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Quality issues for the elderly at adult residential care homes in Hawaii

Karel, Harumi Sasaki, Ph.D.

University of Hawaii, 1991

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QUALITY ISSUES FOR THE ELDERLY
AT ADULT RESIDENTIAL CARE HOMES IN HAWAII

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISIONS
OF THE UNIVERSITY OF HAWAI'I IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

SOCIOLOGY

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BY

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ACKNOWLEDGMENTS

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ABSTRACT

Concern about the quality of health care is a major issue in delivering health care services. Over the past several decades, a tremendous amount of research has been conducted on the quality of care; however, studies examining the quality at community-based facilities has been very limited. Since the rapid expansion of the elderly population concomitant with the escalated health expenditures, the community-based care facilities which house many elderly and other disadvantaged populations have recently become the focus of attention as an alternative to long-term institutionalization.

The issue of quality of care is a very complex one. Although many researchers have attempted to clarify the concepts and methodologies, various issues are yet to be resolved.

Thus, the approach of this study was exploratory. It was to examine the life experiences of the elderly in the community-based adult residential care facilities in Hawaii and to investigate the issue of quality of care from the consumer's perspective. The patient's satisfaction towards the care provided was used to measure the quality of care at the adult residential care homes. In utilizing various sociological concepts as guides, the development of a conceptual framework for the study of the relationship and
the interaction of care home operators and the residents was attempted. The majority of the data presented here were based on the visitation of 79 out of 414 adult residential care homes in Hawaii together with my past experience as a social worker. A typology of the care home operators was created based on the motivational approach of its operators.

The analysis of quality of care was conducted by utilizing both quantitative and qualitative (case study) approaches. Based on the analysis, a majority of the elderly residents who were mentally alert were satisfied with the care they received. Whether their responses were affected by the reluctance of the elderly residents to freely express their feelings due possibly to fears of repercussion or low expectations were not clear. However, the case studies revealed the very intricate and sensitive nature of the elderly who were housed in adult residential care homes in Hawaii.
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<td>AARP</td>
<td>American Association of Retired Persons</td>
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<td>ADL</td>
<td>Activity of Daily Living</td>
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<td>ANOVA</td>
<td>Analysis of Variance</td>
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<td>ARCH</td>
<td>Adult Residential Care Home</td>
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<td>DHS</td>
<td>Department of Human Services</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DRG</td>
<td>Diagnostic Related Groups</td>
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<tr>
<td>DSSH</td>
<td>Department of Social Services and Housing</td>
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<tr>
<td>EOA</td>
<td>Executive Office on Aging</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activity of Daily Living</td>
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<tr>
<td>ICF</td>
<td>Intermediate Care Facility</td>
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<tr>
<td>MANOVA</td>
<td>Multivariate Analysis of Variance</td>
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<tr>
<td>SHPDA</td>
<td>State Health Planning and Development Agency</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>SSP</td>
<td>State Supplemental Payment</td>
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CHAPTER 1
INTRODUCTION

Concern about the quality of health care is by no means a recent phenomenon. Over the past several decades, a tremendous amount of research has been produced concerning the measurement and study of this concept (Brook, 1975, Brook, Avery, Greenfield, Harris, Leiah, Solomon, & Ware, 1976, Brook, Davies, & Kamberg, 1979; Donabedian, 1969, 1980, 1985; Ellis, 1988; Friedman, 1988; Kraft, 1989; O'Connor, 1988; Oriol, 1989; Ruberts, 1988; Smith, 1979; Wyszewianski, 1988; McCullough, 1988). Although long-term nursing and custodial care have been provided through different institutions and community-based facilities such as psychiatric hospitals, nursing homes, foster homes, and care homes, attention to the systematic study of the quality of care at the community-based facility has been very limited (Manard, Kart, & Van, 1975; McCoin, 1989).

