincial health care insurance is no longer 50%, but is instead tied to increases in GDP.
Social Care Facilities Licensing Act	1980	Provincial	Supportive living settings are required to be licensed if they provide services for four or more adults.
Canada Health Act	1984	Federal	Five principles: public administration, universality, accessibility, comprehensiveness, and portability. Extended health care services (home care, continuing care, supportive living) are not required to adhere to the five principles.
Nursing Homes Act	1985	Provincial	Regulation of nursing homes
Alberta Housing Act	1994	Provincial	Regulation of seniors' lodges
Protection for Persons in Care Act	1998	Provincial	Investigates allegations of abuse in care settings

(Northcott, 2005; Government of Alberta, 2002, 2003, 2007, 2008)

Northern Affairs Canada Assisted Living Program (Indian and Northern Affairs Canada, 2008).

The development of a health care insurance program in Canada focused on acute care services to the exclusion of continuing care for chronic conditions (Northcott, 2005). Continuing care services began to be covered through the federal Extended Health Care Services Program in 1977, which supplemented provincial programs such as the 1978

Coordinated Home Care Program in Alberta. However, extended health care services were not included in the 1984 Canada Health Act. Since the Federal-Provincial Fiscal Arrangements and Established Programs Financing (EPF) Act of 1977, provinces have assumed more financial responsibility for the delivery of health care, and as a result, provincial health policy in Alberta has increasingly focused on less costly alternatives to acute care services such as home care and other long term care options.

In Alberta, residential extended care for older adults has been provided through seniors' lodges and nursing homes. The contemporary pieces of legislation under which these housing and care settings operate are the 1994 Alberta Housing Act and the 1985 Nursing Home Act (Government of Alberta, 2002, 2007). In the 1990s, assisted living facilities began to emerge as a type of residential facility that provided more medical services and personal care than a lodge, but not the comprehensive service package of nursing homes. The Government of Alberta has encouraged the growth of Supportive Living options such as home care and assisted living as less costly alternatives to meet the changing needs of an aging and increasingly diverse population.

Development of Assisted Living in Alberta

Extended care services for older adults in Alberta have been shaped by provincial health and social policy. Table 2 provides an overview of policies from 1988 to 2008 that have had an influence on the emergence and growth of assisted living in Alberta. Several themes appear consistently over this twenty-year span, including health promotion, self-reliance, and a focus on community care as an alternative to nursing home care.

TABLE 2: ALBERTA PROVINCIAL POLICY DOCUMENTS

	Date	Source	Recommendations
Moving Into The Future: For the Health of Albertans	1988	Alberta Community and Occupational Health	Support for increased health promotion, illness prevention, and community care. Care in the community seen as providing better care at lower cost for those with chronic conditions.
Caring and Responsibility: A Statement of Social Policy for Alberta	1988	Government of Alberta	Emphasized a culture of self-reliance and support for those in need. Social programs may be expanded during good economic times, with a return to individual responsibility as the economy weakens.
A New Vision for Long Term Care: Meeting the Need	1988	Committee on Long Term Care for Senior Citizens	Recommendations include expansion of community services, housing alternatives, single point of entry to long term care, seniors' independence, and health promotion as cost-reducing measures.
Home Care in Alberta: New Directions in Community Support	1992	Alberta Health	Predicted increase in Home Care demand due to the aging population and cost savings resulting from a shift from institutional to community care.
Budget '94: Securing Alberta's Future	1994	Jim Dinning	Alberta Seniors Benefit Program created. Universal benefits replaced by benefits for low income seniors. Health services restructured and community-based services expanded.
Healthy Albertans Living in a Healthy Alberta: A Three-Year Business Plan	1994	Alberta Health	Identified aging population and age-related disability and chronic illness as financial concerns. Emphasized health promotion, independence, community care, and access to palliative care. Health care premiums subsidized only for low-income.
Government of Alberta Strategic Business Plan for Alberta Seniors	1996	Government of Alberta	Recognized growing number of seniors in Alberta and intended to control costs. Recommended a

1996/97 to 1998/99			greater shift from institutional to community care, greater individual responsibility for care, and providing subsidies for low-income seniors while requiring those with higher incomes to pay for certain services.
Healthy Aging: New Directions for Care **Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta** **Tracking Progress: A Progress Report on Continuing Care Reform in Alberta**	1999 2000 2002	Alberta Health and Wellness	Recommended expansion of supportive living options that provide services to adapt to changing resident needs. Nursing home care to be limited to only the most complex needs. Emphasized a division between housing and care services. Recommended a raise in resident fees to reflect increases in housing costs, while medical fees continue to be covered by the province.
Alberta For All Ages: Directions for the Future	2000	Alberta Community Development	The aging population is recognized as important but not labeled a crisis. Identified 4 guiding principles: 1. individual responsibility, but government support for those in need; 2. healthy aging; 3. independence; 4. cost-effective government involvement that supports the first three principles
Alberta's Healthy Aging and Seniors Wellness Strategic Framework 2002-2012	2002	Alberta Health and Wellness	Product of Seniors Policy Initiative, which involved 18 departments and a range of topics. Strategy for healthy aging involved 4 components: 1. individual choice and healthy environments; 2. independence; 3. self-care for chronic disease; 4. engagement in meaningful relationships and activities
MLA Task Force on Continuing Care Health Service and Accommodation Standards	2005	Alberta Health and Wellness, and Alberta Seniors and Community	Engaged stakeholders across Alberta. Identified 45 recommendations for improved care, housing and services for seniors.

Draft Continuing Care Health Service and Accommodation Standards	2005	Supports	
Supportive Living Accommodation Standards	2007	Alberta Seniors and Community Supports	Established standards for the regulation of Supportive Living facilities and services in AB. Scope does not include health or personal care services.
Supportive Living Framework	2007	Alberta Seniors and Community Supports	Established common terminology for Supportive Living facilities and services in Alberta.
Continuing Care Health Service Standards	2008	Alberta Health and Wellness	Established standards for health and personal care services in nursing homes, supportive living facilities, and home care.
Findings Report	2008	Demographic Planning Commission, AB Seniors and Community Supports	Engaged stakeholders across Alberta. Recommendations included: supporting seniors to remain in own homes, expanding community services, meeting health needs of seniors, supporting family caregivers, and raising awareness of middle-age Albertans to their future needs as seniors.
Continuing Care Strategy: Aging in the Right Place	2008	Alberta Health and Wellness	Identifies 5 strategies: 1. investing in community supports; 2. building infrastructure that meets the "aging in the right place" vision; 3. changing the way long term care accommodations are paid; 4. funding individuals based on needs and or funding providers; 5. providing equitable drug coverage for people wherever they live. Described as a "more client-focused continuing care system" that "promotes increased choice" of where services are provided (p. 3).

(Northcott, 2005; Alberta Community Development, 2000; Alberta Health and Wellness, 1999, 2008a, 2008b; Alberta Seniors and Community Supports, 2007a, 2007b; Demographic Planning Commission, 2008)

Health promotion is supported in these policy documents as a strategy that leads to reductions in chronic and acute health problems, thereby reducing the demand for more costly acute and extended health care services. Individuals are encouraged to take more personal responsibility for their own health through making choices that promote good health and putting more emphasis on self-care in the management of chronic illness. Self-reliance is identified as a shared value in Alberta, and provincial policies encourage citizens to rely on themselves, their families, and communities in addition to the province for extended care and other services. Community care, including the range of supportive living options that are identified in the Supportive Living Framework (Alberta Seniors and Community Supports, 2007b) has been promoted as an alternative to nursing homes and acute care settings that allows older adults to maintain a better quality of life and increased independence at a lower cost to the province. However, while the shift from continuous care in nursing homes and acute care to scheduled care in the community may reduce direct health care costs, it simultaneously increases the demands placed on family caregivers to provide care directly or hire private care services (Northcott, 2005). Finally, health promotion, self-reliance, and community care are also identified as strategies for government cost containment. Due to the aging of the population and the absence of federal cost-sharing for extended health services, the Alberta Government has advocated for health and extended care policies that promote the maintenance of good health and the sharing of the cost of care with individuals, families, and communities.

Themes that have emerged and developed since 1988 in Alberta include the impact of the aging population and limiting financial support for older adults to those most in need. While the fact that the population is aging has been acknowledged

throughout the 20-year span of these policy documents, the perception of its impact on the province has changed. In policy statements prior to 2000, the aging population is described as an impending financial crisis for the province, especially if service delivery models remain unchanged. In the document Alberta For All Ages: Directions for the Future (Alberta Community Development, 2000), the aging population is an important consideration, but not viewed as a crisis (Northcott, 2005).

In 1994 the Alberta Seniors Benefit Program did away with universal benefits for older adults in favour of benefits for low-income seniors only. In the same year, it was announced that health care premiums would be subsidized only for those with low incomes. The Government of Alberta Strategic Business Plan for Alberta Seniors 1996/97 to 1998/99 introduced fees for extended care services for those deemed able to pay (Northcott, 2005), and Healthy Aging: New Directions for Care (Alberta Health and Wellness, 1999) emphasized a division between housing and care services in assisted living and nursing homes by recommending a raise in resident fees to reflect increasing housing costs, while stating that medical fees would continue to be covered by provincial insurance (Canadian Healthcare Association, 2004; Policy Advisory Committee on Long Term Care, 1999). By restructuring health and income benefits, the Government of Alberta has attempted to minimize the financial impact of the aging population by making funds available only to those in the greatest need. In this way, the government has taken financial responsibility for the growth of the low-income seniors' population, but not the seniors' population as a whole (Northcott, 2005). The trend to require seniors who are not assessed as "low-income" to pay for a greater proportion of their health services has continued, as reflected in the long term care and pharmaceutical funding

changes introduced in the Continuing Care Strategy: Aging in the Right Place (Alberta Health and Wellness, 2008b).

Current Policy Context of Assisted Living in Alberta

Assisted living in Alberta is currently defined by the Supportive Living Framework (Alberta Seniors and Community Supports, 2007b), which situates all Supportive Living care options within a continuum of care from home living to facility living (see Table 3). The simultaneous introduction of the Supportive Living Framework and the Supportive Living Accommodation Standards in 2007, followed by the Continuing Care Health Service Standards in 2008, provided a classification system, set of standards, and licensing requirements for all private, non-profit, and publicly-contracted housing and care services that are identified as Supportive Living, including assisted living facilities.

The Supportive Living Framework identifies four levels of Supportive Living: Residential Living, Lodge Living, Assisted Living, and Enhanced Assisted Living (see Table 4). This study focuses on the Assisted Living and Enhanced Assisted Living levels, which include both Designated Assisted Living and private-pay options. Designated Assisted Living (DAL) "refers to a facility where there is a contract between a regional health authority and an operator for a certain number of spaces within the facility. Under the contract, the operator provides health and support services based on assessed need. The regional health authority, in collaboration with the operator, makes decisions regarding admission and discharge" (Alberta Seniors and Community Supports, 2007b, p. 10). Private assisted living is not under contract with a health authority,

TABLE 3: CONTINUING CARE SYSTEM IN ALBERTA

Home Living	Supportive Living	Facility Living
• Independent living in: o Houses o Apartments o Condominiums	• Residential Living • Lodge Living • Assisted Living (including Designated Assisted Living) • Enhanced Assisted Living	• Long-Term Care Facilities: o Nursing Homes o Auxiliary Hospitals

(Alberta Seniors and Community Supports, 2007b)

TABLE 4: LEVELS OF SUPPORTIVE LIVING IN ALBERTA

	1. Residential Living	2. Lodge Living	3. Assisted Living	4. Enhanced Assisted Living
Resident Needs	Can manage own care and make decisions about day-to-day activities. Can manage most daily tasks independently. All personal assistance can be scheduled. Primarily needs housing for safety, security, socialization	Can manage own care and make decisions about day-to-day activities. Can manage some daily tasks independently. All or most personal assistance can be scheduled. May require some assistance to participate in social, recreational and	Has choices but may need assistance with some decisions about day-to-day activities. Requires assistance with many daily tasks. Most personal assistance can be scheduled. Infrequent need for unscheduled personal assistance. May require increased assistance to participate in social,	Has choices but needs assistance with decisions about day-to-day activities. Requires assistance with most/all daily tasks. The need for unscheduled personal assistance is frequent. Requires enhanced assistance to participate in social,

		rehabilitation programs.	recreational and rehabilitation programs.	recreational and rehabilitation programs.
Building Features	All Levels - Building safety and design features are appropriate for residents' needs. Ideally, each suite is private, includes a lockable door, a bedroom, sitting area, bathroom and a kitchenette. Residential Living suites may also include a full kitchen. Except for Residential Living, that might only contain a common area for dining, all other levels of supportive living are expected to have common areas for dining and social/recreational activities.			
Hospitality Services*:				
Meal Services	At least one main meal per day is available	Full meal services are available	As Level 2. Some special dietary requirements can be met.	As Level 2. Most special dietary requirements can be met. Nutrition intake monitored.
Housekeeping Services	Services are available	Weekly services are available	More than weekly services are available. Additional sanitization as required.	Daily services are provided. Additional sanitization as required.
Personal Laundry	Equipment is available. Services may be available.	As Level 1.	Equipment is available. Services are available.	As Level 3.
Laundry and Linen Services	May be available	Weekly services are available	As Level 2.	Weekly/daily services are provided
Safety and Security	24-hour security provided	24-hour staff on site. Personal response system provided.	As Level 2. Routine checking of residents as required.	As Level 3.
Social, Leisure and Recreational Opportunities	Services may be available.	Services are available.	As Level 2.	Services are provided.

Coordination and Referral Services to Community Supports	Guidance role may be available. Assistance with accessing community services may be available.	Guidance role is available. Assistance with accessing community services is available.	Guidance role is provided. Assistance with accessing community services is provided.	Guidance role is provided. Assistance with accessing community services is provided.
Health and Wellness *General Service Needs* *Medication Support*	All Levels: Case management by RHAs for publicly funded services. Assessment for publicly funded health and personal care services completed by the RHA based on unmet need. Other health services, services of health professionals are available as arranged locally and on an as needed basis. Personal assistance and/or professional services may be provided to residents by: the RHA directly, the operator on contract to the RHA, the operator privately, or private pay by an alternate vendor. Support will be provided by RHA's based on assessed unmet need. Support can also be purchased privately. Residents are responsible for the costs of their medications including dispensing fees.			
Staff	All Levels: Scheduled visits by RHA staff and other community supports.			
	No health staff on site on a 24-hour basis	No health staff on site on a 24-hour basis	Suitably qualified, certified or trained staff on site on a 24-hour basis	As Level 3, plus regulated professional staff on site on a 24-hour basis

*__May be Available__- Housing operators may or may not have the ability or capacity to co-ordinate this service or provide it to residents.
Is/Are Available – The housing operator has the capacity to provide the service directly or arrange for its delivery by another source, if the resident needs or wants the service.
Provided –These are the services that housing operators supply to meet residents' need. (Alberta Seniors and Community Supports, 2007b)

and the facility operator makes decisions about resident admission and discharge.

Personal services in private assisted living can be provided by facility staff, Home Care staff, or an external care provider. All services are paid for by the resident, except Home Care services that are covered by Alberta Health Services based on assessed resident need. A single facility may offer more than one type of Supportive Living in the same

building, such as Residential Living and Assisted Living. A single facility may also offer a both DAL and private assisted living options in the same building. All types of assisted living care are subject to licensing and to the Supportive Living Accommodation Standards and the Continuing Care Health Service Standards.

The Supportive Living Accommodation Standards (Alberta Seniors and Community Supports, 2007a) regulate eight areas of assisted living accommodation: physical environment, hospitality services, safety services, personal services, coordination and referral services, residential services, human resources, and management and administration. The residential services area includes three standards that apply to resident admission and discharge. Standard 25 requires that all Supportive Living facilities provide information to "potential residents or their representatives" about "eligibility requirements (e.g. physical and cognitive abilities, etc.)" and "exit criteria leading to termination of tenancy or residency" (p. 19). Standard 26 requires that the facility develop "written processes regarding how they ensure the compatibility of applicants' physical, emotional, and cognitive abilities with the facility's physical design and available services" (p.20). Finally, Standard 27 outlines the requirements for the development and review of managed risk agreements. Managed risk agreements between the assisted living facility and the resident or family outline the risks that are involved in a particular resident's continued residency at the facility, and the process that will be followed to manage these risks.

The responsibility for investigating abuse in publicly-funded care settings is divided among several provincial ministries. The Ministry of Health and Wellness has

jurisdiction to investigate reports of abuse through the Protection for Persons in Care Act (Government of Alberta, 2003) for assisted living facilities, nursing homes, auxiliary hospitals, acute care hospitals, personal care homes, and AADAC treatment facilities. The investigation of abuse in other settings is undertaken by the Ministry of Seniors and Community Supports (seniors' lodges, unique homes, and settings under the Persons with Developmental Disabilities program), the Ministry of Children and Youth Services (women's shelters and youth shelters), and the Ministry of Housing and Urban Affairs (homeless shelters).

The Social Care Facilities Licensing Act applies to a wide variety of housing and care services in Alberta. The Act governs the licensing of services for children, including day cares and out-of-school care centres, as well as residential care facilities for adults that are not defined as nursing homes, lodges, or hospitals (Government of Alberta, 2008). The 2005 MLA Task Force on Continuing Care Health Service and Accommodation Standards found that the Social Care Facilities Licensing Act had not been consistently interpreted and enforced with respect to assisted living facilities, resulting in some facilities operating without a license and not being subject to inspections (Prins & Webber, 2005). In 2007, Alberta Seniors and Community Supports released the Supportive Living Accommodation Standards (2007a), and in the following year Alberta Health and Wellness released the Continuing Care Health Service Standards (2008). Since 2007, all assisted living facilities have been subject to licensing and inspection though the Supportive Living Accommodation Standards, under the authority of the Social Care Facilities Licensing Act (Alberta Seniors and Community Supports, n.d.d).

Following the introduction of licensing and regulation through the Supportive Living Accommodation Standards in 2007, the Ministry of Seniors and Community Supports created a website (Alberta Seniors and Community Supports, n.d.c) that allows the public to view the status of each supportive living facility in Alberta regarding their adherence to the Supportive Living Accommodation Standards. This website provides improved public access to information about assisted living, as it provides a single comprehensive list of all supportive living options in Alberta, and gives potential residents and their family members easy access to information about each facility.

The policy context of continuing care in Alberta is very complex, and can be confusing for older adults and professionals alike. For example, terms for types of housing and care are often used interchangeably, such as "long-term care" and "nursing home". Facilities may have the term "lodge" in their title, but be licensed as an assisted living facility. The distinctions between types of facilities, such as lodges and assisted living, are very slight. Furthermore, the same terms for housing and care types are used differently in other Canadian provinces, which can create confusion for older adults who move to Alberta from other provinces.

In addition to the problem of terminology, the regulatory environment of Supportive Living is confusing. Facilities are categorized in the Supportive Living Framework (Alberta Seniors and Community Supports, 2007b) as Residential Living, Lodge Living, Assisted Living, and Enhanced Assisted Living, but licensed under the Social Care Facilities Licensing Act (Government of Alberta, 2008) as Group Home, Lodge, or Assisted Living. Several levels of Supportive Living care can exist in one building, but each building is licensed as only one type of Supportive Living, making bed

counts of assisted living very difficult. Since it is difficult for me as a health professional to understand the complexity and confusion of the assisted living context in Alberta, it must be very difficult for older adults and their family members to access information about housing and care options.

Capital Funding Support for Assisted Living in Alberta

The Government of Alberta has demonstrated its support for supportive living as an important element within the continuum of care for older adults by establishing funding programs to encourage the development of more supportive living spaces. Table 5 outlines capital funding initiatives for Supportive Living development and modernization since 2000. The most recent funding program, the Affordable Supportive Living Initiative, indicates a commitment to provide funding over a three-year period from 2008 to 2011.

The funding for the 2009/2010 year has been designated for the development of Assisted Living or Enhanced Assisted Living only. The description of the funding program states that "the purpose of the Affordable Supportive Living Initiative is to provide affordable supportive living options to accommodate low and moderate income seniors and persons with disabilities who require accommodation services in combination with health and personal care services to remain in their communities" (Alberta Seniors and Community Supports, n.d.a).

TABLE 5: CAPITAL FUNDING INITIATIVES FOR SUPPORTIVE LIVING IN ALBERTA

	Funding Dates	**Total Dollars Allocated**	**Total Dollars Granted**	**Total Supportive Living Units**
Seniors Supportive Housing Incentive Program (SSHIP)	2000/2001 fiscal year	$10,000,000	$10,000,000	17 facilities
Healthy Aging Partnership Initiative (HAPI)	2001/2002	$20,000,000	$13,983,150	12 facilities
Rural Affordable Supportive Living Program (RASL)	2005 2007	$100,000,000 $25,000,000	$94,093,507 $17,454,000	1,695 units in 40 facilities 512 units in 11 projects
Rural Affordable Housing Initiative	2005	$25,000,000	$20,966,006	105 units (512 total) in 3 projects (12 total)
Lodge Modernization and Improvement Program (LMI)	2008/2009	$35,600,000	$35,600,000	1,992 units
Affordable Supportive Living Initiative (ASLI)	3 fiscal years: 2008-2011	$78,000,000: Year 1 $50,000,000: Year 2	$84,400,000	1,153 units (890 new, 263 modernized)

(Alberta Seniors and Community Supports, n.d.a)

Current Presence of Assisted Living Facilities in Calgary

For reasons of government cost savings and promoting independence among older Albertans, the Alberta government's priority in care for older adults is to ensure that clients remain in their own homes for as long as possible, move to assisted living if necessary, and move to nursing homes only as a last resort. The government argues that by reducing the public costs associated with facility-based care, it can be better prepared to meet the needs of a population that is simultaneously aging and growing through migration to the province (Policy Advisory Committee on Long Term Care, 1999). The Demographic Planning Commission of Alberta Seniors and Community Supports (2008) reported that the Government of Alberta will need to collaborate with non-governmental organizations, the voluntary sector, the non-profit sector, and Albertans at large in order to respond to the needs of an increasing population of older Albertans who require housing and care services.

Transitions to all publicly-funded supportive living or continuing care services are managed by Alberta Health Services through a single point of entry system. Individuals are assessed by a registered nurse, who determines the care options available, which may include Home Care, an Adult Day Support Program, a residential Supportive Living setting such as a Personal Care Home or Designated Assisted Living, or a nursing home (Northcott, 2005).

As of August 2009, there are 30 facilities that provide Designated Assisted Living and/or private assisted living for older adults in Calgary, Alberta. All are licensed through the Social Care Facilities Licensing Act, and many of the facilities offer other types of Home Living, Supportive Living, or Facility Living in addition to Assisted Living. Of the

4,276 licensed assisted living beds in Calgary, 433 are contracted by Alberta Health Services as Designated Assisted Living. Six of the facilities are owned and operated by non-profit organizations, and twenty-four are owned and operated by private companies. Further description of these facilities will be provided in Chapter Three.

Changes to the Alberta Context Following Data Collection

As of March 31, 2009, the nine health regions in Alberta, the Alberta Cancer Board, the Alberta Alcohol and Drug Abuse Commission, and the Alberta Mental Health Board were no longer legal entities. A new organization, Alberta Health Services, came into existence on April 1, 2009 and took over the governance and operations of the above entities, plus Emergency Medical Services throughout the province (Alberta Health Services Board, 2009). The effects of these organizational changes have yet to be seen in terms of the management of Designated Assisted Living and contracted Home Care services that are provided for Supportive Living residents.

As previously mentioned, the Alberta Ministry of Seniors and Community Supports introduced a system of licensing and inspection in 2007, and improved public access to information about supportive living options by publishing the results of all facility inspections on their website (Alberta Seniors and Community Supports, n.d.c).

Policy and Professional Issues

The development of assisted living in Canada is a relatively recent phenomenon, and the industry continues to grow through the support of provincial health care policy and public preference for the assisted living philosophy of housing and care. Within this context, several issues emerge that are worthy of study. These issues include establishing

a definition for assisted living and ensuring the affordability and accessibility of assisted living care.

As a new model of housing and care for older adults along an existing continuum of care in Canada, assisted living is still in the process of being defined. Since assisted living is in provincial jurisdiction, the only federal definitions of assisted living arise within the Indian and Northern Affairs Canada Assisted Living Program that provides funding for low to moderate levels of care for aboriginal people living on reserves (Indian and Northern Affairs Canada, 2008). Due to varied provincial policy contexts in which assisted living has emerged, there is no standard definition of assisted living across Canada. Even within Alberta, assisted living encompasses a variety of housing and care services that include accommodation in private or non-profit facilities, and that may or may not include the involvement of Alberta Health Services to oversee resident care or manage resident transitions. However, the Alberta government has increasingly promoted assisted living and other supportive living options as cost-effective care options for an aging population. The issue of the definition of assisted living also exists in the United States. The Assisted Living Federation of America, a national industry association in the United States, advocates for standards of regulation throughout the United States, but the ability to define and regulate assisted living services remains up to each state (Assisted Living Federation of America, 2009). This policy context creates issues for research in the area of assisted living, as the literature from both the United States and Canada is not necessarily consistent in the types of care that fall into the category of assisted living.

In addition to the problem of definition, several other issues emerge as a new model of care is developed. The funding of assisted living through private industry,

Alberta Health Services, provincial income programs, and the private savings of individuals, raises questions about the affordability of assisted living and the level of support that the provincial government has provided for the delivery of this type of care. The aging population will lead to increasing numbers of older adults in Canada, particularly in the oldest age groups, and increased preferences for a variety of supportive living options (Canada Mortgage and Housing Corporation, 2000). Consumer choice has influenced the development of the assisted living industry in the United States (Zimmerman et al., 2007), but such choices have not been financially accessible to lower income individuals in that country (Doty, 2008). The growth of the assisted living industry in Alberta may allow for more choice within the continuum of care for those who can afford private services, but may also lead to misperceptions about the degree to which independence and aging in place are possible in assisted living for all Albertans who require continuing care.

From a social work perspective, issues of resident and family autonomy and self-determination are primary. As an emerging model of care, assisted living presents issues for social work practice and research. According to the Social Work Code of Ethics, a central value of the social work profession is "respect for the inherent dignity and worth of persons" (Canadian Association of Social Workers, 2005, p. 4). Aspects of this value include the right to client self-determination, respect for the diversity of clients, the right of client autonomy, and the right of society to limit self-determination of individuals if their chosen actions would cause harm to themselves or others. Within an assisted living setting, these values relate to the ability of assisted living residents to make decisions about their place of residence and the services they receive, and the responsibility of the

residence and other service providers to protect residents from harm. A second value within the social work Code of Ethics is the pursuit of social justice. Aspects of this value include ensuring client accessibility to public services and benefits. Since assisted living is a publicly contracted care option, and the government of Alberta supports the development of assisted living as a care option through public policies and funding opportunities, assisted living should be physically and financially accessible for all Albertans who require this type of housing and care.

Since assisted living is a relatively recent addition to the continuum of care services in Alberta, there are several issues in this area that are worthy of more research. For the purposes of this study, I will be investigating the ways in which assisted living can be operationally defined by resident admission and discharge policies and practices, and the extent to which admission and discharge policies and practices affect the ability of residents to age in place in assisted living.

Rationale

There are currently established social work roles in a variety of health settings, including nursing homes, home health care, acute care hospitals, hospices, and rehabilitation centres, among others. Specific roles for social workers in these settings include counselling, family support, referral, discharge planning, and client advocacy (Nathanson & Tirrito, 1998; Cowles, 2000). However, social workers are currently not employed in assisted living settings in Calgary, Alberta. The Supportive Living Framework (Alberta Seniors and Community Supports, 2007b) identifies “coordination and referral to community supports”, including a “guidance/advocacy/advisory role” (p.

6) as a set of services that must be provided in Level 3 – Assisted Living and Level 4 – Enhanced Assisted Living settings. These roles fall into the domain of social work practice, and yet they are identified in the Supportive Living Framework as one of many "Hospitality Services". Neither the Supportive Living Framework nor the Supportive Living Accommodation Standards (Alberta Seniors and Community Supports, 2007a, 2007b) require that any of the above roles be carried out by a social worker or any other professional. Furthermore, the assisted living philosophy, including resident autonomy, privacy, and maintaining a home-like atmosphere, is compatible with social work values and practice. Given the roles of social work in other settings within the continuum of care for older adults, and the fit between assisted living philosophy and social work theory and values, it would appear that the profession of social work could play a much larger role in assisted living settings.

Summary

Assisted living arose over the past two decades in Alberta as a housing and care option for older adults and people with disabilities. Alberta's aging population, and increases in chronic illness and family caregiving issues will likely lead to an increased public interest and research focus on assisted living as a community care option. The Government of Alberta has supported the development and growth of the assisted living industry through policies that support community care and through capital funding programs for the development and refurbishment of assisted living units. There are many issues that are worthy of study in this emerging topic area. The focus of this study is the extent to which the admission and discharge policies of assisted living facilities in

Calgary, Alberta allow older adults to access assisted living and to age in place as their care needs increase.

CHAPTER TWO: LITERATURE REVIEW

Assisted living is an emerging research area, and as such the amount of research available is small but growing. Studies from the United States have examined a variety of topics in assisted living operations and resident experiences, including quality of care, resident satisfaction, staffing issues, costs, and the American policy context. Since my research investigates resident admission and discharge in assisted living facilities in Calgary, Alberta, I limited my literature search to studies of resident transitions and aging in place. I found studies in four related theme areas: admission and discharge criteria, admission and discharge decision-making and choice, indicators of aging in place, and discharge outcomes. I included research from both Canada and the United States because Canadian research in this area is sparse. As assisted living is still a relatively new housing and care option in Canada, more Canadian-based research in this area is needed to determine the role of assisted living compared with other housing and care options, including the extent to which assisted living residents are able to experience independence and age in place.

Social Work Theory

From a social work viewpoint, the ecosystems perspective is useful model in which to understand in assisted living admission and discharge decisions because of the focus it places on the fit between the person and his or her environment. The ecosystems perspective borrows concepts from biology and ecology in order to understand the interactions between individuals and their physical and social environments. Ecological concepts are used as metaphors for social structure and interaction (Germain &

Gitterman, 1996). Habitat refers to the place in which people live, including the resources available to them. Within a habitat, each individual occupies a niche, or a position that allows him or her to feel a sense of meaning and belonging in the habitat. When there is a good fit between the person and his or her environment, growth and benefits take place for both the individual and the community. Stress is the individual response to stimulus within the environment, and it can have positive or negative effects (Heinonen & Spearman, 2001). Problems with individual functioning are viewed as the result of complex exchanges between the person and his or her environment, rather than through a linear cause-and-effect paradigm (Germain & Gitterman, 1996). The environment, habitat, or "place" of interest in this study is the assisted living facility.

The person-in-environment concept is an adaptation of the ecosystems perspective (Heinonen & Spearman, 2001; Payne, 2002). The focus of assessment using a person-in-environment framework is the individual client and his or her interaction with physical and social environments (Cowles, 2000). For example, before the assisted living admission process, a social worker could assess an older adult's individual functioning in the context of the fit between an older adult and his or her current living situation. The social worker could identify sources of environmental stress in the home, and discuss with the older adult possibilities such as in-home services or relocation to another residential or care setting. If the older adult chose to relocate to an assisted living facility, a social worker could assess the fit between the older adult and possible assisted living facilities.

The person-in-environment approach is useful to the assessment of a resident's fit within an assisted living environment and to the continued assessment of resident needs.

In an assisted living environment, this approach could be used to continually assess the balance between ensuring resident privacy, and providing appropriate levels of supervision and promoting resident interaction as care needs increase (Zimmerman et al., 2007). Person-in-environment would also be a useful approach for social workers involved in an assessment of the available supply of assisted living. For example, a social worker could assess the needs of current and future older adult population in Calgary and estimate the level of fit between the needs and preferences of the population, and the physical environments and management processes of assisted living facilities in Calgary. When assessing the fit between person and environment, the social worker places priority on the values and preferences of the person or client system. Using the person-in-environment approach, "environmental characteristics determine the availability (supply) of resources, and personal values, desires, or goals determine the optimal use of these resources" (Zimmerman et al., 2007).

The holistic nature of the person-in-environment approach provides social workers with a theoretical framework that is useful to both micro and macro social work practice. The model integrates a micro social work focus on behavioural, psychological and interpersonal functioning of the individual with a macro social work focus on social systems and community change (Payne, 2002). From its roots in the ecological perspective, the person-in-environment approach includes the recognition that individuals are influenced by aspects of their physical environments, communities, social institutions, and social policy context. Thus, social work conducted on the micro level of individuals and the macro level of community and social policy are interconnected. For example, social workers at all levels of practice may identify organizational or social policies that

create barriers for individual clients and client populations. Using the person-in-environment approach, they could assess the environment of their organization or the social policy setting in order to determine effective macro-level advocacy strategies (Germain & Gitterman, 1996). The ecological perspective and person-in-environment approach would thus be applicable to social work practice at all levels of intervention with assisted living residents, systems, and policies.

Boundaries of Search for Empirical Literature

My initial search for literature on assisted living was quite broad, in order to assess the amount and type of literature available. I began my search using academic databases and the search terms "assisted living", "aging in place", "continuum of care", "supportive living", "resident admission", "resident discharge", "residential care", and "transition".

After an initial assessment of the growth of the assisted living industry and the corresponding emergence of assisted living as a field of study, I limited the scope of the literature search to studies published from the year 2000 onwards. Few empirical studies were conducted prior to 2000, and the nature of the development of the assisted living industries in the United States and Canada resulted in inconsistency regarding the use of the term "assisted living" to refer to a consistent model of residential care. Later review articles (Hyde et al., 2007; Kane, Wilson, & Spector, 2007) confirmed my assessment that the assisted living literature prior to 2000 consisted mainly of industry reports, reports on policy, expansion from studies of board and care homes, preliminary clinical

and administrative studies, and the beginnings of longitudinal studies of which data were reported on and several secondary data analysis studies conducted after 2000.

I found very little literature on assisted living in Canada, so I included literature from the United States in my search as well. I chose not to include literature from other countries for two reasons. First, the definition and use of the term "assisted living" is inconsistent across Canada and in United States. This study is already limited by the extent to which assisted living literature in Canada and the United States may refer to slightly different care environments and services. Secondly, the policy context of care for older adults in general and assisted living in particular also varies across Canada and the United States. Therefore, the development, funding, and accessibility of assisted living facilities and the place of assisted living within the continuum of care for older adults vary considerably within North America. Future studies may review or compare the literature available regarding assisted living globally.

Other exclusion criteria included review articles that did not involve empirical studies, studies limited to populations under age 65, or studies that did not refer specifically to the admission and/or discharge of assisted living residents. Next, I searched for articles that fit my criteria within the reference sections of the initially selected studies, and searched for books using the search term "assisted living" that included empirical studies or collections of studies.

I used the literature that I collected initially in 2006 to compile a draft literature review and develop my interview guides (see Appendices A and B). I conducted a second literature search in early 2009 using the same search process in order to locate more recent studies. I found that research on assisted living has become more plentiful, and the

research area has grown significantly between the times of my two searches. Of particular note is the fact that in 2007, the academic journal *The Gerontologist* published a special issue entirely dedicated to assisted living research. Several of the articles in the special issue were review articles. The review articles served as summaries of the available research, and I used them to check my conclusions about the progress of assisted living literature to date.

Assessment of the Literature

Table 6 contains a review of the empirical studies that fit my search criteria and relate directly to assisted living admission, discharge, or aging in place. Since assisted living is still a developing research area, there were only 17 studies that fit my criteria exactly. Other studies and review articles were used to provide context for the study or to assess the state of assisted living as a research area, but did not suit the needs of the literature review.

Four of these studies used qualitative approaches to examine resident admission and discharge in assisted living. The researchers interviewed assisted living residents (Ball et al., 2000; Eales et al., 2001), administrators (Aud, 2004), or a combination of residents, family members, administrators, and other facility staff (Mead, Eckert, Zimmerman, & Schumacher, 2005) to determine the nature of admission and discharge decision-making processes and resident autonomy. Only one of these studies took place in Canada, involving two cities in Western Canada. The other three studies were each limited to a single state in the United States.

TABLE 6: EMPIRICAL LITERATURE ON ASSISTED LIVING

	Location	Participants	Method	Research Questions	Findings
Ball et al., 2000	Three suburban counties in GA	55 residents	Qualitative	• Identify how residents define quality of life	• 14 domains identified • Five most significant: psychological wellbeing, independence and autonomy, social relationships and interactions, meaningful activities, care from the facility • Residents reported having little autonomy or control over decision to move to assisted living
Kopetz et al., 2000	MD	144 AL residents in single facility	Quantitative	• Describe clinical characteristics of assisted living residents and compare to residents with dementia at home or in nursing home • Describe resident outcomes • Determine predictors of discharge	• Assisted living residents' cognitive and functional abilities were intermediate (between home and nursing home levels) • No clinical differences between residents of dementia-specialized assisted living and general assisted living population • Primary outcome: discharge to nursing home, citing need for higher level of care • Predictors of discharge to nursing home: wandering, falling, depression
Chapin & Dobbs-Kepper, 2001	Kansas	141 facilities	Quantitative	• Determine whether assisted living admission and retention policies support or inhibit aging in place • Examine reasons for	• Aging in place limited by admission and discharge policies that are more restrictive than state regulations • Reasons for discharge: behavioral or cognitive problems, incontinence • Discharge destinations: nursing home,

				discharge and discharge destination	hospital, death • Length of stay: 6 months to 7 years (average 2.36 years)
Eales et al., 2001	Two cities in Western Canada	46 residents	Qualitative	• Determine elements of client-centred care from resident perspective	• Physical setting, people, and community congruent with resident values and preferences • Decision about where to live influences client-centredness • Residents express contentment when experiences fit expectations
Doherty & DeWeaver, 2002	A major southeast ern city (USA)	41 residents age 60 and over	Mixed methods	• Determine the relationship between the nature of disability, income, and time required for relocation from home to assisted living • Investigate whether degree of choice in relocation affected satisfaction with assisted living situation • Investigate influence of perceived degree of choice re: loneliness, isolation, and perception of future	• 78% of residents reported having no choice to relocate, based on ability of family to continue to provide care • Despite most residents reporting having no choice, 61% were satisfied with their current living situation. Choice was not related to variables of satisfaction, loneliness, isolation, and the perception that they would not move to another setting before death • Availability of in-home caregiving was cited as crucial to allow the choice to remain in own home
Hawes et al., 2003	USA	1,251 administrators	Quantitative	• Determine the size and nature of the supply of assisted living in USA • Describe characteristics of assisted living industry (services, accommodations, basic price)	• 11,459 facilities, 611,300 beds, 521,500 residents • Discharge policies limit aging in place: transfers, moderate-severe cognitive impairment, behavioural symptoms, need for nursing care • Industry mostly private-pay and

					unaffordable for people with moderate income
Phillips et al., 2003	USA	1,581 residents	Secondary analysis of quantitative data	• Identify discharge outcomes and reasons • Characteristics of facility and resident that influence outcome, especially facility characteristics re: discharge to nursing home	• Primary outcome was discharge to nursing home, citing need for higher level of care • Discharge decision mutual (45.5%), resident/family (30.3%), or facility (24.2%) • Discharge to nursing home more likely: resident older, more ADL assistance, severe cognitive impairment • Discharge more likely: facility is for-profit, no full-time RN
Sloane et al., 2003	FL, MD, NJ, NC	127 staff, 97 family of assisted living or nursing home residents	Quantitative	• To define the current state of end of life care in assisted living and nursing homes • To compare the care provided at end of life in assisted living and nursing homes	• Nursing home residents received more medical care at end of life, but levels of family satisfaction was higher at assisted living • Measures of resident discomfort and negative moods were low in both settings
Utz, 2003	Ohio	Qualitative: 10 admin. 2 marketing directors Quantitative: 100 facilities	Mixed methods	• Identify challenges providers face when trying to achieve assisted living philosophy in daily operations • Discern whether providers vary in their ability to achieve the philosophical goals of assisted living	• Challenges: individual preference and quality of care vs. cost, providing assistance while supporting independence, autonomy vs. safety, institutional vs. home-like • Licensed nursing home administrators associated with poorer adherence to assisted living philosophy

Aminzadeh et al., 2004	Ottawa	178 residents	Quantitative	• Examine the health and functional profile, service use, and medical/care needs of assisted living residents	• Average 6.3 medical diagnoses (majority ≥5); high rates of falls, cognitive impairment, depression • ADL assistance provided by facility staff, publicly funded and private home support services, and family or friends • High levels of care provided in assisted living Special Care Unit ("pseudo-nursing homes"), especially for residents with dementia, but care needs are met and satisfaction is high for the majority of residents
Aud, 2004	St. Louis, MO	14 facility administrators	Qualitative	• Describe the behaviours of residents with dementia that influenced decisions about discharge from assisted living to nursing homes	• Two types of behaviours identified: those that indicated immediate need for discharge (often safety concerns), and those that indicated need for continued assessment • Particular "behaviours" included progression of dementia, increased need for care, urinary incontinence, wandering, non-compliance with facility policy, falls, and aggression. • Secondary influences include staffing patterns, design and location of the facility, and differences in discharge criteria and decision-making among different facilities.
Golant, 2004	USA	Six previous surveys	Secondary analysis of quantitative	• Identify extent to which people with physical or cognitive impairments and	• Assisted living residents less physically and cognitively impaired than nursing home residents

			data	health care needs reside in assisted living in USA	• Assisted living more likely to admit and retain residents with lower health needs and impairments • Assisted living discharge criteria more lenient than admission criteria (allowing for changing needs)
Aud & Rantz, 2005	Missouri	15, 977 nursing home residents	Secondary analysis of quantitative data	• Identify reasons for nursing home admission from assisted living facilities (compare with nursing home admission from other settings)	• Residents admitted from assisted living: older, dementia or depression, more often placed in special care units for Alzheimer Disease in nursing homes
Mead et al., 2005	Maryland	23 residents, 20 family members, 4 admins, 13 care staff, 2 other professionals	Qualitative	• Explore the decision-making process of the retention or discharge of residents with dementia.	• Facility managers play a pivotal role in the retention/discharge decision. • Other influences include market conditions, staff retention, understanding of dementia, relationship between staff and resident, advocacy and care provided by family members, and the degree to which the facility culture was "dementia-friendly".
Munroe & Guihan, 2005	Illinois	Five staff (representing five facilities)	Mixed methods	• What were the differences between facilities in terms of how they articulated discharge criteria and implemented flexible service plans for changing resident needs? • How consistently did the facilities apply discharge	• The ability of residents to age in place in assisted living is dependent on a facility's discharge criteria, how the criteria are applied, and the willingness of the facility to develop flexible service plans to meet changing needs. • Providers frequently use a situational approach to determine need for discharge. Factors include the resident's

				criteria?	changing needs, availability of services, occupancy rate, and percentage of residents with higher needs. • Providers found it difficult to define the factors that lead to resident admission and discharge. • More experienced providers were more willing to accommodate residents with higher care needs.
Sales et al., 2005	Western WA state	269 residents	Mixed methods	• Investigate factors in resident's choice of Medicaid-funded residential care setting in western WA	• Characteristics that influence choice of care setting: resident age, marital status, education, functional status, reported memory and behavioural problems, and restrictiveness of facility policies
Lyketsos et al., 2007	Maryland	198 residents	Quantitative	• Determine association between dementia and length of stay in assisted living • Determine factors that lead to shorter length of stay for residents with dementia	• Residents with dementia had shorter lengths of stay in assisted living than residents without dementia. • Presence of other medical conditions and lack of treatment for dementia increased risk of early discharge

Four studies employed a mixed methods approach. Doherty & DeWeaver (2002) further investigated the level of autonomy exercised by older adults in their decision to move to assisted living. This study, which outlined implications for the social work profession, involved interviews with residents that solicited both qualitative and quantitative data. Utz (2003) conducted qualitative interviews and quantitative mail-in surveys with facility administrators to explore the challenges in implementing the philosophy of assisted living. Munroe and Guihan (2005) conducted a four-year longitudinal study involving quantitative measures and qualitative interviews with assisted living providers about the articulation and implementation of discharge criteria. Sales et al. (2005) conducted quantitative surveys and qualitative interviews to identify factors that influence resident admission to particular facilities.

Quantitative studies remain the most common in the area of resident admission, discharge, and aging in place in assisted living. Of the nine quantitative studies identified, three involve secondary analysis of data from large state-wide or national surveys. While four studies involve data from at least four states, four studies are limited to single states, and only one study is from Canada. In addition to identifying admission and discharge criteria that are used in assisted living facilities, the quantitative studies also provide profiles of assisted living residents, discharge outcomes, and the nature and supply of assisted living facilities.

While most of the studies do not state a professional perspective or state implications for a particular profession, Doherty and DeWeaver (2002) and Sales et al. (2005) emphasize the role of clinical social work in providing education about assisted living options to older adults, and in supporting client choice and autonomy in the

decision to move to an assisted living facility. Aud (2004) and Aud and Rantz (2005) provide recommendations for nursing practice in assisted living, and Lyketsos et al. (2007) provide clinical recommendations for the profession of geriatric psychiatry.

The impact of dementia on assisted living admission and discharge decisions and outcomes is the primary topic of four studies, involving both qualitative and quantitative methods (Kopetz et al., 2000; Aud, 2004; Mead et al., 2005; Lyketsos et al., 2007). In addition, Hyde et al. (2007) published a literature review on the topic of assisted living residents with dementia. While the scope of this study is limited to the admission and discharge policies and practices of assisted living, the study of dementia in all aspects of assisted living is recognized as a potentially growing field and an area of potential for future research.

Due to the relative lack of national policy to provide a definition and parameters to assisted living in the United States or Canada, the term "assisted living" may be used to refer to a variety of facilities and services throughout the United States and Canada. For this reason, assisted living from different regions may not be comparable, and thus assisted living literature from different regions may suffer the same limitation. Further research is needed to determine the consistency of use of the term "assisted living" in different regions.

Four Major Themes in Empirical Literature

I identified four major themes in assisted living literature that are concerned with the processes of admission and discharge of residents. These themes are descriptions of admission and discharge criteria, issues of decision-making and choice in the admission

and discharge processes, length of stay as a measure of aging in place, and discharge outcomes.

Admission and Discharge Criteria

I found three types of quantitative studies of resident admission and discharge: studies of resident profiles in a single facility (Kopetz et al., 2000; Aminzadeh et al., 2004), surveys of several facilities in more than one city (Chapin & Dobbs-Kepper, 2001; Hawes et al., 2003), and secondary analyses of multi-state surveys (Phillips et al., 2003; Golant, 2004; Aud & Rantz, 2005). In addition, Aud (2004) and Mead et al. (2005) conducted qualitative interviews to identify factors that lead to resident discharge.

Admission and discharge criteria together influence resident length of stay and capacity to allow for aging in place (Golant, 2004). An individual's increased need for assistance with activities of daily living is a common reason for admission to assisted living facilities, but studies are lacking in precise indicators of eligibility for admission based on increased medical acuity or need for assistance (Aud & Rantz, 2005). Discharge criteria was reported more frequently than admission criteria, and included assistance with transfers, moderate cognitive impairment, behavioural symptoms including wandering or resisting care, or requiring nursing care for over two weeks (Hawes et al., 2003), two-person transfers, bowel incontinence, cognitive impairment, or inability to pay for care (Chapin & Dobbs-Kepper, 2001), cognitive impairment, functional impairment, or severe behavioural problems (Phillips et al., 2003; Aud, 2004), severe dementia, depression, functional impairment, incontinence, wandering or falls (Kopetz et al., 2000; Aud, 2004), and cognitive impairment, depression, reduced mobility, incontinence, or increased need for assistance with activities of daily living (Aud &

Rantz, 2005). While some of the discharge criteria, such as the need for assistance with transfers, is quite specific, other criteria requires further clarification. For example, there is no research that indicates the degree of cognitive or functional impairment that would lead resident discharge, and how the level of impairment would be measured.

Discharge criteria tend to relate to the health or functional abilities of individual residents. However, Phillips et al. (2003) found that characteristics of facilities also affected the timing of discharge. In their review of national studies in the United States, residents of for-profit facilities were over three times more likely to be discharged than residents of non-profit facilities, and residents in facilities that did not have full-time RN services were twice as likely to be discharged than residents in facilities that had these services. According to Mead et al. (2005), the discharge of residents with dementia can be influenced by market conditions, staff retention issues, the staff's knowledge of dementia, the relationship between staff members and the resident, the level of advocacy and care provided by family members, and the degree to which the facility culture was "dementia-friendly" (p. 119).