The reason for the lack of attention to long-term care services is due mostly to the dominant ideology based on the "medical model." The development and the expansion of scientific medicine which focuses on the curative approach to disease has provided the basis for the profitable health care industry in our society (Doyal, 1981). Thus, the recognition of long-term nursing and custodial care has long been neglected.
However, the cost of medical care in general in recent years has skyrocketed, leading policy makers to seek alternative means to the delivery of health care in the United States. Recent health policy focuses on alternatives to long-term care institutionalization or deinstitutionalization. The policy encourages the establishment of community support systems nationwide. Although cost containment affected the change in the policy, new alternative modes of care also resulted from the idea that prolonged institutionalization creates negative and dehumanizing effects. The new policy emphasizes the provision of less structured living; smaller facilities; individual residences rather than group residences; greater integration into the community, and increased independent living (Scheerenberger, 1977; Thiele, Paul, Neufeld, 1977; Gelfaud & Olsen, 1980; Hilker, 1987; McCoin, 1985; Lerman, 1982; Bowker, 1982; Grob, 1983). Notwithstanding the good intention of providing more appropriate, more humane, and less restrictive community-based care for the mentally ill and the elderly, the deinstitutionalization movement has been criticized as inadequately meeting the needs of the frail elderly and the mentally ill (Brown, 1980; Grob, 1983; Rathwell, 1984; Markson, 1985; Wegner, 1990). In addition, the trends toward unplanned discharge of thousands of state hospital patients into growing nursing homes and community-based facilities has become a great concern. Some have
charged that these clients become the victims of a profit-making health industry (Brown, 1980). Contrary to the goal of deinstitutionalization to promote a home-like environment, residents in many community-based care facilities experience lack of privacy, lack of freedom of choice and restrictions by the operators (Mor, Gutkin, & Sherwood, 1986).

Consequently, adult residential care as one type of long-term community-based care service has received considerable attention in recent times (Williams, 1980). A critical analysis on the quality of care at the adult residential care homes is now emerging, but it is as yet in the early stages. What follows is an investigation into the quality of care and the life of the elderly at adult residential care facilities in Hawaii. This dissertation also examines the issue of quality of care in such a way that it can be used to improve the provision of community-based care services.

Deinstitutionalization

The Aim of Deinstitutionalization

The current history of deinstitutionalization began by the mid-1950s due to the remarkable change in attitudes and practices toward dealing with mentally ill patients (Grob,
1983). The aim of the deinstitutionalization movement was to exchange physically isolated treatment settings for physically integrated community settings, on the assumption that community-based treatment settings could provide more humane and better quality services. Normalization and the least restrictive environment were two fundamental guiding principles in deinstitutionalization (McCoin, 1985; Strauss et al., 1984). In addition, community-based care was widely believed to be more economical than institutional care (Backrach, 1983).

More specifically, deinstitutionalization sought 1) to prevent both unnecessary admission to and retention in institutions, 2) to develop appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of the mentally disabled, and 3) to improve the condition of care and treatment (Lerman, 1982).

Consequently, one of the elements of the movement of deinstitutionalization was the issue of quality of care and the quality of life of people in the institutions (Tobin, 1976).

Critics Toward the Conception of Deinstitutionalization

The delivery of adequate and quality care cannot be simply administered by the act of moving the patient from the institution to community-based care facilities.

Some researchers indicate that the shift of residents from the state mental hospitals to alternative settings is
not really a "de"institutionalization but "re"institutionalization (Linn, Klett, & Caffey, 1980; Goldman, 1983). Another perspective indicates that deinstitutionalization refers to reduced reliance on "traditional" institutions and not on institutions per se (Lerman, 1982). Community-based alternatives, although they are non-traditional, may represent types of institutional facilities. Thus, McCoin's notion that normalization and least restrictive environment as fundamental principles of deinstitutionalization may not be realized as another form of custodial care. Lerman concludes that:

It is apparent that the country has been engaging in the invention and expansion of many new institutional types since the 1930s: nursing homes (SNF and ICF); nonmedical board-and-care homes; homes and schools for the emotionally disturbed; community mental health and multipurpose inpatient facilities; group homes and halfway houses in the fields of alcohol, drugs, mental health, mental retardation, and juvenile corrections. The addition of these types testifies to an expansion of the total institutional system (Lerman, 1982, p. 49).

However, the negative effects of institutionalization and the function of social control placed upon the total institution have not been eliminated by the community-based facilities. Some of the examples are 1) house rules and curfew restrictions, 2) locked rooms, as well as other forms of physical controls, 3) operator demands and/or threats, 4) limits on use of resident spending money, and 5) use of
psychotropic drugs as a way to control the behavior of residents (Thiele et al., 1977).