Some assisted living facilities have special care units for residents with dementia. The discharge criteria for these units may be less restrictive due to the enhanced care that is provided on the units. In a study of assisted living facilities in Ottawa, all of the residents in special care units met eligibility requirements for nursing home placement in Ontario, but only 36.8% of other assisted living residents were eligible (Aminzadeh et al., 2004).

American national studies of assisted living facilities (Hawes et al., 2003; Golant, 2004), have found that admission criteria tend to be much more restrictive than discharge

criteria. In other words, facilities will only admit residents up to a certain level of care needs, but will retain residents as their care needs become more severe. Therefore, most assisted living facilities in the United States provide some degree of ability to aging in place in assisted living as care needs increase. However, some facilities will admit residents with certain conditions but not retain them; therefore, the facilities' discharge criteria are more restrictive than their admission criteria. In these cases, residents are admitted on the condition that their high care needs are temporary (Chapin & Dobbs-Kepper, 2001). The flexibility of an assisted living facility to respond to temporary increases in care is important to the facility's ability to allow residents to age in place despite relocation stress upon admission or temporary acute medical conditions.

While research has identified the admission and discharge criteria in the facilities under study, there is no data on the frequency of use of these policies, and the process by which the facility uses the policies in the discharge of a resident (Golant, 2004).

Admission and Discharge Decision-Making and Choice

Although admission and discharge criteria are important aspects of an older adults's ability to access assisted living services, they do not provide information about the involvement of the older adult and the facility in care choices. Phillips et al. (2003) found that most of the decisions regarding resident relocation were reported to be mutual decisions made by the resident or family and the facility.

Three studies (Ball et al., 2000; Eales et al., 2001; Doherty & DeWeaver, 2002; Mead et al., 2005) used qualitative interviews with residents to explore the extent to which they were involved in relocation and care decisions. Ball et al. (2000) found that assisted living residents were frequently able to exercise autonomy by making small, day-

to-day decisions such as when to eat a snack. However, the majority of residents reported little or no control over larger matters, such as the decision to move to an assisted living facility. In a study involving assisted living residents in Western Canada, Eales et al. (2001) identified a distinction between important life decisions and tacit decisions. Important life decisions are often associated with life transitions, such as the decisions to move to an assisted living facility, and involve an assessment of several alternatives. Tacit decisions are based on established patterns or habits in a person's life, such as a preference for certain types of leisure activities. Residents reported higher levels of autonomy in areas of tacit decision-making than in important life decisions. In a study of 41 assisted living residents in the United States, 78% reported that they did not have a choice to move to an assisted living facility (Doherty and DeWeaver, 2002). Many of the residents said that they would have chosen to remain at home rather than relocate to an assisted living facility if enhanced home care services were available.

Mead et al. (2005) conducted qualitative interviews with residents, family members of residents, facility owners, administrators, and staff to explore the decision-making process regarding the discharge of residents with dementia. The study found that discharge decisions could be delayed due to increased family caregiver support, resident advocacy by family members, or positive relationships between the resident and staff members. However, the facility manager was identified as the locus of control over resident discharge decisions, and the decisions of facility managers were influenced by market conditions, staff retention issues, and his or her understanding of dementia.

In Alberta, the client choice to move into subsidized assisted living is limited by a health region assessment that determines their eligibility for placement in an assisted

living facility. Furthermore, the choice of facility is limited by a single point of entry system, in which clients apply to the health region for admission to assisted living rather than applying to a specific facility (Eales et al., 2001).

Aging in Place: Discharge Criteria and Length of Stay

Aging in place is only one part of the assisted living philosophy, but it is a concept that has been studied through examinations of the admission and discharge criteria of assisted living facilities, resident retention policies, average length of residency, and discharge outcomes. The notion of aging in place is attractive to many older adults because the incidence of chronic conditions and disability increases with age, particularly for people over 80 (Spitzer et al., 2004). Aging in place aims to prevent frequent relocation, which among older adults can result in stress, social isolation, and a decline in physical and psychological functioning (Chapin & Dobbs-Kepper, 2001).

Despite the popularity of the assisted living philosophy, little research has been done on the extent to which facilities are able to incorporate the philosophy into daily operations at the facility. Findings from a national survey in the United States indicate that assisted living facilities that were part of a multi-facility campus, including other care options such as nursing homes, showed a greater capacity to allow residents to age in place by having more inclusive retention criteria and offering higher levels of nursing care (Hawes et al., 2003). Using qualitative interviews, Utz (2003) identified dilemmas that assisted living administrators face regarding aging in place, including quality versus cost of care, supporting autonomy versus ensuring safety and security, supporting resident preferences versus cost, and providing a home-like environment versus an institutional setting.

Hawes et al. (2003) found that aging in place is possible in assisted living to a limited extent. The American study, which spanned 34 states, concluded that most assisted living residents could age in place from relative independence to requiring moderate needs for assistance. However, most residents face relocation to other care settings when care needs become severe. Lyketsos et al. (2007) determined that assisted living residents in their study who were diagnosed with dementia, particularly those who did not receive pharmaceutical treatment or who have other medical conditions, had a higher risk of being discharged than residents without dementia.

One indicator of the opportunity of residents to age in place is the average length of stay in assisted living facilities. Reported length of stay varied in the research I reviewed, with reports of 2.36 years (Chapin & Dobbs-Kepper, 2001), 1.5 to 3 years (Golant, 2004), and 3.5 years (Aminzadeh et al., 2004). Length of stay can be measured in four ways: 1) a cross-sectional measure of the length of stay of current residents, 2) the length of stay of all residents to date, including current residents, 3) a longitudinal measurement of the length of stay of a cohort of residents, and 4) the length of stay of all residents who have died or been discharged from assisted living (Hyde et al., 2007). Chapin and Dobbs-Kepper (2001) asked facility administrators to estimate the average length of stay of their residents. Golant (2004), Aminzadeh (2004), and Lyketsos et al. (2007) measured length of stay through a cross-section of current residents. Longitudinal studies or studies of residents who have died or been discharged from assisted living would provide more accurate measurements of length of stay in assisted living.

Discharge Outcomes

Approximately 98% of assisted living residents in the United States reported that they expected to continue to live in assisted living as long as they want to (Phillips et al., 2003). However, most assisted living residents relocate, most frequently to nursing homes (Kopetz et al., 2000), and 78% of residents and their family members cited a need for more care as one of the reasons for the move (Phillips et al., 2003). Other common reasons for the resident and the family to choose relocation are costs associated with care, moving closer to family members, and dissatisfaction with the current facility (Kopetz et al., 2000). Compared with other outcomes, residents that relocate to nursing homes are more likely to be older, and have diagnoses of dementia, depression, or arthritis (Aud & Rantz, 2005).

While assisted living care is sometimes considered as an alternative to nursing home care, the ability of assisted living facilities to provide nursing home level care depends on the availability of nursing staff. The discharge outcome for residents is more likely to be relocation to a nursing home if the assisted living facility does not provide full-time nursing care (Phillips et al., 2003). However, assisted living may not be the most appropriate way to provide care for all residents. As yet, research has not suggested that residents with severe cognitive impairments can be cared for effectively in an assisted living setting (Phillips et al., 2003; Eckert et al., 2009), and relocation to a nursing home may be a preferable option to aging in place in assisted living for these residents. The high rate of resident discharge from assisted living facilities may be viewed as either a reflection of the increasingly high care needs of assisted living residents, or as a failure of assisted living facilities to provide an environment where

older adults can age in place regardless of medical need or cognitive or functional impairment (Golant, 2004).

In addition to transfers to other care settings, residents may also experience discharge from assisted living facilities through death. If assisted living facilities are truly facilities where residents can age in place as care needs change, assisted living facilities must be prepared to offer end of life care to residents. In the United States, an estimated 16% to 22% of assisted living residents die each year, and about 28% (Golant, 2004) to 33% (Sloane et al., 2003; Spitzer et al., 2004) of assisted living residents age in place within the assisted living facility until death. In a more recent review of assisted living literature, Hyde et al. (2007) found that an average of only 25% to 26% of assisted living residents remain in assisted living until end of life. While Sloane et al. (2003) found that assisted living facilities are able to provide good end of life care for their residents, the question remains whether assisted living facilities could provide adequate end of life care to residents with higher medical needs who had been discharged to nursing homes.

Although literature in the area of assisted living admission and discharge in Canada and the United States remains sparse, research exists in four topic areas: admission and discharge criteria, resident choice, aging in place and length of stay, and discharge outcomes. Of particular note among the available literature were the small number of studies from a social work perspective, and the limited geographic scope of quantitative surveys.

The Social Work Profession in the Literature

Although the body of research in the area of assisted living has increased substantially over the past ten years, research from a social work perspective is still quite rare. One possible reason for a relative lack of social work research in this area is that the social work profession is not as well represented in assisted living settings as it is in other health settings, such as Home Care, nursing homes, or acute care. In contrast, studies from a nursing perspective are more prevalent, possibly due to the common presence of the nursing profession in assisted living settings.

Within the literature that I collected about resident admission and discharge, only two studies are written from a social work perspective. Both focus on the clinical social work role of providing education, support, and referral to individual older adults and their family members. Doherty and DeWeaver (2002) conducted qualitative interviews with assisted living residents to explore the factors that led to assisted living admission and the degree of involvement that residents had in the decision to relocate. Sales et al. (2005) used mixed methods to investigate the characteristics that influence the choice of care settings for particular residents. In a study on the environments of assisted living facilities, Zimmerman et al. (2007) recognizes parallels between the person-in-environment theory of social work practice and the type of assessment required to match residents with appropriate assisted living facility environments. However, each of these articles stops short of identifying management and policy implications that are consistent with macro social work practice. More research is needed into the potential leadership or policy advocacy roles for social workers in the field of assisted living.

Finally, since I limited my literature search to empirical studies, the research that I reviewed was mostly descriptive of the current state of assisted living residency and care. There were few studies that speculated about potential changes to roles for health professionals in an assisted living setting, such as a greater involvement of social work in admission and discharge decisions.

Gaps in the Literature

Research into assisted living admission and discharge is an emerging field of study. Although the literature prior to 2000 is sparse, a body of literature has begun to develop over the past 10 years. Initial research in the area of assisted living was limited to industry reports and academic studies that included assisted living as a variation of existing types of residential care, but assisted living can now be considered a field of study in its own right. However, specific aspects of assisted living research, including examinations of the place of assisted living in the continuum of care for older adults, and the ways in which admission and discharge policies influence the ability of residents to age in place in assisted living or seek out other care options, still require further study.

Significant gaps in the literature are evident in the area of assisted living admission and discharge. More studies of Canadian assisted living facilities are necessary, especially given the inconsistency of the use of the term “assisted living” throughout Canada and the United States. More research is required into the qualities of assisted living residences, assisted living resident profiles, and the consistency of the use of the term “assisted living” to refer to this type of residential care. Research from a variety of disciplines is required in order to better define the often collaborative or

interdisciplinary nature of admission and discharge decisions, which may involve social work, nursing, business management, marketing, and other professions. Finally, more study in all areas related to assisted living admission and discharge is warranted, in order to expand the knowledge base in this area and test the conclusions of the few studies that are available.

In order to address some of these gaps, my research investigates the policies and practices of resident admission and discharge in assisted living facilities in Calgary, Alberta, Canada. Implications for social work practice and further research will be identified.

Research Questions

1. What are the resident admission and discharge criteria for assisted living in Calgary, Alberta?
2. How are the resident admission and discharge criteria interpreted by the facility and the health system in the processes of admission and discharge?
3. To what extent do the admission and discharge criteria of assisted living facilities in Calgary, Alberta allow residents to age in place?

Since admission and discharge criteria and policies differ throughout North America, the first research question inquires whether there is consistency among the admission and discharge criteria in assisted living facilities in Calgary, Alberta. The criteria themselves may indicate the degree to which assisted living in Calgary allows residents to age in place. More specifically, the criteria define the ability of assisted living

facilities in Calgary to allow residents to remain at the same facility as their medical, cognitive, and functional abilities and care needs change. For this reason, admission and discharge criteria may serve as one indicator of the ability of assisted living facilities to provide an appropriate environment for people with chronic, progressive, or degenerative illnesses.

The second research question leads to an investigation of how admission and discharge criteria are applied in the context of facility administration, contractual obligations to the former Calgary Health Region, and the preferences and involvement of residents and their families. Regardless of the degree of consistency of admission and discharge criteria in Calgary, the process by which admission and discharge criteria are applied has implications for the ability of assisted living facilities to allow for aging in place, encourage resident self-determination, and provide a viable care option for people who require an intermediate level of care.

Summary

In summary, assisted living is a growing but very diverse industry that provides services that fall between independent seniors housing and nursing homes. Although assisted living facilities are providing care to an increasingly cognitively impaired and medically advanced resident population, the parameters of aging in place in assisted living are not well defined. Further analysis of the admission and discharge criteria of assisted living facilities, especially in Canada, is required in order to determine the role of assisted living within the larger category of housing and care options for older adults. In addition, investigation into the extent of client choice in the admission and discharge

processes has implications for the role of social workers who work with older adults. Though sparse, the existing literature on resident admission and discharge in assisted living facilities informs this study of assisted living in Calgary, Alberta.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter outlines the process that I followed in order to investigate my research questions. First, I explain why I chose to use qualitative methods to explore my research questions. The chapter concludes with a description of the steps that I took to complete data collection and analysis.

Choosing a Methodology

My research questions focus on the question of the nature and characteristics of assisted living in Calgary, Alberta, and the decision-making process involved in resident admission and discharge. I chose to use qualitative methods, as they are the best fit for an exploration of my research questions. Janesick (2003) states that qualitative methods are well suited to a variety of research questions, including those concerning "the meaning or interpretation of some component of the context under study" (p. 51) or "participants' implicit theories about their work" (p. 52). Since my research questions pertain to the context of assisted living and to the process by which participants make resident admission and discharge decisions, I determined that qualitative methods were the best fit with my research questions.

There are a number of methods for carrying out qualitative research. The choice of one approach over another is determined by the research questions and the aim of the researcher. One way to conceptualize different qualitative approaches is by the focus of the research. Research that is focused on the characteristics of language includes content analysis or the ethnography of communication. Research focused on the meaning of text or action includes approaches such as phenomenology or hermeneutics. Research that

aims to discover patterns and themes includes approaches such as holistic ethnography, naturalistic inquiry, or grounded theory (Miles & Huberman, 1994). In this study, I have used a qualitative descriptive approach in order to identify and categorize themes that emerged from interview data, and discover the connections among these findings.

I chose a qualitative descriptive approach for this study because it is best suited to the exploration of my research questions. In order to investigate my research questions, it is necessary to gather information about different assisted living settings in Calgary and determine the common patterns and variation among them. A qualitive descriptive approach provides a framework for data analysis that uncovers regularities and important elements in the interview data (Miles & Huberman, 1994).

In qualitative descriptive methods, the research process is necessarily influenced by the point of view, knowledge, and experience of the researcher, because it is not possible to eliminate one's perspective or bias in order to conduct research as an objective observer. The research process is influenced by several factors: the researcher's past experience and interest in the research area, knowledge of the relevant literature through an initial literature review for the purposes of the research proposal, participation in the interview process, and perspectives of ongoing structural and policy changes in the area over time (Strauss & Corbin, 1994; Lempert, 2007). In an attempt to be as transparent as possible about my perspective and its possible influence on this study, I have included a description of my personal and professional point of view in this topic area. Further discussion on the topics of bias and trustworthiness can be found later in this chapter.

My Personal Experiences with Assisted Living

My first experiences in the area of residential care for older adults were as a volunteer visitor in nursing home settings in New Brunswick and Alberta. I had very positive interactions with older adults in this setting, but I found the structured, institutional environment to be very unwelcoming, unattractive as a place to live, and separate from the local community. I also found the high concentration of residents with severe physical and cognitive impairments to be overwhelming.

After completing my BSW, my first job was at the Alzheimer Society of Calgary. In this role, I provided education, support, and referral to people with dementia and their family members and friends. Within this context, I worked with many clients who were considering a move to an assisted living facility for themselves or their family members. This experience led me to develop mixed feelings about assisted living as a care option for older adults. On one hand, I appreciated the home-like atmosphere of many newer assisted living facilities, the relative independence that assisted living offered residents in comparison to a more structured nursing home environment, and the flexibility of services available to private-pay residents. Such flexibility included residency and care for those who do not qualify for subsidized services through the (now former) Calgary Health Region, and shared suites that allow couples to remain together as care needs change. However, on the other hand I saw that many people could not afford to pay privately for these housing and care options, and the progression of dementia symptoms had the potential to lead to safety concerns, short lengths of stay, and uncertainty about the ability of a resident to remain at the assisted living setting until other care arrangements were made. Based on this experience, I came to the conclusion that assisted

living was a good care option for those who could afford it, for physically frail older adults with few care needs, and for people in very early stages of dementia provided that their symptoms did not progress quickly. I observed many clients who were confused about the various terms used for residential care options, including lodge, assisted living, supportive living, independent living, nursing home, continuing care centre, and long term care facility.

As a social worker, I was interested in the possible differences in accessibility and services provided in publicly-subsidized Designated Assisted Living compared to private-pay assisted living, and the involvement of residents and their families in the decision for them to remain in assisted living until end of life or leave for another option within the continuum of care. I viewed these questions through the lens of the person-in-environment approach, which allowed me to maintain a focus on the needs and preferences of older adults in Alberta while investigating macro-level research questions involving the policies and practices of assisted living admission and discharge.

The qualitative descriptive method is commonly used in social work research, in part because of the parallels between the processes of qualitative research and direct social work practice. Social work practice involves skills in client interviewing in natural settings, collection of data through multiple sources, and the modification of initial hypotheses to suit the particular situation of the client or participant (Sherman & Reid, 1991).

Participants

In total, I conducted ten interviews for this study. One interview served as a pilot test of my interview guide, and one participant withdrew from the study following in the interview, for a total of eight interviews that were included in the data analysis. One of the eight participants agreed to participate and allowed the interview data to be used in the analysis, but requested that the interview not be quoted in the final report. The fact that one participant withdrew from the study after viewing the interview transcript, and another participant refused to allow the transcript to be quoted suggests that they may have perceived some amount of personal or professional risk in participating in this study.

Two of the interviews at facilities with both DAL and private assisted living beds involved two participants from the facility: the Director of Care and Director of Marketing. The participants themselves identified the need for both people to participate in the interviews, since the admission and discharge of residents involved both roles. Thus, I had a total of ten participants, but only eight interviews. Since the participants who were interviewed together tended to either provide similar answers or choose which one will answer each question based on their role in the facility, the two individuals in each case were considered as one participant. In Table 7, Participants 2 and 3 refer to the interviews that involved both the Director of Care and the Director of Marketing.

TABLE 7: PARTICIPANT CHARACTERISTICS

Participant #	DAL	Private Assisted Living	Profession	Organization
1	•	•	RN	Private company
2	•	•	RN and Marketing	Private company
3	•	•	RN and Marketing	Private company
4		•	LPN	Private company
5		•	Management	Private company
6		•	LPN	Private company
7	•		RN	CHR Home Care
8	•		RN	CHR Transition Services

Six participants represented different assisted living facilities. Participant 7 was an employee of the Calgary Health Region who was affiliated with the DAL beds in two facilities, neither of which were the same as the first six participants. Participant 8 was not affiliated with a particular facility, but was involved with transitions to and from DAL beds throughout Calgary. Table 7 outlines the characteristics of each participant, including the type of assisted living for which they are involved in resident admission and discharge.

None of the participants were social workers. Although the profession of social work has established roles throughout the continuum of care in Alberta, including home care, other community support services, acute care, and nursing home care, the fact that there were no social workers suggests that social work is less well represented in the area of assisted living.

Obtaining Ethical Clearance

Due to the fact that my research participants included employees of the (now former) Calgary Health Region, I was required to submit an Application for Scientific,

Administrative and Ethical Review of Clinical Trials/Health Research to the Conjoint Health Research Ethics Board at the University of Calgary. As part of the application process, I created interview guides (see Appendixes A and B), a consent form (see Appendix C), and a call for research participants from assisted living facilities and the former Calgary Health Region (see Appendixes D and E). My proposal was accepted without any questions or requests for revisions.

Participation in this study involved very low risk, as no personal or health information was collected, and all information regarding the participants and their workplaces was removed at the point of transcription. All participants signed consent forms (see Appendix C) that described the study, including risks and benefits to participation, and their ability to withdraw from the study.

In order to ensure confidentiality, I removed all names and references to specific facilities during transcription. I sent each participant a copy of their transcript by e-mail for the purposes of checking for accuracy of the data and to demonstrate that all identifying information had been removed from the transcript. In addition, all data has been kept secure at my residence in a locked filing cabinet and on a password-protected computer. After the research is complete, any data on the computer will be transferred to memory sticks and erased from the hard drive of the computer. All data will be stored in a locked filing cabinet at my home for five years, in accordance with the requirements of the University of Calgary.

Participant Selection Process

Using a qualitative descriptive approach, sampling is focused on the selection of participants who are informed and knowledgeable about the research topic. The sampling

process begins with convenience sampling, in which participants are chosen based on their familiarity or experience with the topic area. In many cases, subsequent participants are chosen through the process of theoretical sampling, in which participant selection is focused on their ability to provide data to contribute to the further development of emerging theory (Morse, 2007). However, extensive theoretical sampling is not necessary. In cases such as this study, in which participants are selected from different subgroups, it is possible to begin with convenience sampling in each subgroup, then use theoretical sampling to select only one or two more participants in each subgroup to confirm or refute initial findings (Sherman & Reid, 1994).

Since qualitative interviews produce a large amount of data, the challenge of sampling is to select enough participants that sufficient data is collected, but not so many that the amount of data creates a barrier to effective analysis. Since a relatively small number of participants are involved in the study, it is possible to select participants from different subgroups, but comparison between subgroups is somewhat limited (Morse, 2007). In the case of this study, subgroups included participants from facilities with DAL beds, participants from facilities with only private beds, and employees of the former Calgary Health Region.

Defining the Participant Population: Assisted Living Facilities

I chose research participants from assisted living facilities and from the former Calgary Health Region's Home Care and Transition Services teams. The Calgary Health Region participants were chosen through a separate process, which will be described following the facility selection process.

As of April 2007, a complete listing of all licensed supportive living facilities in Alberta has been available through the Ministry of Seniors and Community Supports. However, when I was developing my research design and sampling procedures earlier in 2007, there was no definitive list of assisted living facilities that was publicly available from the Province of Alberta. I was able to compile a list of facilities with assisted living beds using a list of Designated Assisted Living facilities from the former Calgary Health Region (Calgary Health Region, n.d.), and a list of facilities offering private assisted living services that is distributed through the Kerby Centre in Calgary (Kerby Centre, 2007). I also searched the InformAlberta database, which provides listings for health and community services across Alberta. I searched using the terms "assisted living" and "supportive living", but found the database to be incomplete in its listing of DAL sites. Private assisted living facilities are also absent from this database because its mandate is to list only public and non-profit services. Since the lists from the Kerby Centre and the former Calgary Health Region included facilities in Calgary and the surrounding rural area, I removed all facilities that were located outside of Calgary city limits to match the geographic limits of the study.

When Alberta Seniors and Community Supports launched the Supportive Living Public Reporting website (Alberta Seniors and Community Support, n.d.c), I compared the list that I had created with the provincial list of licensed assisted living facilities. In addition to facilities for older adults with increasing care needs, the provincial list of licensed assisted living facilities includes facilities funded and staffed for the care of people with developmental disabilities. I did not include these facilities in my sample population. However, the categorization and licensure of these facilities as assisted living

raises questions for further research into the definition and characteristics of assisted living for people with developmental disabilities. In addition, further research will be needed regarding the housing and care services available for an aging population of people with developmental disabilities who will increasingly experience physical frailty and/or dementia, resulting in increased care needs.

My final list of facilities was similar to the provincial listing of licensed assisted living facilities in Calgary. One facility on the provincial website was missing from my original list, as it was constructed after my sample was chosen. Four facilities were listed in the Kerby Housing Directory as private assisted living but are not currently licensed supportive living facilities. Their absence from the list of assisted living facilities is likely due to a subsequent classification as home living rather than supportive living. Since none of these facilities participated in the study, they have been removed from the list to more accurately reflect the sample of assisted living facilities in Calgary. The list of assisted living facilities that were eligible for my study can be found in Table 8.

Defining the Participant Population: Calgary Health Region

The former Calgary Health Region included two teams of registered nurses that were involved in the admission and discharge of assisted living residents: Transition Services and Home Care. Transition Services is responsible for transitions of people from the community, acute care, or nursing home settings to DAL, other supportive living settings, and nursing home facilities. I chose to contact the Transition Services team that is responsible for transitions to and from home and community living settings, including DAL. Although Home Care provided a variety of services to clients in home living and community living settings, the Home Care DAL team was responsible for the monitoring

TABLE 8: ASSISTED LIVING FACILITIES IN CALGARY (OLDER ADULT)

Residence	**Management; Headquarters location**	**Organization Type**	**Types of Care**	**Assisted Living Capacity**
Bethany Calgary	Bethany Care Society; Calgary, AB	Non-profit	Private Assisted Living	19
Beverly Estate	AgeCare; Calgary, AB	For-profit	DAL Private Assisted Living	22 78
Eau Claire Retirement Residence	Chartwell Seniors Housing REIT; Mississauga, ON	For-profit	DAL Private Assisted Living	45 110
The Edgemont	Revera Retirement; Mississauga, ON	For-profit	DAL Private Assisted Living	31 111
Fountains of Mission	Allegro Residences/ Maestro Group; Montreal, QC	For-profit	Private Assisted Living	102
Garrison Green Seniors Community	United Active Living; Calgary, AB	For-profit	Private Assisted Living	150
Lake Bonavista Village Retirement Community	Diversicare Canada; Mississauga, ON	For-profit	Private Assisted Living	225
The Lodge at Valley Ridge	Diversicare Canada; Mississauga, ON	For-profit	Private Assisted Living	150
The Manor Village at Garrison Woods	Manor Village Life Centres Inc./ The Statesman Group; Calgary, AB	For-profit	Private Assisted Living	170
The Manor Village of Huntington Hills	Manor Village Life Centres Inc./ The Statesman Group; Calgary, AB	For-profit	Private Assisted Living	150
The Manor Village at Rocky Ridge	Manor Village Life Centres Inc./ The Statesman Group; Calgary, AB	For-profit	Private Assisted Living	150
The Manor Village at Signature Park	Manor Village Life Centres Inc./ The Statesman Group; Calgary, AB	For-profit	Private Assisted Living	150
Masterpiece Evergreen	Masterpiece, Inc.; Calgary, AB	For-profit	Private Assisted Living	308

McKenzie Towne Retirement Residence	Revera Retirement; Mississauga, ON	For-profit	DAL Private Assisted Living	42 118
Millrise Place	Triple A Living Communities Inc.; Calgary, AB	For-profit	DAL Private Assisted Living	30 110
Monterey Place	Triple A Living Communities Inc.; Calgary, AB	For-profit	DAL Private Assisted Living	40 70
Peter Coyle Place	Trinity Place Foundation of Alberta; Calgary, AB	Non-profit	Private Assisted Living	70
Prince of Peace Manor	EnCharis; Calgary, AB	Non-profit	Private Assisted Living	129
The Renoir Retirement Residence	Revera Retirement; Mississauga, ON	For-profit	DAL Private Assisted Living	39 121
Rouleau Manor	Enterprise Universal; Calgary, AB	For-profit	Private Assisted Living	100
Royal Park Retirement Residence	Chartwell Seniors Housing REIT; Mississauga, ON	For-profit	Private Assisted Living	120
Scenic Acres Retirement Residence	Revera Retirement; Mississauga, ON	For-profit	DAL Private Assisted Living	26 120
Seniors Residence at the Colonel Belcher	Chartwell Seniors Housing REIT; Mississauga, ON	For-profit	DAL Private Assisted Living	30 170
Staywell Manor Village at Garrison Woods	Manor Village Life Centres Inc./ The Statesman Group; Calgary, AB	For-profit	Private Assisted Living	210
Sunnyhill Wellness Centre	Northwest Property Corporation; Toronto, ON	For-profit	DAL	38
Trinity Lodge	Diversicare Canada; Mississauga, ON	For-profit	Private Assisted Living	240
Wentworth Manor – The Court	Brenda Strafford Foundation; Calgary, AB	Non-profit	DAL	40
Wentworth Manor – The Residence	Brenda Strafford Foundation; Calgary, AB	Non-profit	Private Assisted Living	102
The Westview	MCF Housing for Seniors; Calgary, AB	Non-profit	Private Assisted Living	190

Whitehorn Village	Origin Retirement Communities; Toronto, ON	For-profit	DAL Private Assisted Living	50 100

(Kerby Centre, 2007; Calgary Health Region, n.d.; Alberta Seniors and Community Supports, n.d.c)

and oversight of the contracts through the former Calgary Health Region for DAL accommodation and care. Together, these two teams comprised the list of possible participants from the former Calgary Health Region.

Selection of Participants

I mailed each facility a package inviting them to participate in my study, including a description of the study (see Appendix D) and a copy of the interview guide for assisted living facilities (see Appendix A). The description of the study included an invitation to contact me to participate in the study, and a statement that I may contact some of them to follow up. One facility representative contacted me, and declined participation, citing lack of time due to staff shortages.

When contacting the facilities, I telephoned the main contact number and asked to speak with the person who was most responsible for the admission and discharge of residents. At some residences, I was referred directly to the person who I eventually interviewed. At other residences, I explained the purpose of my research to more than one person before the appropriate interviewee was selected. At two facilities, I interviewed two staff members.

I selected Home Care and Transition Services participants by contacting the Home Care team responsible for the monitoring of DAL contracts, and the Transition Services team responsible for transitions from the community. Both managers received

an overview of the study (see Appendix E) and copies of the consent form (see Appendix C) and interview guide for Calgary Health Region participants (see Appendix B). Both of these teams were comprised of Registered Nurses who had a defined role in the admission and discharge of DAL residents.

The Home Care manager responded to my request by sending me the contact e-mail for two participants. I was not told if the participants had volunteered or been chosen by the manager to participate. The Transition Services manager invited me to attend a team meeting to invite team members to participate. Two Transition Services team members contacted me after the meeting and volunteered to participate. Only two Calgary Health Region participants contributed data to the study, as one participant was interviewed as a pilot test of the interview guide, and another requested that her interview data be withdrawn.

Although all participants signed consent forms and voluntarily participated, the selection of the participants from the Calgary Health Region presents a potential source of bias within my selection process. My interaction with potential participants on both teams was mediated by the team managers. Managers may have asked certain team members to participate over others, or participants may have felt pressured to volunteer.

Since the Home Care and Transition Services participants self-selected for the study, I was not able to influence the geographic representation of these participants. However, I was able to select which assisted living facilities participated based on which ones I chose to follow up with by telephone after the initial written invitation to participate. I identified facilities from the list (see Table 8) that were located in different geographic areas of the city, including central Calgary and the four quadrants of the city:

NW, NE, SW, and SE. Three of the facilities had DAL beds, and three of the facilities had only private assisted living options. Two of the facilities were located in a campus of care setting close to other housing and care options for older adults. I also ensured that each facility represented a different management company. I selected residences in this way in order to ensure that there was as much variety in my sample as possible.

Trustworthiness in Sampling Process

The purpose of trustworthiness in a qualitative study is to support the claim that the findings are "worth paying attention to" (Lincoln & Guba, 1985, p.290). There are four aspects of trustworthiness: credibility, transferability, dependability, and confirmability. Credibility refers to the process undertaken to ensure that data accurately reflect the reality of the situation being studied. Transferability refers to the extent to which the findings of the study apply to other situations outside the context of the study. The dependability of a study concerns how research methods were used consistently and accurately throughout the course of the study. Finally, confirmability refers to the degree to which the findings of the study are supported by the data (Lincoln & Guba, 1985). The methods used in this study to ensure credibility, transferability, dependability, and confirmability are listed in Table 9 and discussed throughout this chapter.

In order to ensure the credibility of the results of my study, it was necessary to collect data that accurately reflected the reality of assisted living admission and discharge in Calgary, Alberta. I recruited participants who were familiar with how resident admission and discharge decisions are made, and investigated initial findings across various categories of assisted living. I used the technique of triangulation, which refers to

collecting data from different sources (Lincoln & Guba, 1985; Krefting, 1991), by selecting participants from different assisted living settings and roles.

I ensured that the participants were well informed and experienced with the topic by describing the requirements of participation to the facility administrator, and allowing facilities to recommend participants who are familiar with the process of resident admission and discharge. Although it is a potential source of bias to request facilities to recommend appropriate participants, I found that the facility administrator and staff were in the best position to identify the most knowledgeable participants within their facilities.

In order to address the issue of transferability, I provided "thick description" (Lincoln & Guba, 1985, p. 125) of the context of the study and of the research participants. My process of purposive sampling also improved the transferability of this study, as the sample is inclusive of a broad range of assisted living settings in Calgary, Alberta. As a result of these methods to improve transferability, the results of this study can be applied to assisted living settings and contexts that are deemed to be similar to the settings and context of this study.

Data Collection

Interview Guides

I used semi-structured interviews to collect data. I created two interview guides: one for use with employees assisted living facilities and one for employees of the former Calgary Health Region (see Appendices A and B). The interview guides are identical except for the wording of questions that refer to either a specific facility or the DAL beds in different facilities for which the participant makes decisions. In addition, the interview

TABLE 9: ASPECTS OF TRUSTWORTHINESS IN QUALITATIVE METHODS

Aspect of Trustworthiness	Methods Used in This Study
Credibility	Triangulation Member checks
Transferability	Provide thick description Theoretical sampling
Dependability	Code-recode process
Confirmability	Practice reflexivity Leave and audit trail

(Adapted from Guba, 1981)

guide for Calgary Health Region employees includes a question about the nature of their role in monitoring the DAL contracts.

Both interview guides contain open-ended questions about assisted living and aging in place, followed by questions about resident admission and discharge criteria and the processes involved in admission and discharge. I also included questions that provide lists of possible criteria for admission and discharge that were taken from the literature. Initially, the lists of criteria were intended to be used as prompts. However, I decided to include the lists as full questions on the interview guides in order to facilitate discussion. As I note in the following discussion of data collection, participants provided more information about admission and discharge criteria by responding to the lists of criteria followed by open-ended questions about the policies in their facilities rather than an open-ended question alone.

Collecting and Transcribing Data

I conducted my first interview as a pilot test of the interview guide. Pilot testing involves examination of the interview guide by others who are familiar with the topic, and practice interviews (Berg, 1995). My interview guide was edited by my thesis supervisor, and then tested through an interview with the first study participant. I made

two observations during the pilot test. I noted that the participant was not able to provide a list of admission or discharge criteria without prompts. Rather than expecting participants to provide a list of criteria in response to questions 7 and 14, I accepted a very brief answer, moved directly to the questions about specific criteria from the literature, and relied on the open-ended questions 9 and 16 to provide more detailed information specific to each facility (see Appendices A and B). Secondly, I found that the participant preferred to describe the process of resident admission and discharge as one complete story rather than respond to a series of questions. Following this observation, I began the sections of questions about admission or discharge process by asking participants to describe the process in full. I used the other questions in the interview guide as prompts if participants did not address them in the initial response. Although I incorporated these observations into subsequent interviews, I did not make any written changes to the interview guides.

In order to ensure that I collected data from a variety of assisted living contexts, I recruited participants from facilities with DAL beds, facilities with only private assisted living, and the Calgary Health Region. As much as possible, I scheduled the interviews in an alternating pattern between the participant categories. By collecting data from all three categories in an alternating pattern, I could identify themes that emerged within each category, and ask about emerging themes in more detail in subsequent interviews with participants in the same or other categories. For example, during my first interview with a participant from a facility with only private-pay beds, the participant told me that the facility does not describe its services as assisted living. Following that interview, I began to ask participants not only about their definition of assisted living, but also prompted

them to define how they identify the services they provide. My early identification of this possible theme resulted in an important comparison between facilities with and without DAL beds.

All interviews were scheduled at least one week ahead of time, and copies of the interview guide and consent form were sent to the participant for review before the interview. In this way, participants were given the opportunity to prepare their responses. All interviews took place at locations chosen by the participants. In each case, the participants chose to meet at their workplace in a private office or meeting room. Each interview lasted between 45 and 75 minutes, depending on the length of responses provided by the participants. Interviews were recorded with a digital voice recorder and transcribed within 30 days to ensure accuracy of the data and to allow the transcript to be submitted to the participant for review in a timely fashion.

My experience with the data collection process was generally positive, with a few exceptions. I found, as noted by Sherman & Reid (1994), that positive interactions with participants can be a benefit to data collection, because it allows for the development of trust and the openness to sharing detailed, relevant information. Participants representing assisted living facilities were all very willing to participate in the study, scheduled the interviews within weeks of my initial telephone contact, and appeared to be very comfortable answering the interview questions. In contrast, interviews with CHR employees took place several months after initial contact with the managers. In both cases, the managers appeared to be reluctant to allow me to request participation from their staff. I was invited to the Transition Services team meeting to give a presentation about my research and the opportunity to participate in the study. The team members

asked me several questions about how the data would be used, and I felt as though many of them were suspicious that the study would be used to portray their work in an unfavourable light. I thoroughly explained the purpose of the study, confidentiality guidelines, and how their interview data would be used. The day after the presentation two members of the team e-mailed me and agreed to participate.

The qualitative descriptive approach involves simultaneous data collection and analysis. For this reason, the processes of data transcription and analysis began immediately after the first interview and continued until after the final interview. After each interview, I transcribed the interview data, removed all names of people, facilities, and facility management companies, and e-mailed the completed transcript to the participant for review. I requested that the transcript be reviewed for accuracy, and that any changes be sent to me within two weeks. One participant withdrew after reading the transcript, stating that the information was too fragmented. Another participant allowed interview data to be used in the data analysis process, but not to be quoted in the final report. All other participants allowed their transcripts to be used without changes.

Although I did not gain access to the Atlas.ti software until over half of the interviews were complete, I did begin the initial data analysis process through conducting the interviews and transcribing all interview data myself. Over the course of the interviews, data transcription and subsequent re-readings of the transcripts, I developed a close familiarity with the data and emerging patterns within it. I identified emerging patterns in the initial interviews, such as the safety of residents, the physical and social environment of the facility, and the use of external caregiving resources. In subsequent interviews, I explored emerging patterns in greater detail through spontaneous questions

or prompts in order to confirm, refute, or further develop the concepts. After all eight interviews were complete, I was able to identify patterns within the data and understand the complexity of the topic of assisted living admission and discharge. Through my data collection and initial data analysis, I determined that I had collected enough data to reach the point of data saturation. Data saturation is the point at which new data no longer significantly contributes to the data analysis (Morse, 2007).

Trustworthiness in the Data Collection Process

Member checking, which is the process of confirming the accuracy and relevance of the data and initial findings with research participants, is a strategy for improving the credibility of a study (Krefting, 1991). As part of my data collection process, I sent the interview questions to participants in advance so that they could prepare their answers. I recorded each interview to ensure the accuracy of the data, and I transcribed the interviews verbatim. As I finished transcribing each interview, I conducted member checks by e-mailing each participant a copy of their interview transcript and asking them to confirm that the data was accurate. None of the participants requested changes to the transcript. One participant confirmed that the interview data was accurate, but requested not to be quoted in the final research report.

The main technique for supporting confirmability is to establish an audit trail that allows future researchers to understand the process of the study and confirm the findings (Lincoln & Guba, 1985). All records from this study, including data collection instruments, interview audio files, transcribed interviews, and process notes will be stored at my home for a period of five years to allow for an audit of the study by another researcher.

Data Analysis

Analysing the Data

The data collection and data analysis processes began simultaneously. Since I carried out each interview and transcribed the data, I was able to familiarize myself with the data and begin to identify common themes from the time of the first interview. Once I obtained access to Atlas.ti software, I entered the interview transcriptions and began a more systematic coding process. I used Atlas.ti as a tool for organizing the transcribed interview data, categorizing similar pieces of data into codes, writing memos, and identifying the larger families or themes indicated by the relationships between the codes.

Codes are "labels for assigning units of meaning to the descriptive or inferential information compiled during a study" (Miles & Huberman, 1994, p.56). The initial process of coding involves identifying meaning units and creating appropriate codes for each meaning unit. Codes must be specific enough to help the researcher to identify and categorize data in a meaningful way. However, they must also be general enough to allow the possibility that many quotations will be assigned the same code. Although I was able to identify some initial codes through the process of data collection, transcription, and continued rereading and reflection on the data, the process of coding on Atlas.ti allowed me to identify every instance of each code, view the codes in a comprehensive list, write memos that explain the characteristics of codes, and create reports that list all quotations in each code.

Codes can be merely descriptive of a segment of the data, or they can be interpretive of the context in which the data is situated (Miles & Huberman, 1994). For example, I used the descriptive code "admission Pathways system" to identify instances

when participants spoke directly about the Pathways computer program. I used the interpretive code "Leadership and power in facility" to identify quotations that referred to the decision-making power of facility management, even if the participant was not directly addressing this topic in the quotation.

There are several coding methods that are used in qualitative research. For example, Miles and Huberman (1994) describe the process of creating a master list of codes prior to data collection. In contrast, when using the grounded theory approach described by Glaser and Strauss (1967), codes are not created until the researcher has become familiar with the data and discovered the themes and patterns present in them. Coding can also take place line-by-line; that is, by examining one line of data at a time and assigning codes to these small meaning units (Charmaz, 2003). The line-by-line coding technique allows the researcher to focus on small units of data, thereby ensuring that codes emerge from the data rather than preconceived generalizations of the researcher. I used a combination of the latter two coding methods. Before applying any codes, I became familiar with my interview data through the transcription process and by re-reading the transcripts. Once I entered the data into Atlas.ti, I reviewed the data line-by-line in order to create and assign initial codes.

The coding process took place over 18 months, which allowed me the time to conduct initial coding on an interview, leave the data for several weeks, then return and recode. This process of coding, reflecting, and recoding resulted in a more refined series of codes, ensured that quotations were correctly assigned to each code, and improved my data analysis skills as a researcher.

I found the memo function in Atlas.ti to be a useful tool for making notes about the meaning of each code and the criteria that was used to assign the particular code to quotations. For example, I created a memo "Certainty" to outline the criteria that I used to apply the code "Certainty" to a quotation about admission or discharge criteria: the participant answered quickly, usually gave a yes or no answer, and provided little description. I also took memos using Atlas.ti and in a notebook to track the development of broader themes and the relationship between codes. For example, I took notes in a notepad describing characteristics unique to the interviews from facilities without DAL beds: a hesitation to use the term "assisted living" to describe their services, and the use of hospitality terms such as "suite" rather than medical terms such as "bed". I then entered the memo into Atlas.ti and linked the memo with the applicable quotations. Thus, memos can be used to track both descriptive and analytical process (Lempert, 2007).

I undertook the process of identifying themes and emerging theory without the use of Atlas.ti software. Once I had completed my initial coding and memo-writing, I ran reports on Atlas.ti that listed each code followed by all quotations and memos that apply to that code. I then reread the quotations in their code categories, and began to identify larger themes and relationships between themes. For example, I found that the codes that involved descriptions of assisted living facilities fell into two categories. The codes "Assisted living definition", "Assisted living image", "DAL private differences", and "Continuum of care" contained quotations that described how participants understand assisted living as a care option, and the distinctions between different types of assisted living. The second category included codes such as "Facility as community", "Physical environment", "Supportive structure of community" and "Safe units", in which

participants described the physical and social environments of the facilities in which they work.

I wrote the larger themes on sticky notes and placed them on a wall so that I could view all of the themes at the same time and determine the relationships between them. I used sticky notes so that I could easily add emerging themes, remove less relevant themes, and place related themes and sub-themes in physical proximity to each other on the wall to create a visual image of emerging theory. I found that creating a visual pattern of sticky notes facilitated my discovery of relationships between codes and larger themes. Whenever I became unsure of the placement of a theme, I returned to the data and reread the quotations associated with the codes in that particular theme. In order to capture the changing themes and patterns, I took photographs of the notes on the wall after each significant change.

Through the process of identifying themes and creating clusters of theme areas, I identified four major themes from my data: 1) the definition and types of assisted living, 2) aging in place in assisted living, 3) application of admission and discharge criteria, and 4) involvement of the facility and resident in admission and discharge decisions. Upon further reflection and rereading of the data, I determined that the first two themes act as a backdrop to the interrelated themes of the application of resident admission and discharge criteria and the factors that influence admission and discharge decisions.

Trustworthiness in the Data Analysis Process

Dependability can be increased by coding data over time through the use of a code-recode process (Krefting, 1991). Using this process, I coded short segments of data at a time, refrained from coding for a period of at least two weeks, then returned to the

data and reviewed the initial coding decisions, recoding as necessary. Since my data analysis process took place over 18 months, I was able to take the time necessary to reconsider my initial coding decisions and change certain codes to more accurately reflect the data.

The degree to which a researcher acknowledges and assesses the influence of his or her own past experience on the research process is referred to as reflexivity (Krefting, 1991). Throughout the research process, I held the roles of researcher, social work practitioner, and Master of Social Work student. Since my interest and experience with assisted living in Calgary necessarily influenced the study, from the choice of my research questions to the data analysis process, I reflected on my experience and biases by recording them in a journal and referring to these notes throughout the course of the study.

Summary

The process of participant selection, data collection, and data analysis described above resulted in the emergence of findings related to the three research questions. In the next chapter, I will outline the findings of the study regarding the definitions of assisted living and aging in place, and the influences of the resident and family, facility, and policy context on resident admission and discharge decisions.

CHAPTER FOUR: FINDINGS

Two major themes emerged from the data analysis. First, the participants' definitions of assisted living and aging in place demonstrate how each term is understood in the context of assisted living in Calgary, Alberta, and the degree to which aging in place is considered an expectation within the assisted living industry. Secondly, assisted living admission and discharge decisions are based not only on certain standard criteria, but also influenced by various characteristics of the resident and their family, the facility, and the policy environment.

Assisted Living Definition

In order to investigate the admission and discharge criteria in assisted living facilities, and the impact that these criteria have on the ability of residents to age in place, it was first necessary to establish what was meant by the term "assisted living." As was the case in the literature, there was no single definition used by participants, and not all of the descriptions were consistent. Participants reported definitions that included descriptions of assisted living philosophy, the place of assisted living in the continuum of care for older adults, the amount and type of care provided in assisted living, and the similarities and differences between DAL and private assisted living.

Social Model of Care; Assisted Living Philosophy

Some participants described assisted living in terms of a social, in contrast to a medical model of care, or in terms of a philosophy that was different from other care options. The concept of resident independence was emphasized by participants as a central element of the assisted living philosophy.

> **Participant 1:** *This is a social model of care. It's not a medical model of care. And then they would move from the social model to the medical model, where their needs increase.*

> **Participant 2:** *The way that I always describe it to families from a nursing perspective is that assisted living is meant to assist the resident, to provide for their needs to maintain them to be as independent as they can possibly be. So that could be related to behaviours, it could be related to just what we call activities of daily living, where they're doing, you know, getting dressed, things like that.*

Some participants understood resident independence in terms of residents experiencing privacy within their suites, but having access to the assistance they need within the facility at their request. In the following quotation, nursing staff refers to licensed practical nurse (LPN) care available 24 hours per day, and registered nurse (RN) care available on-call.

> **Participant 3:** *Assisted living is living somewhat independently. The only difference is when you go outside your door there's nursing staff that can assist you with medications and things, whatever-, it's very individual for each person why they're here, but they just get a little bit more assistance than they would in their own home.*

> **Participant 4:** *Assisted living is just, I think for our environment, simply, um, put, it's individuals who require assistance, um, with their ADL's, and that could mean five minutes of assistance, that could mean they simply need meals prepared for them. Uh, it's highly individual.*

The social model of care that is associated with assisted living can allow assisted living facilities to market themselves a housing option for older adults who have very few care needs. The following quotation illustrates how a participant describes the particular facility as appropriate for individuals who may also be considering housing without care services. The participant defines the facility and its services as being at the beginning of a continuum of housing and care options.

> **Participant 5:** *I see us right at the beginning of people realizing okay, inevitably my health is going to change. I wanna make that change now while I'm still able*

> *to enjoy some of the things that that facility might, might offer, and, um, so that's us, and then as well, we move into the next stage because we do have the suppor [sic], because we're offering the support. Um, so we're right at the beginning. There's some places in front of us would not have any nursing care… So they'd be the same as us, except they're not, they're not extending that person's stay.*

One Step in the Continuum of Care

While the social model of care in assisted living may be viewed as an alternative to nursing home care, it was most frequently described as a step along the continuum of care. Rather than being an alternative to a medical model of care, assisted living provides a level of care that is between home or lodge living and nursing home care. These descriptions tended to focus on staffing and hours of care required.

> **Participant 1:** *We're a niche. We're a, the cog in the wheel between being totally independent and needing, um, increased care in a long term care facility. So people come to us that are, um, needing some assistance perhaps with medications, they're getting mixed up, they definitely need to have a supportive environment where their meals are prepared for them. Um, and security, that they're safe and that there is staff here 24 hours a day if they have any problems. It's really care in the community. It's care at home. Um, so if we have a major problem, we dial 911 and off they go to acute care. We don't have doctors on staff. Um, the majority of our staff are home health care aides, and an LPN on each shift.*

> **Participant 3:** *Independent living is basically independent living, you're living independently, so that one's pretty self-explanatory. Um, lodge level is not quite at an assisted living level. You're still expected to do quite a few things on your own. You may just get the meal assistance is really what you're getting at the lodge level. Um, once you're past the lodge level, then you're looking at assisted living where you're getting the more nursing care. You're starting to get to that stage where you need some-, a nurse on 24 hours a day because you have a medical condition that, you know, we need to provide that care. Um, and then you're looking at a nursing home stage. You're basically at a point where you need full-time hospital environment. So that's pretty much the difference between the different facilities.*

Assisted living falls into the continuum care between home living on one hand, and nursing home care on the other (see Table 3). However, the continuum of care also involves a variety of other care options, including acute care, auxiliary hospitals, group

homes, and private nursing that can provide or supplement care in a variety of settings. The care options along this continuum may overlap, in which case more than option may be available to an individual. The continuum may also have gaps, in which an individual may face barriers to receiving the type or amount of care that they need in the environment of their choosing. One participant described a recent policy change that would allow assisted living facilities some flexibility in order to accommodate temporary needs for higher levels of nursing care.

> **Participant 7:** *There used to be. There used to be kind of this, um, 2-hour cap that they would give, but now all that's changing. Um, they are trying to accommodate if somebody requires increased care temporarily, um, the Region will pay for the facility to increase the staff for that time, as long as the care plan, as long as the nurses, um, change the care plan and see those hours are needed, then they will fund it.*

Even when the decision has been made for a resident to be discharged due to increased care needs, the facility may be able to retain a resident until a nursing home bed becomes available.

> **Participant 4:** *But we will, at the same time, I will add that we will hold onto you and care for you until that long term care bed becomes available.*

However, it is not always possible to retain residents in assisted living in order to wait for a preferred nursing home placement. Aging in place in assisted living is only possible up to a certain level of care needs, and the process of discharge may be accelerated if needs progress too quickly or a preferred placement does not become available quickly enough. In such a case, Transition Services would place the resident in the first available nursing home bed in Calgary that could meet their care needs.

> **Participant 3:** *You know, we try to accommodate up to a certain amount, but we can only provide, like I said, so much care.*

> **Participant 3:** *Typically yes, you, you want to go with the first available bed, but some families aren't necessarily uh, very perceptive to that, right? But we try. We*

> *try to work with the families. You know. It's a difficult situation, I think, so we try not to uh, push too much but at the same time, you know, we want to find that they're… proper care needs.*
>
> **Participant 7:** *Now the only thing is, if they're going to age in place, we have to be able to assure that we can provide them the care they need… So, um, if we know that we won't be able to meet their care needs, then they have to go first available bed.*

In some cases, the facility will formalize the agreement to retain a resident in the assisted living facility while waiting for nursing home placement through a managed risk agreement. These agreements, between the assisted living facility and the resident or family, outline the risks that are involved in continued assisted living residency, and the agreement that the facility and resident or family have reached regarding these risks. Managed risk agreements are reviewed periodically, and if the risk is assessed as being too great, the resident may be discharged before a preferred placement is available.

> **Participant 1:** *Some people, um, will opt to live at risk. Um, we do have them sign a managed risk agreement. If they say, okay, they need to go, but we want to wait for our, for the long term care facility, uh, so we sit down and put together a managed risk agreement that says that they agree to have them live at risk, da da da, for these reasons, and that we will review it every three months if that's appropriate. Sometimes we'll say within a month, you know, we need to review this because it's getting impossible. And then they're usually, um, pretty reasonable once they start to listen to, you know, you don't want your mother to be on the floor for 5 hours with a broken hip, and that's a possibility. You know, if they don't ring their buzzer, or they don't have the ability, uh, the cognitive ability to know that they should ring that buzzer anymore? You know, those are things that, and they don't want that to happen.*

Defined Amount or Type of Care

While assisted living may be defined using the concepts of a social model of care or a specific place on the continuum of care, it may also be described in terms of the amount and type of care that is provided in assisted living facilities.

Although two participants defined assisted living by the maximum hours of care provided, the maximum number of hours and type of care varies by facility. In the following examples, Participant 3 is referring to a facility with both DAL and private assisted living, and Participant 4 is defining the private assisted living services at that facility, in which care is provided by both facility staff and (former) Calgary Health Region Home Care staff.

> ***Participant 3:*** *Up 'til long term care basically. Once you're over the five hours of nursing care, then you are looking at long term care.*
>
> ***Participant 4:*** *Again, that comes down to the two hours, right? … That's what we provide. Um, if it's more than two hours of personal care that they require, we call in Home Care to supplement our care. Anything over four hours is long term care.*

Assisted living is defined not only by the amount of care available to residents, but also by the type of care, and whether the care can be scheduled or not. An example of scheduled care, as explained by Participant 7 in the following quotation, is a resident who requires assistance changing a colostomy, because the assistance can be provided at a planned, predictable time. An example of unscheduled care could be a resident with bowel incontinence who is not able to manage his or her own personal care and requires immediate assistance at unpredictable times. The following examples indicate that DAL includes 24-hour availability of LPN care, so that unscheduled care needs within the LPN scope of practice can be accommodated.

> **Participant 7:** *But, um, it's the person who requires, um, like unscheduled LPN 24/7. And a good, um, example would probably be like a diabetic. Or, um, say, somebody who has a colostomy and they're blind, and they need assistance with changing that colostomy… And they don't have any family in community, or anyone living with them that could assist. Um, yeah, it's hard, because they do need that assistance, but they're not at long term care level.*

> **Participant 7:** *So basically, like, it goes back to unscheduled… because we can't provide those unscheduled visits out in community.*
>
> **Participant 2:** *The difference between the independent and the assisted living would be that more unscheduled care, that's sort of how I refer to it, that 24 hour assistance that's there, as opposed to, when you're in independent living you have more scheduled things that you need, like maybe baths or meds but there's not someone there all the time to assist you unless it's an emergency.*
>
> **Participant 2:** *Very specific care needs, like maybe slipping on pressure stockings, whereas the people who need assisted living, their care can be more unpredictable and can change from day to day depending on how they're feeling or the particular day.*

One participant noted that it is sometimes difficult for individuals to qualify for assisted living because they must be simultaneously independent and in need of a certain amount of care that can not be provided in their home.

> **Participant 7:** *If their care needs can be met in their own home, um, like that's the ideal place for them to be.*
>
> **Participant 7:** *But, um, yeah, they do need to be very independent. That's the unfortunate part. So for them to meet the criteria sometimes it's difficult.*

All three participants from facilities without DAL beds described some or all of their services as specifically not assisted living, even when their services were consistent with other participants' definitions of assisted living and the definition within the Supportive Living Standards. All three of these facilities were licensed as assisted living facilities within one year of the interviews. These changes in terminology and licensing requirements reflect the fluid nature of the policy context in which assisted living is taking shape in Alberta.

> **Participant 4:** *That if they require ongoing supervision and monitoring, that is not a criteria that fits assisted living… Assisted living is, is just that. If, if this is something that they require, then they require memory care… They require, they require a very structured environment. Assisted living is not structured.*
> **Interviewer:** *Okay. And would you consider the memory care unit to be a, a different type of assisted living? Or, or its own separate…*

> **Participant 4:** *No, it's its own separate entity… within the building. Um, it is strictly dementia. Not that we don't have people that are mildly impaired in assisted living; however, they're not to the point where they're getting lost.*

Two participants representing facilities with exclusively private assisted living defined the care provided in the facility as supportive living, not assisted living. However, their descriptions of the social model of care and available supports are consistent with assisted living. Since the interview, both facilities have been identified and become licensed through Alberta Seniors and Community Supports as assisted living facilities.

> **Participant 5:** *I would say assisted living is a higher level of care than we would ever offer here.*

> **Participant 5:** *What we call ourselves beyond independent is we give supportive living, so that it still supports them in their attempt to be independent in their, in their, you know, in their desire to be independent. Assisted is in fact, well there's more care needed, and you need, you know, ongoing assistance on a daily basis to maintain a routine.*

> **Participant 6:** *Okay, it's very loose. I would say that this is more supportive living, and the, the next step is assisted living, okay. So once a person can't cope… I guess the best way to, um, to define it is if there becomes a safety issue, both for the resident and for the community, then we look at the next step, which would be assisted living.*

Furthermore, a participant implied that assisted living necessarily involves subsidized care. This statement is in contradiction to the models of assisted living that focus on the type of housing, care, or hospitality services that are available. It is also in contradiction to the Supportive Living Framework, which includes both subsidized and private-pay assisted living options.

> **Participant 6:** *None of them are assisted living or designated assisted living; they're all private pay.*

Participants made distinctions and comparisons between the services offered in DAL and private assisted living settings. While DAL is provided under contract by the

(former) Calgary Health Region with the goal of providing care to residents, private-pay assisted living is provided under a business model that has two goals: providing care to residents and producing profits. In the following example, DAL residents were able to have unscheduled nursing care as part of the normal services they receive. In private assisted living, unscheduled nursing care would be considered an extra service.

> **Participant 7:** *The client needs to be fairly independent. Um, but the difference with DAL is they have that 24-hour support of, um, the LPN and the nursing assistant. Um, and there is an RN that needs to be available for that LPN 24 hours, so. I know with private assisted living they can't have unscheduled visits, but with DAL they can have unscheduled visits. So, say somebody's ill and they require, um, assistance during the night getting up to the washroom… They can do that in the DAL without having to put in extra time.*

DAL and Private Assisted Living

DAL and private assisted living are differentiated by the way that resident care is provided and funded. The former Calgary Health Region (now Alberta Health Services) contracts facilities to provide DAL. The care is funded by the former Calgary Health Region (now Alberta Health Services), provided by the facility staff, and overseen by the Home Care Coordinator affiliated with the particular facility. Private assisted living care may be provided by facility staff and funded by the resident, provided and funded by Home Care, or funded by Home Care and provided by facility staff. The third option is sometimes referred to as PAL, which stands for private assisted living. However, for the purposes of this study, all assisted living options that are not contracted by the former Calgary Health Region are referred to as private assisted living.

> **Participant 1:** *PAL is like Home Care. We have a DAL, PAL, and then totally private. If you're coming from out of province and you can meet the criteria, uh, physically, and emotionally, psychologically, you can come and live here, and if*

> *you need, uh medication assistance or bathing, any extra services, we will bill you for them.*
>
> **Participant 1:** *After three months, then we can refer them to Home Care. And then they will say sure, oh, obviously this person needs blah blah blah blah blah, and then that cost is, uh, is not billed anymore to the individual. The Region pays us to do the care.*
>
> **Participant 7:** *The private assisted living are really just Home Care clients that chose to live in that building… and the only difference is, um, they're not having an outside agency come in their home like they would if they lived outside of that building… They're having the facility provide the care… Um, so there is an advantage. Plus they have the, um, the dining room… So it would be like living in a lodge and they have an outside agency coming in… to provide the care. So, um, and it has to be scheduled. That's the thing.*

Despite differences in the way that care is funded and delivered in DAL and private assisted living, one participant observed that the resident experience is the same in both settings.

> **Interviewer:** *And would you say that, um, your definition for assisted living would apply to both the private and the DAL beds?*
> **Participant 3:** *Yes, yes.*
> **Interviewer:** *That it would be the same care?*
> **Participant 3:** *They get the same exact care. They really do.*

However, another participant observed differences in the resident experience and outcomes. This participant indicated that DAL residents experience more stability and support for independence due to the continuous monitoring from LPN's and the availability of physician assessment and care.

> **Participant 7:** *A lot of them actually, you'll find that a lot of our clients seem to be more stable, and that is because they have that consistency… They have LPN's that are in there. They have LPN's that see them every day because the LPN's are administering the medications. Um, they have more frequent, um, physician contact because, um, the private assisted living clients are really only seen as needed. Um, unless they have a nursing assistant that's in there, but it's not an LPN or an RN.*

Aging in Place Definition

Research participants described aging in place in many different ways. Common themes included ability to remain in one location as care needs increase or until end of life, and redefining "place". One participant described a dual understanding of aging in place that encompasses two perspectives: philosophical and nursing. Although the facility has a philosophy of aging in place, it may not always be possible from a nursing perspective for a resident to remain at the facility, depending on a resident's changing care needs.

> **Participant 2:** *Aging in place, the way I explain it to families is two components. There's really sort of um, the philosophical part of it, which is to allow, like what [Director of Marketing] said, for people to stay here as long as possible, but if you get into some of the more concrete, the nursing part of it, it's really, um, a physical, like how can we meet their needs. And there are certain criteria that definitely aging in place has limitations in our building from a nursing perspective, so we need to be really clear with families when they move in that, although we have a philosophy of aging in place, and we truly believe in that philosophy, we try to have people stay here as long as possible, there are limitations with the residence, the equipment we have, the staffing we have, from a nursing perspective that keeps them safe and allows them to stay here so that their care needs are met.*

Increased Needs

Participants described aging in place as allowing residents to maintain their independence by remaining at an assisted living facility as their care needs increase.

> **Participant 2:** *When I first heard about aging in place it was allowing residents to live as independently as possible, but, um, being able to stay in a residence where they can receive more care as it's needed.*

> **Interviewer:** *How does assisted living allow for aging in place?*
> **Participant 4:** *It keeps the individual as independent as possible for as long as possible.*

Participant 5: *What it does is as their situation changes, so for example, somebody comes in totally independent, they don't need anything from us, and then as they age here, um, you know, for example, then they need to have, uh, those very tight stockings. Um, they need to wear them. They've been diagnosed that that's going to help them. And they can't do that on their own. I don't think I could do that on my own. So they need that help, and so we will offer that help, but once we've got the stockings on, they're just as independent as they were when, the day they moved in.*

Participant 5: *I describe us as being independent, um, but we allow people after they're living here to age in place.*

Participant 5: *So we, so that, that service is there to, uh, maintain their independence, to help them maintain their independence. And what it does is it extends their stay while they live here. So instead of having to leave because something in their situation changes, we have that service there, so it still allows them to be here.*

Participants reported that the structure and services of assisted living allows residents to remain at the facility as their needs increase. Depending on the degree to which their care needs increase, many residents are able to remain at assisted living facilities until end of life.

Participant 5: *For me, to age in place means that you, there's a structure like ours that extends their stay. So to me, they can age here. So they come in independent, but the impact of aging is going to take place here, and we're going to have some, some ability to help them with that, so it extends their stay. That's my, my explanation of aging in place. So the goal is that when people come here that, you know, may they would be able to have, this could be their last residence for their, for their entire life, depending on how their health changes. Um, if we have some levels of support, uh, available to them, and that would a-, that's going to allow them to age right here. They don't have to go anywhere else if they've aged, depending on how severe that aging process is for each individual.*

Interviewer: *What does it mean to age in place?*
Participant 7: *Um, I guess being able to stay in your same residence until hopefully death. Um, with, uh, I guess services in place, or if they don't need services, then, you know family support*

Participant 7: *Assisted living works in that way that, um, they can still maintain their independence, and some of them can stay here up until… you know, up until they're physically able to and some of them actually can, um, pass away here. I would hope.*

Length of Stay and Minimizing Moves

Two indicators of the capacity of assisted living facilities to allow for aging in place are length of stay and the prevalence of assisted living residents who remain in assisted living until end of life. When making resident admission decisions, participants reported that assisted living facilities take into account the potential length of stay of an individual and the fit between the individual and the assisted living facility. Participants reported that residents with relatively high care needs and those who would otherwise be considered a poor fit with the facility may not be admitted in order to avoid a short length of stay and the disruption to the resident and family caused by frequent moves. Participant 1 described the family caregiver stress associated with frequent resident moves, and Participant 7 identified frequent moves as traumatic to the resident.

> **Participant 5:** *And if you take somebody that you see needs already, you know, is already, you know, would really need two levels of care, the time they're gonna be here is so short that I'm sure that's not what they want, right? Nobody wants to be moving all the time. So you want, people want to think that, you know, with any luck, this'll be the, you know, maybe the last place that I have to move into, and I can stay here for the, for the, you know, to live my life out here.*

> **Participant 1:** *That maybe she wouldn't have been at [facility] too long before she'd need long term care. And that's another issue is making sure you get the right move the right, the first time, because family have to bring all the furniture, get them settled, it's a big process. And if they're here 48 hours and we're like hey, we can't do this… It happens, even with Transition Services.*

> **Participant 7:** *Because once they get into DAL, then it's another process of trying to move them elsewhere. So you really try to make sure it's a good fit because it's very, um, traumatic for that client to move that many times.*

Understanding of "Place"

Participants identified that "place" is a broader concept to them than simply a private residence or a particular suite in a facility. For example, an individual could age in

place by moving to different care settings within the same neighbourhood, thereby maintaining the security of a familiar geographic location and long-term relationships.

> **Participant 2:** *Without leaving the neighbourhood and the support that they might have built up here. We have a lot of spouses that live here so that it keeps them close together.*

According to the study participants, aging in place could also occur in a single facility or a campus of care, featuring affiliated facilities on the same property. As care needs increase, a resident could move from one suite to another, or from one facility to another while remaining in the larger physical and social environments that constitute "place". For example, Participant 3 considers a resident who moves from an "independent floor" to a "care floor" in the same facility to be aging in place.

> **Participant 3:** *Uh, aging in place means that, uh, you could for instance with [residence] you could start out on an independent floor, and if you felt that maybe your health has deteriorated somewhat, you just move to a care floor that we offer, where they would just receive a little bit more care.*

> **Participant 3:** *That just goes back again to the different levels that we have, that, you know, you can live independently or you can live with a little bit more nursing care on the care floors.*

> **Participant 7:** *Because we have different levels of care, we're able to keep the residents here for a longer period of time. So they can come in as an independent individual, all, and follow all the way through to memory care.*

The campus of care model not only allows the resident to age in place in one physical location, but it also may provide housing and care options for family members and friends of the resident. In the following quotation, Participant 1 indicates that a campus of care model could allow a spouse who requires assisted living to remain close enough to visit his or her spouse who requires care in a nursing home. Family members and friends may otherwise experience barriers to maintaining relationships and providing care and support to the resident.

> **Participant 1:** *Some assisted living facilities, though, do have the ability to age in place, and they have sort of what we refer to as a campus of care, where they have independent living over here, in either lodge style or, uh, like bungalow style housing, where people are totally independent, cook their own meals, or may have the ability to purchase some meals, um, and then they move on to assisted living, and then they can move into a more medical model… And then they would move from the social model to the medical model, where their needs increase. And that's a very nice model, because they may have a spouse that is still at the assisted living, uh, stage, and his wife, or her husband, may need long term care, and then the accessibility, if you have a campus of care, the accessibility for them to visit each other is there. And maintain that relationship where now it's very difficult to get, um, a husband and wife in the same long term care facility. Very often it's, it's impossible, it doesn't happen.*

For one participant, aging in place is a concept that has more to do with individual autonomy and choice than about remaining in one physical location. Although facilities that provide independent or assisted living have limits to their capacities to provide care to residents, they can still be considered part of a process of aging in place. For this participant, an individual's sense of control over where and how he or she lives is more important than remaining in one physical location.

> **Participant 6:** *Um, in a assisted living environment - for example, some place like [facility] - where they have a, secure unit, you know, they have private dwellings, and then they have a secure unit, and then they have a, um, assisted living designation, and I don't even know if they, enough about the organization, but I know they don't go into long term care. So that's where it stops, there, okay. Here it stops at the assisted living piece. So when you talk about aging in place, I don't believe that is something that can be provided in one central location. I think what it boils down to is having a team that are familiar enough with that individual and can anticipate that individual's needs, which consists of multidisciplinary professionals and the families… and the resident themselves, to age in place. It's something, I think that is, it needs to be taken in the context of the individual, the person. I'm going to age in place for me… How am I going to control that. What are my choices and decisions. That's, I think, where we can be more successful in facilitating those options.*
> **Interviewer:** *So would you say it's more about fostering individual choice than aging in one physical location?*
> **Participant 6:** *Yes, absolutely.*

Conjoint Agreements with Nursing Homes

In order to support residents' decisions to age in place in a neighbourhood or in a particular building, some assisted living facilities have conjoint agreements with a neighbouring nursing home, or with nursing home beds within their facility. These agreements give residents of the assisted living facility a higher priority in terms of their application date for the affiliated nursing home.

> **Participant 7:** *Well actually the policies, the policies are changing now that, um, typically somebody, when they require long term care they need to go first available bed when they're in DAL, but in this situation that I know, it's the same over at [other facility], it's changing where they can stay in place and move to the long term care side when needed.*
>
> **Participant 7:** *Now the other bonus here is, their move-in date is the conjoin date. Um, so whatever day they move into the DAL, that puts them, um, they're on the waitlist from that date to go to long term care also… So that, that helps.*
> **Interviewer:** *Okay. And that's only DAL, not private, independent or assisted?*
> **Participant 7:** *Just DAL.*
>
> **Participant 2:** *So, and that's part of what we at [residence] have as a unique aging in place is that when people do move to that next level of a nursing aging in place where they really for safety and their best interest, have needs beyond what we can apply to assisted living and need long term care, we have a conjoint program across the street with [care centre], which is a long term care, so we, they can age in place across the street and transition… Without leaving the neighbourhood and the support that they might have built up here. We have a lot of spouses that live here so that it keeps them close together.*
>
> **Participant 2:** *And they would be waitlisted then by the day that they go on the long term care waitlist, their waitlisting as part of conjoint would be the day that they move into our residence. So if they've lived here for 5 years, their waitlist date would be 5 years ago.*

Admission and Discharge Criteria

Although participants were able to identify and describe a wide range of admission and discharge criteria for assisted living, none of the participants brought a list of criteria used in their facilities to the interviews. Some participants were able to list a

few criteria and assessment tools that are used in the admission and discharge process, but none of the participants provided a comprehensive list of criteria when they were asked to identify the criteria that they used in their work. It was only through a combination of open-ended questions and specific probes that participants were able to identify a range of criteria that they use, and describe how the criteria are applied.

Participants did display a great deal of certainty and clarity about some admission or discharge criteria. These criteria tended to be factors that related to both admission and discharge criteria – factors that would cause a resident to be either eligible for admission and not discharged, or ineligible for both admission and resident retention. On one hand, participants showed certainty about criteria that would both prevent admission and lead to discharge.

> **Participant 7:** *Um, like I said, for one, independence is a main thing. They do have to be able to get to and from the washroom on their own. Um, they can't have uncontrolled incontinence, which means, um, you know, they have to be able to, um, be able to wear, like, Attends or incontinence products and have somebody, like, we can assist them with changing that but, uh, if they're taking them off places and… Definitely dementia, we have to look at that, like if they're a wandering risk. Um, things like… hmm. Oh, a two-person assist we cannot do. A one-person assist we can.*
>
> **Participant 7:** *Yeah, we can't, um, we can't deal with violent behaviour… I think that's what it was. It was incontinence, 2-person transfer, and abusive behaviour.*
>
> **Interviewer:** *At most a one-person transfer?*
> **Participant 4:** *Absolutely.*
> **Interviewer:** *And the reason for that would be?*
> **Participant 4:** *That's what assisted living is.*
>
> **Participant 4:** *Geriatric assessment, we've covered that; they must be able to afford it; uh, must be independently mobile, assistive devices can be used; transfer independently or assistance of one person, we've covered that… Um, able to manage ADL's independently or with assist with a limit of two hours per day.*

> **Participant 4:** *Other than that, they can't be a safety risk to themselves or others, and they have to eat independently.*
>
> **Interviewer:** *Inability to pay for care?*
> **Participant 5:** *Yes. Then…yeah, they would have to go, because, I mean, if care was what they needed to maintain, to stay here… and they weren't able to pay, then they would probably make that choice on their own to look for a subsidized… you know, they'd have to look for another facility where subsidies were available.*

On the other hand, participants were also clear about certain criteria that would cause a resident to be eligible for admission and would not lead to discharge.

> **Interviewer:** *Does not require ongoing supervision or monitoring?*
> **Participant 7:** *Um, as long as that can be done on the LPN level, that's fine.*
>
> **Participant 4:** *The colostomy and ileostomy care are not an issue here. We do have current residents that do have colostomies or ileostomies.*

In this study, participants reported that several factors influence admission and discharge decisions. These factors fall into three categories: those associated with the resident and resident family members, the facility, and larger policy issues.

Resident and Family Influences in Resident Admission and Discharge

Factors associated with assisted living residents or their family members may have an influence on admission and discharge decisions. These factors include resident care needs, behavioural characteristics, and access to financial and caregiving resources.

Resident Care Needs

The decision to admit residents to assisted living is partly influenced by the care needs of the individual. In the case of DAL, residents must be assessed as requiring more care than can be provided in their current place of residence, but not as much care as would be provided in a nursing home.

In this study, facilities differed as to whether the admission criteria for private assisted living are the same as DAL, or whether there is a lower limit of care needs for DAL but not for private assisted living.

> **Interviewer:** *Would it be the same type of admission criteria for the DAL residents and the PAL and private residents?*
> **Participant 1:** *For everyone, yes. These are, we really, our admission criteria really follow all of the, um, DAL policies.*
>
> **Interviewer:** *Okay. Um, and is there a difference between the designated and private assisted living in terms of these criteria…so far? Would residents be admitted, um, you know, to the designated assisted living beds and private ones, um, with the same types of nursing needs?*
> **Participant 2:** *In assisted living?*
> **Interviewer:** *In assisted living.*
> **Participant 2:** *Yup.*
>
> **Interviewer:** *The upper limit of care might be the same, but the lower limit, the Health Region might require a higher level of care than, than you require in your private beds. Would that be fair to say?*
> **Participant 2:** *Mm hmm. Right, and they'd come in privately, yeah.*

Participants reported that discharge decisions are frequently initiated due to increased care needs.

> **Participant 3:** *I don't really think it's who initiates the decision, I think it's maybe a circumstance that may initiate the decision. You know, like a bad fall… Or, you know, a, a decline in health is I think the biggest factor as to what determines the situation.*
>
> **Participant 3:** *Um, usually, um, we have a form, which was made by the facility which, uh, indicates, the increased care that the resi-, the staff monitors the residents, if they have been doing more laundry for them, uh, two-person transfer, uh, more incontinence care, that's all being recorded, and if it's an ongoing thing then we reassess, and if we think that they are not, um, appropriate for here anymore then that's the time that they get discharged to long term care.*

Behavioural Characteristics of the Resident

Participants stated that the behaviour of residents may prevent admission or lead to discharge. Although behavior changes are generally acceptable within assisted living facilities, there are limits to the ability of facilities to retain residents with more extreme behaviours. In some cases, behavioural contracts or managed risk agreements may be used. However, participants were clear that residents who display behavior that is assessed as abusive, or as putting themselves or other residents at risk are not eligible for assisted living.

> **Participant 7:** *Um, severe behavioural problems. Anything that, um, like abusive behaviour. Like, if we can set the limits and, um, like even have a behavioural contract, then we could do that. Like, there are other ways to look at that, but um, if none of this would be effective, then we would look at, we wouldn't be able to meet their needs… Like if they're putting themselves or any other clients at risk, definitely.*

> **Participant 2:** *Again, they can not have, um, mental health issues or issues with the dementia that cause behaviours that put themselves or others at risk and that are, that would be considered unstable, or if their behaviour becomes unpredictable in a harmful way…*

Access to Financial and Caregiving Resources

The economic situation of the resident or the resident's family can affect admission and discharge in private-pay assisted living. The cost for DAL is partly subsidized by the province, and support is available to find resources to allow residents to enter and remain in DAL. Access to private assisted living is dependent on the financial resources of the individual.

> **Participant 7:** *Um, yeah actually that's assessed through Transition, and they actually, um, they're able to get funding for clients that come in for assisted living, so that's never, that's never really, um, an issue.*

Participant 6: *And sometimes with people with money, they're, and more knowledgeable, and sometimes even more manipulative with the system. Do you know what I mean?… And it does take money to live here.*

Participant 4: *Because this is a private facility, there is a significant cost difference from independent living to assisted living.*

Participant 1: *Yeah, we can't keep them. These are for-profit facilities.*

Participant 6: *But I think you have to look at it, this is the first step in, uh, the continuum, okay? Because, you know, just as you or I are independent livers, we're living in our own homes, um, we can make the choice to live in a condo… Right? And we choose to pay that condo fee. And when we decide we don't want to pay that condo fee, or we can't pay that condo fee, then we have to make other arrangements, don't we?… That's really the best context to put it in, or one of the contexts.*

Participants reported that the cost of residency in a private-pay suite must be covered solely by the resident. The cost of care may be covered by Home Care, but only up to the assessed limit. Beyond the assessed limit, private care can be purchased from the facility or an external agency at the resident's expense. Another alternative is to arrange for family members to provide the necessary care.

Participant 7: *Yeah. Oh, definitely. It's definitely a case by case situation… Like, especially if, you know, if you have family involvement… You know, it's still a one-person assist if there's a family member in that room that will help… So, um…*
Interviewer: *Or private caregivers hired?*
Participant 7: *Exactly.*

Participant 4: *They are made aware of the cost. Either you purchase the suite or you lease the suite.*

Participant 6: *Usually what happens is the resident will come… well, they have come on their own, too, but we'll have family involved, and they know how much it costs to rent a suite, and it's not cheap. So is it kind of addressed directly? We don't do, I'm not even sure. Do we do credit checks? I don't know. Um, but, you know, for the most part, if you or I were to go to a place, um, to rent an apartment, and you can't afford to pay for that apartment, would you take that apartment?*
Interviewer: *No. It's a resident or family decision?*

Participant 6: *My point exactly.*

Participant 4: *Um, if someone is sort of borderline, um, for independent and assisted, um, we'll ask that, well first of all I should tell you that we do have a fee for service for independent living… If they require, for example, somebody, someone goes for cataract surgery… and requires drops four times a day for six weeks… there's a fee for service. We're able to accommodate that… Um, there is a fee for service. If they are Home Care clients, they can certainly access Home Care to do that… So there is that option for them.*

Participant 6: *So that if a person, you know, if I'm seeing that an individual requires care, they have no ability to pay me or pay the organization for care, then that Home Care system, which we all have the right of access to, should kick in… And will kick in.*
Interviewer: *So in this context, it would be more the inability to pay for the housing aspect of it…*
Participant 6: *Yes.*
Interviewer: *…would lead to someone not being able to continue to rent?*
Participant 6: *Yes.*
Interviewer: *Okay, but the care would be separate.*
Participant 6: *Yeah, that's a good definition.*

Interviewer: *If a person's, um, health becomes beyond an assisted living level for, say, a temporary illness, and, um, you know, at one point would that person then, um, be discharged?*
Participant 4: *Um, well there's a couple different options you can, you can have here… Again, you can call in Home Care. If it's over our two hours of care, you can have that supplemented up to four hours of care… There's also the option of hiring private care… Um, and that's perfectly acceptable as well. Um, we view this as their home. If they, if this temporary illness turns into a terminal illness, for example, it's perfectly acceptable for them to pass away here.*
Interviewer: *Okay. And if they require more care, they're able to hire that and have those extra caregivers come in.*
Participant 4: *Absolutely.*

Interviewer: *Um, in any of these situations where a person may need more care or more supervision than is available or appropriate, um, would families also have the option of hiring outside caregivers?*
Participant 6: *Anytime. And we also have the option of hiring our staff privately.*

One facility has care services priced to a much higher level than they would normally offer. Therefore, the option for this amount of care appears to be available to the resident who has the resources to pay for it, but it is unclear whether the facility would be able to provide the care with its current level of staffing.

> **Participant 5:** *We have, you know, we've kind of priced it up to, you know, 5 levels, but we have never moved beyond level 2, which would be an hour of care. So each level is half an hour.*

Autonomy in Decision-Making

Regardless of the financial or family caregiving resources that a resident may have access to, respondents reported that the degree to which assisted living residents and their families are involved in admission and discharge decisions varies. The decision to admit a resident into an assisted living facility is influenced by several other factors, including the assessed needs of the individual, the nature of the facility, and health and housing policy. However, older adults and their family members do have control over the decision to decline assisted living admission and remain at home until care needs progress to a nursing home level. An older adult may decline admission to an assisted living facility for a variety of reasons, including the location of the facility, the physical environment of the facility, or the desire to remain in his or her current residence.

> **Participant 7:** *Um, because a lot of the times they'll come into this facility thinking this is it, and we want them to know upfront that, you know, that there is a possibility it may not be.*
> **Interviewer:** *Okay. So, um, discharge criteria, then, is discussed?*
> **Participant 7:** *Yeah.*
> **Interviewer:** *This is what we can't accommodate?*
> **Participant 7:** *Yeah, yeah. Because we want them to know upfront, because we find that sometimes they'll come in with unrealistic expectations. So, um, if you're more upfront with them, then they're able to ask questions and they can get a better picture, because some people, they may not be ready to move, and, um, it makes that decision a little bit easier for them, that maybe they do want to stay in their home and wait there until they can move to long term care.*

> **Participant 3:** *Um, family members will often come in or the resident themselves. Um, they'll tour the facility with myself. I will tell them what we offer; I will talk prices, square footage, what their care needs are. I explain the admission process to them. Um, I basically provide them with all the information that they need when they come in, and once, uh, they have that information it's up to them*

ultimately to decide whether they're gonna pursue coming to [residence] or going to another facility.

Participants reported that older adults and their family members are given the opportunity to decline an admission to a particular assisted living facility, and residents are free to move out of the facility at any time. However, decisions to admit or retain residents in an assisted living facility involve not only the resident and family, but also the facility staff. Transition Services is also involved with the admission and discharge of DAL residents.

Interviewer: *Who makes the final determination that yes, this person needs to, I guess it would be normally move to long term care?*
Participant 7: *Um, it would be usually myself with the family, the client. Transition would come in, um, very rarely have they ever come in and said, um, no, I don't think this client needs to move to long term care. If anything, it's the client or the family refusing.*

Participant 3: *We don't have a lot of residents that choose to leave. It happens very rarely. Our biggest, uh, problem that makes [residence] kind of a revolving door is long term care.*

Participant 3: *Um, if they question the need, we'll try and work with the family. We try to work with them as much as possible. Like I said, we'll tr-, we'll sit down with them, maybe brainstorm some ideas on how we can improve the situation. You know, and if, if it's like a constant, continuous thing, though, and we know that it's something that's not going to change… Then we ha-, we go back again to meeting with the family and expressing why this needs to change. Um, sometimes it's simple: moving them to a different care floor or, you know, maybe um, you know, coming up with signs 'cause they're not recognizing where the bathroom is, you know. We have all these little things that we can come up with… but when those little things aren't working, then that's when, you know, we kind of have to… be quite… um, what's the word for it? You really gotta stick to your guns, pretty much when, when you do make a decision like that… because you gotta look at the care that that might, that individual might be taking from someone else that's here as well.*

As mentioned above, respondents reported that residents and their family members may have more influence in resident admission and retention decisions if they

have the financial and/or family caregiving resources to supplement the care provided at the assisted living facility.

Facility Influences in Resident Admission and Discharge

Physical and Social Environment

Although an older adult may require assisted living services, participants reported that admission to assisted living facilities can be limited by the characteristics of the physical and social environments of different facilities. For example, a resident may need to have the mobility and cognitive functioning to be able to go to the dining room each day, which is on another floor of the building.

> **Participant 7:** *So, um, they do need to be able to go down for meals or be able to get their own meals in their room.*
> **Interviewer:** *And the dining room is…*
> **Participant 7:** *On the main…*
> **Interviewer:** *You said go down, so they have to use the elevator?*
> **Participant 7:** *Yeah.*

The same issue with the dining room was reported by another participant, but in this case the floors for residents with the highest care needs have their own dining rooms.

> **Participant 3:** *Providing, you know, the cueing that they need, uh, just reminders, you know. Uh, the difference also with the care floors is that they're… they don't have to come down to the main population dining room… so they don't have to deal with that extra stress of coming up and down. They can just go right to their floor where the dining room is.*

A resident may be denied admission to a particular facility because the physical structure of the facility could contribute to isolation.

> **Participant 7:** *Well we had some not admitted because of the depression, and that's because the rooms that we had available were at the farest, like, the*

> *furthest ends of the hallway, so, um, they would be more isolated… and that wouldn't, that would definitely not improve their situation.*

> **Participant 7:** *When we know that, um, like such a, like this building here. You need to be very independent because they're isolated in these long hallways. So, um, dementia, like we don't have any locked units, so that's um, that's a big indicator for long term care is if they have dementia. Or if we can move them, like if they're still high functioning we can move them to another DAL that has a secured unit.*

Regardless of the layout, the sheer size of a larger facility can be confusing for some residents.

> **Participant 7:** *But, um, but yeah. And the size of this building makes a difficult, we're finding, for some clients.*

Decision-making can be affected by the occupancy rate of the facility, because facilities generate their revenue from DAL contracts and private-pay residents. Participants identified that a facility may be more accommodating with admission and discharge criteria when there are many suites available and stricter with the application of admission and discharge criteria when the facility is full.

> **Participant 5:** *No pets… And that was the only other one. Now even on that we've made some compromises, but that was before we were full, and so of course there's changes once you're full, right?*

The social environment of a facility also has an influence on the admission and discharge of assisted living residents. As previously mentioned, the behaviour of a resident is a factor in admission and discharge decisions. However, in the congregate living situation of an assisted living facility, resident behaviour is not only assessed according to the care needs of the individual, but also according to the impact on the community of facility residents.

> **Participant 4:** *If we have, um, they cannot have behaviour problems. Um, we view this as a community, um, and we don't accept people with a history of*

> *behaviour problems. Um, we don't want to agitate, uh, the community itself. And so we're… selective, I'll say, in that aspect.*
> **Interviewer:** *Okay, and so examples of behaviour problems would be?*
> **Participant 4:** *Um, outbursts, verbal outbursts… It's not acceptable… It's disruptive, it agitates other people, it's just a disruption to the entire community, and it's not tolerated.*

In addition to behaviour, the personality of a resident may be a factor in the decision to admit them to a particular assisted living facility. This participant mentioned that personality mix is a factor in the admission process, but that it is very difficult to define or describe it as a criterion.

> **Participant 5:** *But we do, that's kind of the subtle thing that we look at, is personality, just how we, how they interact and what they feel like in terms of… because we want, we want people getting along, right?… You have to have a population, you can't have people fighting or arguing or those kinds of things. You want a cohesive family, people that, and so that has to be, realistically has to be an aspect of it… But it's so, you know, it's like hugging smoke, right? How do you define it? How do you… So, it's kind of very subtle that you kind of look at those things.*

Although some assisted living facilities aim to allow residents to age in place for as long as possible as care needs increase, others prefer to maintain a more homogenous mix of residents. In the following quotations, Participant 5 states that the goal of the facility is to allow residents to remain in the facility for as long as possible as care needs increase. Participant 6 clearly states a preference for a more homogenous resident mix, in which residents who require an assisted living level of care may be discharged.

> **Participant 5:** *For me, to age in place means that you, there's a structure like ours that extends their stay. So to me, they can age here. So they come in independent, but the impact of aging is going to take place here, and we're going to have some, some ability to help them with that, so it extends their stay. That's my, my explanation of aging in place. So the goal is that when people come here that, you know, may they would be able to have, this could be their last residence for their, for their entire life, depending on how their health changes. Um, if we have some levels of support, uh, available to them, and that would a-, that's going*

> *to allow them to age right here. They don't have to go anywhere else if they've aged, depending on how severe that aging process is for each individual.*
>
> **Participant 6:** *We work really hard at developing a sense of community, and so when you have someone who has a need level that is more of an assisted living type of need, then they are not necessarily appropriate for this facility.*

Admission decisions can also be influenced by the management philosophy of the facility. In the example below, the facility selects for the most independent residents in an attempt to build a more stable community.

> **Participant 5:** *We've still determined that we want to have the most independent people, so that we have, because it becomes a family… and people get to know each other and, you know, help each other, and they're very supportive of each other. If there was too much turnover, I think it would be more of a negative place… And so to make it more positive, you want people to stay as long as they possibly can, so that they've built relationships and friendships and they enjoy each other for a longer period of time… If everybody was turning over very quickly it would be, people would be, I think, more isolated… You know, they wouldn't come together as a community. If they're here for a longer time, they're gonna come more together as a community, and that's what we want. That's what we want to see. And that's just our personalities as people that work here, what do we, what do we want our environment to be when we come to work? It's the same thing, you know?… We want it, it's a, it's a great place, and we love that about it, and people tell us all the time, and so we want to maintain that… We want to encourage it. So that' why we have the philosophy of as independent as possible at the beginning to extend the stay as long as possible.*

However, a stable community may also have negative aspects. One participant mentioned that resident discharge decisions are kept confidential until the resident moves out, partly due to how the community of residents may react to the news.

> **Participant 5:** *Like, to me, again, privacy is, is paramount, and so in fairness I don't think, you know, we have five receptionists. Do they all need to know that, you know, I'm working through an eviction process? Um, nah, it's not necessary. Um, I mean, word gets out anyway, you know, maybe. And the other thing is, definitely not the residents. Um, it's all very, you know, they are a little bit high-schoolish sometimes, you know? It's like any group of people that lives together as a family.*

Participants reported that the staff may also feel a sense of community with the residents for whom they provide care. Discharge decisions may be delayed or made more difficult when staff feel reluctant to see a resident move to another care setting.

> **Participant 5:** *The emotional risk for the staff, because it's not just me. People are emotionally involved with these people, and if we see that we can't meet their needs, it's, it's hard on everybody.*

> **Participant 6:** *The situation may be there just may not be the appropriate place for this individual to go… You know? Because we do grow attached. I mean, you know, after taking care of somebody for 5 years, and you know that, you know, the husband is fine, but he's got to go, and he's got to let go of his wife, and you know?*

Facility Staffing

Although a resident may be eligible for assisted living based on individual characteristics and appropriate fit with the physical and social settings of the assisted living facility, resident admission and discharge is also influenced by the staffing pattern available at the facility. A resident's needs may be within the scope of assisted living care, but the resident may be discharged or declined admission due to a lack of staff to provide the necessary care. This lack of staff may be due to low staffing levels or to the number of residents in the facility with comparatively high care needs. In the following quotations, participants reflect on these issues.

> **Participant 7:** *Um, but with here, with only 2 nursing assistants and 30 residents spread throughout the building, it does make it difficult for, let's say all 30 of them needed, um, you know, assistance to the dining room. It would make it difficult… So we do, um, we do have residents in wheelchairs that, you know, are quite independent, so that does make it easier.*

> **Participant 5:** *So we've never had anybody beyond level 2. The reason being is we wouldn't probably be able to get beyond that is because we wouldn't have the staff to do it.*

> **Participant 1:** *And the appropriateness of what staff, uh, what staffing levels we have.*
>
> **Participant 1:** *And if you start to talk about safety, and say they're not safe here for this reason at night, we have two staff members here. That's it, you know? We can't be at that bedside for an hour or an hour and a half.*

While each facility can determine their own criteria for admitting residents, the facilities and their criteria are influenced by policies that define and regulate assisted living care. Facilities that have contracts with the former Calgary Health Region (now Alberta Health Services) to provide DAL are also affected by the terms of those contracts. The third sphere of influence on assisted living admission and discharge decisions concerns the policy environment. In the following section, all references to the Calgary Health Region were current at the time of data collection, but refer to Alberta Health Services as of April 2009.

Policy Influences in Resident Admission and Discharge

Funding from the Former Calgary Health Region

The way a facility is funded may have an impact on the admission and discharge of assisted living residents. A facility that receives operational funding from the Calgary Health Region based on the assessed needs of each resident may have admitted or retained residents with higher care needs in order to receive necessary funding to hire and retain caregiving staff.

> **Participant 6:** *One of the things that is a challenge for us is that we have a contract with Calgary Health Region, and they fund us at a certain level, okay. If we do not have hours that equal that level, then we have to pay that money back, which makes it very difficult to maintain a staffing infrastructure, okay.*
>
> **Participant 6:** *I think what you have to keep in the context of all of this is that I have the job of balancing those resources… and you'd be really remiss if you did*

not take the money perspective… into account. You know what I'm saying?… So I may keep someone who may not necessarily be completely suitable… in order to make my books balance… to keep my infrastructure going, and I hate that it's like that. I hate it.
Interviewer: *Right. And just find a way to manage that?*
Participant 6: *Find a way to manage it… Longer, maybe, perhaps longer than I should have to.*

Participant 2: *The difference currently as the Region in the past has defined it as that assisted living, uh, residents require, sort of, more 24/7 supervision, um, cueing, monitoring, uh, they can have in designated assisted living up to 2 hours of care in the 24 hour period. The private assisted living can have up to 4 hours of care in the 24 hour period. The independent residents can also have up to 4 hours of Home Care a day, but they don't get the 24/7 supervision, cueing, and monitoring.*

Participant 7: *It's really a case by case situation. You know, um, like we just had a lady who, um, fractured her knee and didn't have a bed in her room, and it took two of us to try to get her up out of her… she sleeps on her couch. And it took two of us and a transfer belt to try to get her up. Well, I had to send her to a transition bed because we just couldn't meet her needs… Um… Yeah, it's really a case by case situation, because like I said now the Region is looking at, um, increasing the funding for the facilities if they're bringing in extra staff to meet the client's needs.*

Pathways System for DAL and Nursing Home Admission

The Calgary Health Region uses a computer system called Pathways to manage admissions into Supportive Living and nursing home settings in a centralized way. Pathways controls admission of residents by determining the order of resident admission and limiting the choice of facilities to not admit a resident.

Participant 1: *We have people that are PAL, but they're on the DAL waitlist, they're in Pathways, we can't select them. They can stay here and wait in place. If somebody moves to long term care or passes away, then we go in, discharge that resident and hit the button that says 'select a new resident', and they come up to us.*

Participant 3: *And we really do follow those policies 'cause we do have DAL beds and we do have to answer to the Calgary Health Region as to what we're doing on a regular basis, and who we're bringing in, because they're paying for*

> *those beds ultimately, too, right? So, they need to know, you know, that we're not over-providing for people that's taking care from other people, too.*
>
> **Participant 7:** *But like I said, like, if they're going to decline a client, there has to be good reasoning to decline them.*

Calgary Health Region policies include the requirement that individuals must be residents of Alberta for at least one year before becoming eligible for DAL or nursing home placement. Individuals who are not eligible for DAL are required to pay privately for assisted living or find other housing and care alternatives.

> **Participant 1:** *But if you come from out of province, and we probably don't need to get into it, but you will qualify for Home Care after three months, but you won't qualify as a DAL or a long term care resident for a year.*

Several other policies that have been described previously in this chapter affect resident admission and discharge decisions. For example, conjoint agreements with nursing homes can affect discharge decisions and the resident's ability to age in place. In addition, managed risk agreements provide an opportunity for some residents and facility managers to delay or avoid resident discharge decisions by using other methods to address the identified risk.

Calgary Health Region Oversight of DAL

Assisted living facilities provide DAL beds through contracts with the Calgary Health Region. Home Care coordinators on the DAL team monitor the contracts through monthly audits and ongoing daily contact with facility staff.

> **Participant 7:** *Like I said, my main focus is to make sure the client receives the care they need… And basically, well actually we have audits that we do once a month just to tell Supported Living, let them know, um, like, are they being staffed appropriately for what, um, the CHR is funding them… So, um, that way they know, like, is the facility really using that money to provide the care.*

> **Interviewer:** *So it really does fall to you directly to do a lot of that work in the monitoring of that contract?*
> **Participant 7:** *Um, somewhat. Like, I'm kind of the, like, I always call myself the middle-man… I work with the facility, like I think of us very much as a team working here. It's just I don't work for [facility management organization]. I work for the health region, so… If I feel the facility isn't doing what they should be doing, then it's my job to report it to Supported Living. The monthly audit that I do is just very minimal. It's just, they just want some information from somebody who's actually here… So it's like, are the rec therapists doing the rec programs? Is the educator doing the education? And it's just very basic.*

Supportive Living Accommodation Standards

The release of the Supportive Living Accommodation Standards in 2007 and the Continuing Care Health Service Standards in 2008 provided a uniform set of requirements for the accommodation and care services provided in both DAL and private assisted living settings. Although participants did not mention the standards specifically in regards to their process of resident admission and discharge, the following statements indicate awareness of the regulatory function of the standards.

> **Participant 7:** *Basically I know Supported Living does look at, you know, if they're refusing clients, so they do want to make sure that they're not declining, like refusing clients because, um, they require care… that can really be provided, but, um, they just don't want to. So I know they monitor that really closely.*

> **Participant 1:** *And now it's, it's dead easy because it's in the standards, within the DAL standards and we just follow them.*

However, since my interviews occurred only shortly after the Supportive Living Accommodation Standards and Continuing Care Health Service Standards were released, the full extent of the impact of these two sets of standards remained unclear. The following participant was familiar with both documents, but was unsure how they would be applied in the facility.

> **Interviewer:** *So would that relate, um in the 2007 standards that came out for supportive living, would that relate to, um the retirement living, the level 1 versus level 3 assisted living?*
> **Participant 2:** *There's been a lot of discussion about that at our meetings. However, we have not, we're just starting to see documentation to support that shift.*

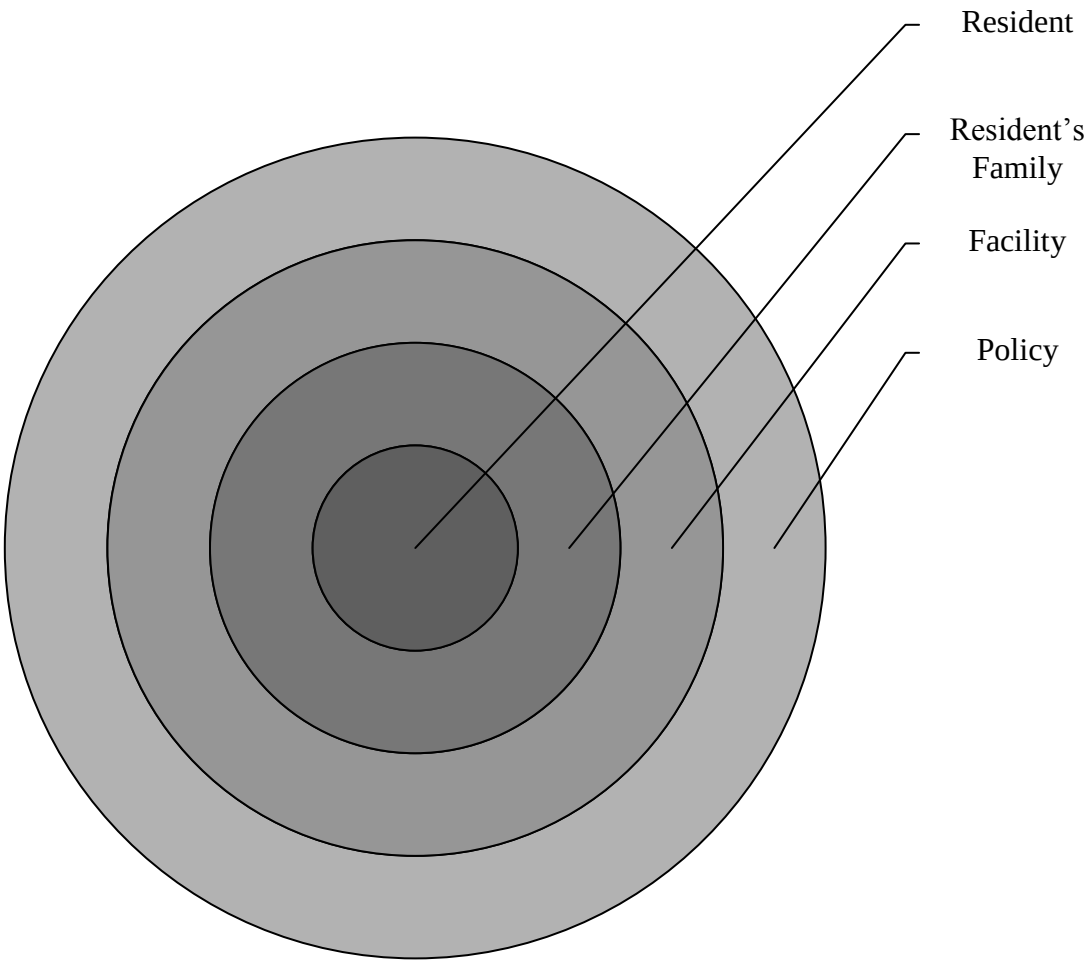
Factors Influencing Resident Admission and Discharge Decisions

As the findings indicate, admission and discharge decisions are influenced by characteristics of the residents, their families, the facility, and policy of the province and health region. The difficulty that participants have in defining absolute admission and discharge criteria is partly due to the complexity of factors in these three spheres.

As shown in Figure 2, admission and discharge decisions are influenced by factors associated with the resident, the resident's family, the assisted living facility, and the policy context. The characteristics of the resident are located at the centre because respondents identified these characteristics as the primary focus of admission and discharge decisions. Characteristics of the resident's family, the facility and the policy context of the Province of Alberta and the Calgary Health Region are represented as concentric circles surrounding the resident. Therefore, the clinical decision of resident admission and discharge can be understood as taking place within these broader contexts.

Interaction between any of the four levels can influence admission and discharge decisions. For example, a resident may be assessed as appropriate for admission to assisted living, but may be turned down for admission to a specific facility due to its physical structure and layout. In a more complex scenario, the provincial government has been promoting assisted living as a nursing home alternative, and providing capital

FIGURE 2: FACTORS INFLUENCING RESIDENT ADMISSION AND DISCHARGE DECISIONS



funding for the creation of new Supportive Living spaces. This may lead an individual who would have otherwise been admitted to a nursing home to be considered for assisted living. At the facility level, the physical environment and staffing may not be sufficient to provide adequate care for the individual. However, the individual may have the resources to hire private caregivers and engage family caregivers in their care. Through the interaction of all four levels of influence, the resident may be considered eligible for assisted living.

Summary

Assisted living is a complex term, which at the time of my interviews had only recently been given a standard definition across Alberta through the Supportive Living Framework (Alberta Seniors and Community Supports, 2007b). Definitions provided by participants included references to assisted living philosophy, a social model of care, an option within a continuum of care, and distinctions between different types of assisted living in Calgary. Participants commented on the possibility of residents aging in place as care needs increased, but explanations of what constituted a "place" and the relative importance of resident choice varied considerably. Resident admission and discharge criteria are determining factors in the possibility that residents will age in place in assisted living. While most participants could describe a range of criteria that they use in resident admission and discharge decisions, these criteria can be influenced by factors associated with the resident, the resident's family, the facility, and the health and political policy context.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

Assisted living is a complex and varied industry across North America and within the city of Calgary, Alberta. Those involved in the admission and discharge of assisted living residents have different understandings of the concepts of assisted living, aging in place, and admission and discharge criteria. The diversity of terminology, policy, and practice within assisted living settings results in a system that is complex and confusing to older adults, their family members, and health professionals. Admission and discharge decisions, which include an assessment of resident and family characteristics, facility characteristics, and an awareness of the influence of the local policy context, involve a complex balancing act of each of these factors. The social work profession, with its holistic psychosocial perspective and value of client self-determination, is ideally positioned to play a greater role in assisted living admission and discharge, management, and policy advocacy.

Strengths and Limitations of the Study

Strengths

This study provides a social work perspective on the area of resident admission and discharge in assisted living. There is currently little research in the area of assisted living from a social work perspective. The research that is available tends to be focused on the clinical social work roles of providing education, support, and referral to residents and their families. These clinical social work roles are situated within home care and nursing home settings rather than being directly affiliated with assisted living facilities. The strength of this study is that it frames the admission and discharge of assisted living

residents in a social work perspective, which enables future discussion on the possible roles for social workers in assisted living practice, and broadens the scope for future social work research in this area.

The length of time taken for the data collection and analysis processes was also a strength of the study, because concepts were able to emerge and develop over a long period of time. My decision to transcribe the interview data myself, and the extended time that I took to complete the data analysis allowed me to gain a detailed familiarity with the data and permitted a careful process of coding, constant comparison of codes and themes, and theory development.

Limitations

One of the limitations of this study was the fact that the research process took place over three years. In that time, several important changes occurred in the assisted living context in Calgary. In the spring of 2007, Alberta Seniors and Community Supports released the final versions of two policy documents for assisted living: the Supportive Living Framework and the Supportive Living Accommodation Standards. In the following year, Alberta Health and Wellness released the Continuing Care Health Service Standards. Data collection for this study took place after these documents had been released, but before the Supportive Living Accommodation Standards were enforced through mandatory licensing of all supportive living facilities. In the spring of 2009, Alberta Health Services assumed responsibility for the delivery of health services across Alberta, in place of local health regions. These changes limit the applicability of the results of the study to some extent, due to the fact that the context of assisted living in Calgary has been modified since my data was collected.

The geographic scope of the study limits the applicability of the results to the assisted living context in Calgary, Alberta. More research would be necessary to explore the applicability of the findings of this study to assisted living admission and discharge in other locations in Canada and in the United States.

Of my original sample of research participants, one participant withdrew and another refused to be quoted in the final research report. Both of these participants were employees of the former Calgary Health Region. Their hesitancy to remain fully involved in the study suggests that they may have considered the data they provided to be sensitive information, and they may have judged that their participation in the study involved some personal or professional risk. The decisions of these two participants raises the possibility that other participants may have considered my research questions to be sensitive, and may have not been completely forthcoming in their interviews.

Another limitation of this study is that it was undertaken by a single researcher who conducted only one interview with each participant. The trustworthiness of the findings would have been improved if more than one researcher had performed the data analysis and confirmed the results with each other. Additionally, subsequent interviews with existing participants could have been used to check the accuracy of initial findings.

Discussion

The Context of Assisted Living in Alberta

As a relatively new option with in the continuum of care for older adults in Alberta, assisted living has emerged and continues to exist within a very fluid policy context in Alberta. At the time that the assisted living facilities emerged in Alberta, the

provincial government was issuing policy documents that supported increased care in the community for older adults as a strategy for health care cost containment. Assisted living facilities operated in a largely unregulated environment until the release of the Supportive Living Framework and the Supportive Living Accommodation Standards in 2007. These documents, along with the licensing and monitoring requirements introduced by Alberta Seniors and Community Supports, have imposed some standardization of information and services within the assisted living industry.

For the past two decades, the provincial government has advocated for more health services to be moved from acute care and nursing home facilities into community settings such as home care and Supportive Living. In light of the impending growth of the older adult population in Alberta, recent capital funding initiatives through Alberta Seniors and Community Supports are encouraging the expansion of the assisted living industry, while the current supply of nursing home beds remains unchanged. Alberta Health and Wellness, in their recent *Continuing Care Strategy: Aging in the Right Place* (2008b), state that "future continuing care clients are expected to be less reliant on government sources of income, to have more disposable income, and have increased expectations for choice in their living accommodations" (p. 14). Furthermore, the document states that the deregulation of nursing home accommodation fees will increase client choices by encouraging the development of more continuing care settings by the private and non-profit sectors. Within this context, there will be greater pressure on assisted living facilities to house and care for an increasing number of older adults as the number of nursing home beds remains constant. In particular, the demand for DAL beds can be expected to increase as the number of older adults with low incomes, and those

whose savings have plummeted during the recent recession, require affordable housing and care options. From a social work perspective, it is important to evaluate the affordability and accessibility of assisted living, as well as the degree to which assisted living provides an opportunity to age in place for all older adults requiring this type of care in Alberta.

Resident Admission and Discharge Influences

Assisted living admission and discharge is determined not only be a set of criteria, but is also influenced by factors relating to the resident and family, the facility, and the local policy context. Residents who have the financial or family caregiving resources to arrange for assistance beyond that which is provided within the facility may have more options to remain in assisted living as their needs increase. While individual resources can provide greater flexibility of care options and increased possibilities to age in place in assisted living, it is important to evaluate the financial accessibility of assisted living as a care option for all older adults, including those without the means to access supplementary care services. Participants in this study indicated that designated assisted living is more financially accessible than private assisted living, because care services are subsidized and residents can access additional income through the Alberta Seniors Benefit or hardship funding through Alberta Health Services to assist with resident fees.

The physical and social environments of assisted living facilities also have an influence on the fit between a resident and a particular facility and set of services. Facilities with physical designs that inhibit socialization and supervisions of residents, or that require residents to navigate multiple floors on a daily basis can be inappropriate for individuals who have even mild cognitive impairments. Greater attention to the design of

assisted living facilities would allow for increased facility choices for individuals who may otherwise face limited assisted living options or be prematurely placed in a secure unit or nursing home.

Recommendations

Improved Clarity Regarding the Continuum of Care in Alberta

The inconsistency in the use of the term "assisted living" and the range of other terms used to refer to similar housing and care options within the continuum of care in Calgary, Alberta creates confusion among older adults, their family members, and health care professionals. Since a range of assisted living options exist in Calgary, older adults and their family members may have difficulty understanding what assisted living provides and deciding whether an assisted living setting is appropriate for their needs. The confusion is exacerbated by the fact that assisted living services and the use of the term assisted living varies between provinces. Older adults or family members who live outside of Alberta may understand assisted living care differently from the way it exists in Alberta. The Canadian Healthcare Association (2004) has used the metaphor of a patchwork quilt to describe the variety of continuing care services and terminology across Canada.

The introduction of the Supportive Living Framework (2007) and the licensing and monitoring of assisted living facilities using the Supportive Living Accommodation Standards (2007) have led to some degree of increased clarity regarding the use of the term assisted living in Alberta. Older adults and their family members now have access to standard descriptions of assisted living care within the Supportive Living Framework,

and basic information about all assisted living facilities in Alberta is now available on the Alberta Seniors and Community Supports website. However, the introduction of the Supportive Living Framework and Accommodation Standards are not sufficient to clarify the complex and confusing policy context of assisted living. In order to improve clarity, it is recommended that the licensing categories for Supportive Living reflect the four levels outlined in the Supportive Living Framework.

One of the participants in this study observed that assisted living in Alberta is ambiguous, because it is described as both a residential setting for independent older adults and a nursing home alternative. The participant noted that it is sometimes difficult for individuals to qualify for assisted living, because they must be simultaneously independent and in need of a significant amount of care. Based on this observation, it is recommended that the Supportive Living Accommodation Standards and Continuing Care Health Service Standards include parameters for admission and discharge criteria to eliminate confusion regarding the eligibility of older adults for assisted living care.

Accessibility of Assisted Living as a Care Option

The theory that access to assisted living is influenced by characteristics of the assisted living facility has implications for the accessibility of assisted living services. The physical environments of assisted living facilities include the number of beds available and the design of the facility. The findings of this study imply that assisted living providers and policy makers must take into account the physical design of facilities when they assess the availability of assisted living in Calgary. Numbers of beds do not necessarily indicate the availability and accessibility of assisted living. Physical environments that obstruct resident supervision and social involvement, and social

environments that disallow certain behaviours or state preferences for certain personality characteristics may present barriers to individuals with cognitive or psychological illnesses.

The financial accessibility of assisted living is also not accounted for in a simple count of assisted living beds in Calgary. The cost of private assisted living is unaffordable for many people in both Canada and the United States (Aminzadeh et al., 2004; Doty, 2008). As the older adult population continues to grow, it will be important to ensure that affordable housing and care options are available for those who will require them. Based on the findings of this study, it is recommended that Alberta Seniors and Community Supports ensure that a significant proportion of the new Supportive Living beds that are being developed through their capital funding initiatives be contracted by Alberta Health Services as DAL beds.

Continued Access to Nursing Homes as a Care Option

Increased access to Supportive Living beds alone will not address the needs of Alberta's aging population. Older adults will continue to require nursing home care due to chronic illness and disability. Although nursing home care is "seldom the first choice of Albertans and their families" (Alberta Health and Wellness, 2008b), it is the only choice within Alberta's continuing care system for those who require 24-hour nursing care. As the findings of this study indicate, assisted living facilities are not able to provide a nursing home level of care, and residents are frequently discharged due to increased care needs. It is recommended that Alberta Health and Wellness ensure that nursing home care remains an available, affordable care option for older Albertans who require 24-hour nursing care.

Social Work Roles in Assisted Living

The philosophy of assisted living, the social model of care, and the person-in-environment context of admission and discharge decisions are all characteristic elements of assisted living that are compatible with social work theory and practice. However, social workers were not involved in the study as participants, social work was rarely mentioned in interviews, and very little social work research has been done in this area. Given the compatibility of social work with the assisted living context in Calgary, Alberta, there is an opportunity for increased social work involvement in assisted living settings in this province.

The Supportive Living Framework (Alberta Seniors and Community Supports, 2007b) identifies roles within the social work domain, including "coordination and referral services to community supports", and a "guidance/advocacy/advisory role" as "hospitality services" that must be provided in assisted living settings (p. 6). The Supportive Living Accommodation Standards (Alberta Seniors and Community Supports, 2007a), by which assisted living facilities are licensed in Alberta, does not require that these services be provided by social workers. The listing of social work roles as hospitality services demonstrates that social work roles have become de-professionalized in the assisted living industry. This presents an opportunity for the social work profession to advocate for social workers to take on these support and referral roles within assisted living facilities.

Social Work Practice Implications

The above recommendations carry implications for social work practice, which may be implemented through macro social work intervention strategies. Rothman (2008) identifies nine macro social work strategies, based on combinations of three primary approaches: planning/policy, community capacity development, and social advocacy. I will identify two macro social work strategies that could be used to address the above recommendations.

Solidarity Organizing combines the approaches of social advocacy and community capacity development. It involves bringing people together who have common issues, and assisting them to organize themselves to advocate for change (Rothman, 2008). Based on the recommendations of this study, social workers could organize groups of older adults who are interested in advocating for improved provincial policies regarding the availability and financial accessibility of housing and care for older adults in Alberta.

Secondly, the Policy Advocacy strategy combines the approaches of planning/policy with social advocacy. It can entail conducting research, writing policy briefs, and working within government administration to develop and change policies (Rothman, 2008). Based on the recommendations of this study, social workers could send research and recommendations to the provincial government through the Alberta College of Social Workers to advocate for the inclusion of social work roles within the provincial Supportive Living standards. Social workers in related health care contexts such as home care and nursing homes could be engaged by the Alberta College of Social Workers to assist in the identification potential roles for social workers in assisted living settings.

Since the current assisted living policy context in Alberta is currently very fluid, the time may be right for the social work profession to find an entry point and establish itself as an essential part of assisted living care in Alberta.

Directions for Future Research

Given the limited geographic scope of this study, further studies in other policy contexts would be required to determine if the process of admission and discharge is similar in assisted living facilities in other parts of Canada. Further qualitative and quantitative studies on the definition of assisted living and its variation across Canada would also be necessary to ensure that similar types of housing and care services are being compared.

Further qualitative studies could be conducted with social workers and with assisted living residents to determine the possible need for and roles of social workers in assisted living admission and discharge in Canada. Such roles may include clinical roles within assisted living facilities, the management of assisted living facilities, clinical or management roles within Alberta Health Services. In addition, further research in the area of health and housing policy for older adults could identify possible roles for social workers as policy advocates or reformers in Alberta Health Services, Alberta Health and Wellness, and Alberta Seniors and Community Supports to ensure that the quality and regulation of assisted living, including facility licensure and the contracting of DAL beds, continue to improve.

Given the ambiguous role of assisted living within the continuum of care, it would be useful to compare the current roles of social workers across the continuum of care,

including in community agencies, home care, acute care, and nursing home settings, and identify the ways in which social workers could have a role in assisted living that is similar to but also distinct from social work roles in other health and social settings. In addition, further research in the area of admission and discharge could investigate how social workers and other professions work together across housing and care settings in order to improve the efficiency, effectiveness, and resident experience of transitions between these settings.

Since the findings from this study are a product of the context in which the data were collected, it would be interesting to replicate the study given the changes that have occurred within the assisted living context in Calgary, Alberta since 2007. Specifically, a follow-up study could examine the impact of current licensing and monitoring requirements through Alberta Seniors and Community Supports, and the change of DAL and Home Care management from the Calgary Health Region to Alberta Health Services.

Summary

Assisted living remains an emerging field of research, particularly from a social work perspective. The current study provides an exploration into the concepts of assisted living and aging in place as they are understood in the context of assisted living in Calgary, Alberta. It also describes and analyzes the context in which resident admission and discharge decisions are made. As the assisted living industry adjusts to recent changes, including the standardization of the assisted living definition through the Supportive Living Framework; the licensing, monitoring, and public reporting of assisted living facilities according to the Supportive Living Accommodation Standards; and the

creation of Alberta Health Services as a replacement for local health regions in Alberta, it remains to be seen how the notions of assisted living, aging in place, and resident admission and discharge will change from the current findings of this study.

REFERENCES

Alberta Community Development. (2000). *Alberta for all ages: Directions for the future.* Edmonton, AB: Government of Alberta.

Alberta Health and Wellness. (1999). *Healthy aging: New directions for care*. Edmonton, AB: Government of Alberta.

Alberta Health and Wellness. (2008a). *Continuing care health service standards.* Edmonton, AB: Government of Alberta.

Alberta Health and Wellness. (2008b). *Continuing care strategy: Aging in the right place.* Edmonton, AB: Government of Alberta.

Alberta Health and Wellness. (n.d.). *Health benefits and services*. Retrieved August 31, 2009, from http://www.health.alberta.ca/services/home-care.html.

Alberta Health Services. (n.d.). *Transition Services services offered: Community Transition Services coordinators.* Retrieved August 31, 2009, from http://www.calgaryhealthregion.ca/transition/community.htm.

Alberta Health Services Board. (2009). *Alberta Health Services annual report.* Edmonton, AB: Author.

Alberta Seniors and Community Supports. (2007a). *Supportive Living accommodation standards.* Edmonton, AB: Government of Alberta.

Alberta Seniors and Community Supports. (2007b). *Supportive Living framework.* Edmonton, AB: Government of Alberta.

Alberta Seniors and Community Supports. (2009). *A profile of Alberta seniors.*

Edmonton, AB: Government of Alberta.

Alberta Seniors and Community Supports. (n.d.a). *Affordable Supportive Living initiative: Program information*. Retrieved August 31, 2009, from http://www.seniors.gov.ab.ca/ContinuingCare/ASLI/ProgramInfo.asp.

Alberta Seniors and Community Supports. (n.d.b). *Definitions – Affordable Supportive Living initiative*. Retrieved August 31, 2009, from http://www.seniors.alberta.ca/ContinuingCare/ASLI/Definitions.asp.

Alberta Seniors and Community Supports. (n.d.c). *Supportive Living public reporting*. Retrieved August 31, 2009, from http://asalreporting.gov.ab.ca/astral/.

Alberta Seniors and Community Supports. (n.d.d). *Who needs and license and how to get one.* Retrieved August 31, 2009, from http://www.seniors.alberta.ca/housing /continuingcare/SL_license/WhoHow.asp.

Aminzadeh, F., Dalziel, W. B., Molnar, F. J., & Alie, J. (2004). An examination of the health profile, service use and care needs of older adults in residential care facilities. *Canadian Journal on Aging, 23*, 281-294.

Assisted Living Federation of America. (2009). *Core principles: Building resident-centered assisted living practices for the 21st century*. Retrieved August 31, 2009, from http://www.alfa.org/images/alfa/PDFs/PublicPolicy/Core_Principles_ 2009.pdf.

Aud, M. A. (2004). Residents with dementia in assisted living facilities: The role of behaviour in discharge decisions. *Journal of Gerontologocal Nursing, 30*(6), 17-26.

Aud, M. A., & Rantz, M. J. (2005). Admissions to skilled nursing facilities from assisted

living facilities. *Journal of Nursing Care Quality, 20,* 16-25.

Ball, M. M., Whittington, F. J., Perkins, M. M., Patterson, V. L., Hollingsworth, C., King, S. V., et al. (2000). Quality of life in assisted living facilities: Viewpoints of residents. *The Journal of Applied Gerontology, 19*, 304-325.

Berg, B. L. (1995). *Qualitative research methods for the social sciences* (2nd ed). Needham Heights, MA: Allyn and Bacon.

Black, K. (2008). Health and aging-in-place: Implications for community practice. *Journal of Community Practice, 16*, 79-95.

Butler, R. N., Lewis, M. I., & Sunderland, T. (1998). *Aging and mental health: Positive psychosocial and biomedical approaches* (5th ed.). Needham Heights, MA: Allyn & Bacon.

Calgary Health Region. (n.d.). *Designated assisted living (DAL).* (Available from Alberta Health Services, 10101 Southport Road SW, Calgary, AB T2W 3N2)

Calkins, M. P., & Keane, W. (2008). Tomorrow's assisted living and nursing homes: The converging worlds of residential long-term care. In S. M. Golant, & J. Hyde (Eds.), *The assisted living residence: A vision for the future* (pp. 86-118). Baltimore: The Johns Hopkins University Press.

Canada Mortgage and Housing Corporation. (2000). *Research report: Supportive housing for seniors.* Ottawa, ON: Author.

Canadian Association of Social Workers. (2005). *Code of ethics 2005.* Ottawa, ON: Author.

Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together:*

Facility-based long-term care within continuing care – Realities and recommendations. Ottawa, ON: CHA Press.

Chapin, R., & Dobbs-Kepper, D. (2001). Aging in place in assisted living: Philosophy versus policy. *The Gerontologist, 41*, 43-50.

Chappell, N., Gee, E., McDonald, L., & Stones, M. (2003). *Aging in contemporary Canada.* Toronto, ON: Prentice Hall.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (2nd ed., pp. 249-291). Thousand Oaks, CA: Sage Publications.

Cowles, L. A. F. (2000). *Social work in the health field.* New York: The Haworth Press.

Demographic Planning Commission of Alberta Seniors and Community Supports. (2008). *Findings report.* Edmonton, AB: Government of Alberta.

Department of Justice Canada. (2009). *Constitution acts, 1867 to 1982*. Retrieved August 31, 2009, from http://laws.justice.gc.ca/en/const/3.html#anchorbo-ga:s_58.

Doherty, J. & DeWeaver, K. (2002). Critical incidents in the lives of elders with a disability: Factors leading to institutional placement. *Journal of Gerontological Social Work, 38*(4), 39-51.

Doty, P. (2008). The influence of public and private financing on assisted living and nursing home care: The past, the present, and possible futures. In S. M. Golant, & J. Hyde (Eds.), *The assisted living residence: A vision for the future* (pp. 299-328). Baltimore: The Johns Hopkins University Press.

Eales, J., Keating, N., & Damsma, A. (2001). Seniors' experiences of client-centred residential care. *Ageing and Society, 21*, 279-296.

Eckert, J. K., Carder, P. C., Morgan, L. A., Frankowski, A. C., & Roth, E. G. (2009). *Inside assisted living: The search for home*. Baltimore: The Johns Hopkins University Press.

Frank, J. B. (2002). *The paradox of aging in place in assisted living.* Westport, CT: Bergin & Garvey.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Hawthorne, NY: Aldine de Gruyter.

Germain, C. B., & Gitterman, A. (1996). *The life model of social workpPractice: advances in theory and practice* (2nd ed.). New York: Columbia University Press.

Golant, S. M. (2004). Do impaired older persons with health care needs occupy U.S. assisted living facilities? An analysis of six national studies. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 59*(2), 68-79.

Golant, S. M. (2008). The future of assisted living residences: A response to uncertainty. In S. M. Golant, & J. Hyde (Eds.), *The assisted living residence: A vision for the future* (pp. 3-45). Baltimore: The Johns Hopkins University Press.

Government of Alberta. (2002). *Nursing Homes Act.* Retrieved August 31, 2009, from http://www.qp.alberta.ca/574.cfm?page=N07.cfm&leg_type=Acts&isbncln=0779705394.

Government of Alberta. (2003). *Protection for Persons in Care Act.* Retrieved August 31, 2009, from http://www.qp.alberta.ca/574.cfm?page=P29.cfm&le gtype=Acts &isbncln=0779728998.

Government of Alberta. (2007). *Alberta Housing Act.* Retrieved August 31, 2009, from

http://www.qp.alberta.ca/574.cfm?page=A25.cfm&leg_type=Acts&isbncln=9780779726653.

Government of Alberta. (2008). *Social Care Facilities Licensing Act*. Retrieved August 31, 2009, from http://www.qp.alberta.ca/574.cfm?page=S10.cfm&leg_type=Acts&is bncln=9780779733880.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal, 29*(2), 75-91.

Hawes, C., Phillips, C. D., Rose, M., Holan, S., & Sherman, M. (2003). A national survey of assisted living facilities. *The Gerontologist, 43*, 875-882.

Heinonen, T., & Spearman, L. (2001). *Social work practice: Problem solving and beyond.* Toronto, ON: Irwin Publishing, Ltd.

Hodge, G. (2008). *The geography of aging: Preparing communities for the surge in seniors.* Montreal, QC: McGill-Queen's University Press.

Hyde, J., Perez, R., & Forester, B. (2007). Dementia and assisted living. *The Gerontologist, 47*(Special Issue III), 51-67.

Hyde, J., Perez, R., & Reed, P. S. (2008). The old road is rapidly aging: A social model for cognitively or physically impaired elders in assisted living's future. In S. Golant, & J. Hyde (Eds.), *The assisted living residence: A vision for the future*. Baltimore: The Johns Hopkins University Press.

Indian and Northern Affairs Canada. (2008). *Assisted living program*. Retrieved August 31, 2009, from http://www.ainc-inac.gc.ca/hb/sp/alp-eng.asp

Janesick, V. J. (2003). The choreography of qualitative research design: Minuets,

improvisations, and crystallization. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (2nd ed., pp. 46-79). Thousand Oaks, CA: Sage Publications.

Kane, R. A., Chan, J., & Kane, R. L. (2007). Assisted living literature through May 2004: Taking stock. *The Gerontologist, 47*(Special Issue III), 125-140.

Kane, R. A., Wilson, K. B., & Spector, W. (2007). Developing a research agenda for assisted living. *The Gerontologist, 47*(Special Issue III), 141-154.

Kerby Centre. (2007). *Seniors housing directory 2007/08*. Calgary, AB: Kerby Centre.

Kissam, S., Gifford, D. R., Mor, V., & Patry, G. (2003). Admission and continued-stay criteria for assisted living facilities. *Journal of the American Geriatrics Society, 51*, 1651-1654.

Kopetz, S., Steele, C. D., Brandt, J., Baker, A., Kronberg, M., Galik, E., et al. (2000). Characteristics and outcomes of dementia residents in an assisted living facility. *International Journal of Geriatric Psychiatry, 15*, 586-593.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*, 214-222.

Lempert, L. B. (2007). Asking questions of the data: Memo writing in the grounded theory tradition. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory*, (pp. 245-264). Thousand Oaks, CA: Sage Publications.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications, Inc.

Lyketsos, C. G., Samus, Q. M., Baker, A., McNabny, M., Onyike, C. U., Mayer, L. S., et

al. (2007). Effect of dementia and treatment of dementia on time to discharge from assisted living facilities: the Maryland assisted living study. *Journal of the American Geriatrics Society, 55,* 1031-1037.

McPherson, B. D. (2004). *Aging as a social process: Canadian perspectives* (4th ed.). Don Mills, ON: Oxford University Press.

Mead, L. C., Eckert, J. K., Zimmerman, S., & Schumacher, J. G. (2005). Sociocultural aspects of transitions from assisted living for residents with dementia. *The Gerontologist, 45*(Special Issue I), 115-123.

Miles, M. B., & Huberman, A. M. (1994). *An expanded sourcebook: qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Morse, J. M. (2007). Sampling in grounded theory. In A Bryant & K, Charmaz (Eds.), *The Sage handbook of grounded theory,* (pp. 229-244). Thousand Oaks, CA: Sage Publications.

Munroe, D. J., and Guihan, M. (2005). Provider dilemmas with relocation in assisted living: Philosophy vs. practice. *Journal of Aging and Social Policy, 17*(3), 19-37.

Nathanson, I. L., & Tirrito, T. T. (1998). *Gerontological social work: Theory into practice.* New York: Springer Publishing Company.

Newcomer, R. J., Fox, P. J., & Harrington, C. A. (2001). Health and long-term care for people with Alzheimer's disease and related dementias: Policy research issues. *Ageing and Mental Health, 5,* S124-S137.

Northcott, H. C. (2005). *Aging in Alberta: Rhetoric and reality* (3rd ed.). Calgary, AB: Detselig Enterprises Ltd.

Payne, M. (2002). The politics of systems theory within social work. *Journal of Social*

Work, 2, 269-292.

Phillips, C. D., Munoz, Y., Sherman, M., Rose, M., Spector, W., & Hawes, C. (2003). Effects of facility characteristics on departures from assisted living: Results from a national study. *The Gerontologist, 43,* 690-696.

Policy Advisory Committee on Long Term Care. (1999). *Healthy aging: New directions for care.* Edmonton, AB: Alberta Health and Wellness.

Prins, R., & Webber, L. (2005). *Achieving excellence in continuing care: Final report of the MLA taskforce on continuing care health service and accommodation standards.* Edmonton, AB: Government of Alberta.

Rothman, J. (2008). Multi modes of intervention at the macro level. *Journal of Community Practice, 15*(4), 11-40.

Sales, A. E., Hedrick, S. C., Sullivan, J., Gray, S. L., Curtis, M., & Tornatore, J. (2005). Factors affecting choice of community residential care setting. *Journal of Aging and Health, 17,* 190-206.

Sherman, E., & Reid, W. (1994). Coming of age in social work: The emergence of qualitative research. In E. Sherman & W. Reid (Eds.), *Qualitative research in social work,* (pp. 1-15). New York: Columbia University Press.

Sloane, P. D., Zimmerman, S., Hanson, L., Mitchell, C. M., Riedel-Leo, C., & Custis-Buie, V. (2003). End-of-life care in assisted living and related residential care settings: comparison with nursing homes. *Journal of the American Geriatrics Society, 51,* 1587-94.

Spitzer, W. J., Neuman, K., & Holden, G. (2004). The coming of age for assisted living

care: New options for senior housing and social work practice. *Social Work in Health Care, 38(3),* 21-45.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*, (pp. 273-285). Thousand Oaks, CA: Sage Publications.

Utz, R. L. (2003). Assisted living: The philosophical challenges of everyday practice. *The Journal of Applied Gerontology, 22,* 379-404.

Wilson, K. B. (2007). Historical evolution of assisted living in the United States, 1979 to the present. *The Gerontologist, 47*(Special Issue III), 8-22.

Wolf, D. A., & Jenkins, C. (2008). Family care and assisted living: An uncertain future? In S. M. Golant, & Hyde, J. *The assisted living residence: A vision for the future.* Baltimore: The Johns Hopkins University Press.

Zimmerman, S., Mitchell, C. M., Chen, C. K., Morgan, L. A., Gruber-Baldini, A. L., Sloane, P. D., et al. (2007). An observation of assisted living environments: Space use and behaviour. *Journal of Gerontological Social Work, 49,* 185.

APPENDIX A: INTERVIEW GUIDE, ASSISTED LIVING FACILITIES

Introduction and Philosophy:

1. What is your role in the assisted living facility?
2. How many private and/or DAL beds are in your facility?
3. What is assisted living?
4. What does it mean to "age in place"?
5. How does assisted living allow for aging in place?
6. What is the role of assisted living among other housing/residential care options for older adults?

Admission Criteria:

7. What are the policies of the facility regarding the admission of residents?
8. The following admission criteria have been identified in assisted living literature. As I read each criterion, please identify if it is found in the admission policy of your facility, and if so, how it is measured.
    a. Resident is ambulatory
    b. At most a one person transfer
    c. Bowel continence
    d. Temporarily unable to perform ADL's without assistance or supervision
    e. Not requiring skilled nursing procedures, e.g. IV meds, catheter, tube feeding, ventilator, colostomy or ileostomy care
    f. At most mild cognitive impairment
    g. Does not require ongoing supervision or monitoring

h. Bed availability

i. Ability to pay

9. What other criteria are found in your admission policies?

10. How did your organization determine the current admission policies?

    a. Literature review?

    b. Medical recommendations?

    c. Legal advice?

    d. Policies from other assisted living facilities?

Admission Process:

11. Who makes decisions about resident admission?

    a. How are residents and their families involved?

    b. How are staff members involved?

        i. Which staff?

            1. Administrative/Management

            2. Nursing

            3. Direct care staff

            4. Other

    c. Who initiates the decision?

    d. Who makes the final determination?

12. By what process are resident admission decisions made?

13. What role do facility staff members have in the admission of residents?

    a. In private beds?

b. In DAL beds (if applicable)?

Discharge Criteria:

14. What are the policies of the facility regarding the discharge of residents?
15. The following discharge criteria have been identified in assisted living literature. As I read each criterion, please identify if it is found in the discharge policy of your facility, and if so, how it is measured.
    a. Resident's increased need for assistance with activities of daily living
    b. Assistance with transfers
    c. Requiring two-person transfers
    d. Requiring nursing care for over 2 weeks
    e. Bowel incontinence
    f. Functional impairment
    g. Falls
    h. Mild cognitive impairment
    i. Moderate cognitive impairment
    j. Dementia
    k. Wandering
    l. Severe behavioural problems
    m. Resisting care
    n. Depression
    o. Inability to pay for care
16. What other criteria are found in your discharge policies?

17. How did your organization determine the current discharge policies?
    a. Literature review?
    b. Medical recommendations?
    c. Legal advice?
    d. Policies from other assisted living facilities?

Discharge Process:

18. Who makes decisions about resident discharge?
    a. How are residents and their families involved?
    b. How are staff members involved?
        i. Which staff?
            1. Administrative/Management
            2. Nursing
            3. Direct care staff
            4. Other
    c. Who initiates the decision?
    d. Who makes the final determination?
19. By what process are resident discharge decisions made?
    a. Case conferences?
    b. Staff meetings?
    c. Other?
20. How are the staff members who are involved in these decisions informed about facility policies of resident discharge?

21. How are residents and their families informed about facility policies of resident discharge?
22. What role do facility staff members have in the discharge of residents?
    a. In private beds?
    b. In DAL beds (if applicable)?
23. What is the grievance or appeals procedure if residents or their families question the need for the resident to be discharged?
    a. How are residents and their families informed of this procedure?
    b. How are staff members informed of this procedure?

APPENDIX B: INTERVIEW GUIDE, CALGARY HEALTH REGION

Introduction and Philosophy:

1. What is your role in the assisted living admission and discharge process?
2. How many assisted living beds are in your jurisdiction?
3. What is assisted living?
4. What does it mean to "age in place"?
5. How does assisted living allow for aging in place?
6. What is the role of assisted living among other housing/residential care options for older adults?

Admission Criteria:

7. What are the CHR policies regarding the admission of assisted living residents?
8. The following admission criteria have been identified in assisted living literature. As I read each criterion, please identify if it is found in the CHR admission policy, and if so, how it is measured.
    a. Resident is ambulatory
    b. At most a one person transfer
    c. Bowel continence
    d. Temporarily unable to perform ADL's without assistance or supervision
    e. Not requiring skilled nursing procedures, e.g. IV meds, catheter, tube feeding, ventilator, colostomy or ileostomy care
    f. At most mild cognitive impairment
    g. Does not require ongoing supervision or monitoring

h. Bed availability

i. Ability to pay

9. What other criteria are found in your admission policies?

10. How did the Calgary Health Region determine the current admission policies?

    a. Literature review?

    b. Medical recommendations?

    c. Legal advice?

    d. Policies from other health regions?

11. Are your admission policies different for different facilities?

Admission Process:

12. Who makes decisions about resident admission?

    c. How are residents and their families involved?

    d. How are staff members involved?

        i. Which staff?

            1. Administrative/Management

            2. Nursing

            3. Direct care staff

            4. Other

    e. Who initiates the decision?

    f. Who makes the final determination?

13. By what process are resident admission decisions made?

Discharge Criteria:

14. What are the CHR policies regarding the discharge of assisted living residents?
15. The following discharge criteria have been identified in assisted living literature. As I read each criterion, please identify if it is found in the discharge policy of your facility, and if so, how it is measured.
    g. Resident's increased need for assistance with activities of daily living
    h. Assistance with transfers
    i. Requiring two-person transfers
    j. Requiring nursing care for over 2 weeks
    k. Bowel incontinence
    l. Functional impairment
    m. Falls
    n. Mild cognitive impairment
    o. Moderate cognitive impairment
    p. Dementia
    q. Wandering
    r. Severe behavioural problems
    s. Resisting care
    t. Depression
    u. Inability to pay for care
16. What other criteria are found in your discharge policies?
17. How did your organization determine the current discharge policies?
    v. Literature review?

w. Medical recommendations?

x. Legal advice?

y. Policies from other assisted living facilities?

Discharge Process:

18. Who makes decisions about resident admission and discharge?
    a. Are residents and their families involved?
    b. What is the role of CHR staff members?
    c. Are facility staff members involved?
        i. If so, which staff?
            1. Administrative/Management
            2. Nursing
            3. Direct care staff
            4. Other
    d. Who initiates the decision?
    e. Who makes the final determination?
19. By what process are resident admission and discharge decisions made?
    a. Case conferences?
    b. Staff meetings?
    c. Other?
20. How are the staff members who are involved in these decisions informed about CHR policies of admission and discharge?

21. How are the CHR staff members who are involved in these decisions informed about facility policies of admission and discharge?
22. How are residents and their families informed about CHR policies of admission and discharge?
23. What is the grievance or appeals procedure if residents or their families question the need for the resident to be discharged?
    a. How are residents and their families informed of this procedure?
    b. How are staff members informed of this procedure?

CHR Oversight:

24. By what process does the CHR monitor the terms of the contracts with assisted living facilities to provide DAL beds?

APPENDIX C: CONSENT FORM

FACULTY OF SOCIAL WORK
CAROL D. AUSTIN
Professor
Telephone: (403) 220-5946
Fax: (403) 282-7269
Email: austin@ucalgary.ca

CONSENT FORM

TITLE: An Examination of Admission and Discharge Policy and Practice in Assisted Living Facilities in Calgary, Alberta

SPONSOR: Social Sciences and Humanities Research Council

INVESTIGATORS: Dr. Carol Austin, Raynell McDonough

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

This study will examine the admission and discharge policies of assisted living facilities in Calgary, Alberta, and the process through which assisted living residents are admitted and discharged. The study involves an analysis of provincial and organizational policies as well as qualitative interviews with representatives from assisted living facilities and the Calgary Health Region.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore the admission and discharge policies and practices in assisted living facilities in Calgary and to examine the differences in policy and practice between private assisted living and designated assisted living. You have been invited to participate in the study because of your knowledge and experience concerning assisted living policy and practice in Calgary.

WHAT WOULD I HAVE TO DO?

You will be asked to provide information about policies and practices concerning assisted living in your organization. I will ask you a prepared set of questions. Depending on the length of your answers, the interview will take approximately 60 to 90 minutes. Your responses will be transcribed, and you will be given an opportunity at a later date to review the transcribed document and make any changes to your responses that you feel are necessary within two weeks.

WHAT ARE THE RISKS?

There are no known risks to participation in this study.

WILL I BENEFIT IF I TAKE PART?

When the study is completed, the findings will be distributed to all participants. This comparative study of assisted living policy and practice in Calgary will provide you with information about the assisted living industry in Calgary.

DO I HAVE TO PARTICIPATE?

Your participation is voluntary, and you are free to withdraw from the study at any time. If you would like to withdraw from the study, please contact Raynell McDonough or Dr. Carol Austin at the phone numbers listed below.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for your participation. However, there are no direct costs to you associated with participation.

WILL MY RECORDS BE KEPT PRIVATE?

Any information you provide will remain confidential. Your comments will be combined with those of other participants, and you will not be personally identified in any presentation or publication of results. The information you provide will be kept in a password-protected computer and locked cabinet only accessible by the researcher and her supervisor. If you choose to withdraw from the study, the information you provided until that point will be retained and included in the study with your permission. The data will be stored for five years, at which time it will be permanently erased.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have further questions concerning matters related to this research, please contact:

Dr. Carol Austin (403) 220-5946

Or

Raynell McDonough (403) 283-2080

If you have any questions concerning your rights as a possible participant in this research, please contact The Ethics Resource Officer, Internal Awards and Research Services, University of Calgary, at 220-3782.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

APPENDIX D: CALL TO PARTICIPATE, ASSISTED LIVING FACILITIES

October 19, 2007

Dear Administrator,

I am a student at the University of Calgary in the Master's of Social Work program. For my thesis research, I am looking at resident admission and discharge policies in assisted living facilities in Calgary, Alberta. As part of my research, I would like to interview you or a member of your staff about your policies of admission and discharge and how these policies are put into practice.

I have attached a consent form and a copy of the interview questions, which will provide you with further information about the study. In brief, participation in this study involves one person from your facility spending approximately 60-90 minutes discussing the enclosed questions about resident admission and discharge. The identity of the research participant and your facility or the management organization would not be identified in the publication of results.

This study has been approved by the Conjoint Health Research Ethics Board at the University of Calgary. There is no identified risk in participating in the study. I believe there is good care being provided in supportive living environments, and I have a great deal of respect for your work. The study does not involve any deception. The intention of my research is to understand how admission and discharge decisions are made in facility-based supportive living in Calgary. I will also interview employees from other supportive living facilities in Calgary, and all responses will be combined with the responses of other participants.

I will contact you by phone to ensure that you received this package and to discuss your possible participation in this study. Thank you very much for your time and I look forward to speaking with you.

Sincerely,

Raynell McDonough, BA, BSW, RSW
MSW Student, University of Calgary
ramcdono@ucalgary.ca
(403) 923-7064

APPENDIX E: CALL TO PARTICIPATE, CALGARY HEALTH REGION

An Examination of Admission and Discharge Policy and Practice in Supportive Living Facilities in Calgary, Alberta

Research Questions:

1. What is the policy context of designated assisted living and private supportive living in Alberta?
2. What are the admission and discharge criteria for private supportive living and designated assisted living beds in Calgary, Alberta?
3. How are the processes of admission and discharge initiated? What are the roles of the facility and the health region in the processes of admission and discharge?

Request of Home Care Participants:

- 2 participants from Home Care (DAL)
- One 60-minute qualitative interview with each participant
- Participants may review questionnaire before the interview
- Each participant will be sent a transcript of the interview and are invited to make changes to responses

Risks:
There are no known risks to participation in this study.

Benefits:
Participants: Involvement in this study will give participants an opportunity to reflect on the admission and discharge policies in supportive living in Calgary, how those policies are applied, and the impact of these policies on their clients and organization. Participants may also use the findings in interactions with community partners or clients to provide clarification about the supportive living industry in Calgary.
Research Community and Society at Large: This study will fill a gap in research concerning supportive living in Canada. The results of the study will provide further clarification into the distinction between supportive living and other types of housing and care for older adults. By highlighting admission and discharge policy and practice, the research will provide information about the characteristics that lead to longer stays in supportive living settings.

Dissemination of Findings:
Once the study has been completed, I will send a summary of the findings to CHR Home Care, Transition Services, providers of DAL and private supportive living in Calgary, and organizations in Calgary that provide information about housing and care to older adults and their families.

For further questions or to arrange an interview, please contact:
Raynell McDonough
ramcdono@ucalgary.ca
(403) 923-7064