The shortcomings of deinstitutionalization have been attributed to poor leadership, failure to plan, lack of administrative and monitoring procedures, uncoordinated service-delivery systems and other implementation deficiencies. Policies have been established in an emergent or ad hoc fashion which were often embedded in older policies designed for other purposes and/or problems (Brown, 1980; Lerman, 1982; Rathwell, 1984; Markson, 1985).

Community-Based Care

Definition

The term "community-based" is rarely defined in the literature. Basically, community-based care indicates various types of long-term care services and facilities provided in the community except hospital-like large traditional institutions. Historically, the term community-based care had broader meanings to indicate any alternative care to mental institutions. Nursing homes were once considered as community-based care facilities for some people. However, the term community-based care has come to have more specific meanings than previously. The community-based care facility refers to the transitional facilities bridging the institution and the community (independent
living) by providing long-term supportive residences and personal/custodial care in a family-like atmosphere. The community-based care facilities include family-care homes, adult residential care homes, foster care homes, board and care homes, group homes, half-way houses, community mental health centers, homes for the emotionally disturbed, and the like.

Family-care homes were one of the first attempts at alternative care for the mentally ill and they made an important contribution to the establishment of a community-based care system. Later, family-care homes and half-way houses were supplemented by the development of the board and care homes, which had taken on the three functions of community-based care: long-term care, transitional care, and placement of first resort (Segal & Aviram, 1978).

Since the late 1960's, the board and care home industries including the nursing home industry proliferated primarily as profit-making enterprises. Lerman (1982) indicated that a majority of care (77%), which accounted for 824,038 persons, were provided by nursing homes, 248,827 (23%) in personal care or domiciliary care in 1973.

Recent Studies on the Quality of Care in Community-Based Care Facilities

Although the study on the quality of care in the long-term care setting is limited, increasing attention has been placed on the quality of care in nursing homes because of
the rapid growth of the elderly population and repeated findings of inadequate care in many nursing homes (Spector & Drugovich, 1989; Institute of Medicine, 1986; Yordy, 1988; Hilker, 1987; Peters, 1989; Trocchio, 1987; Kane & Kane, 1986; Lamb, 1981; Hanson, 1985; Budson, 1981; Abramson, 1986).

Although a regulatory process for nursing homes has been implemented since 1974, this process focuses on the capacity (structure) of nursing homes to provide quality care and not on the caregiving (process) or the outcomes of that care (Yordy, 1988). The Institute of Medicine (1986) completed a study of the quality of care in nursing homes and concluded that the general level of quality is not as high as it could and should be. In addition, there are no reliable methods to make inter-facility comparisons of quality. Their recommendation was that profound changes are needed if the regulatory system is to be more effective.

In comparison to the nursing home study, the study on quality of care at the community-based facility such as at adult residential care facilities is still at an embryonic stage (Kane & Kane, 1988). A study done in Atlanta, Georgia indicated the following problems in these community-based facilities: 1) poor living conditions of care homes, 2) inappropriate placement, 3) lack of medical care, 4) inadequate staffing, 5) possible abuse and neglect, 6) lack of family support, 7) financial exploitation, 8)
insufficient community resources, 9) absence of residents rights, and 10) lack of rehabilitation programs (McClave, 1982). Hilker (1987) noted, after reviewing the licensure of community-based facilities of some states, that the licensure standards only focus on the physical plant, food services, administrative procedures and staffing ratio, and disregarded the emotional and psychological outcomes of institutionalization. He claimed that the reasons for the lack of attention to these factors were due to the difficulties in defining and measuring such outcome variables.

Quality of Care

Basic Concept about Quality of Health Care

Concept.

Numerous studies have examined the issues of quality care, quality assurance, and quality assessment (Wandelt & Ager, 1974; Brook & Williams, 1875; Svarstad, 1976; Ainsworth, 1977; Brook et al., 1976, 1979; Smith, 1979; Donabedian, 1969, 1980, 1985; Spiegel & Backhaut, 1980; Markson, 1985; Institute of Medicine, 1986; Kane & Kane, 1988; Ellis, 1988; Roberts, 1988; Friedman, 1988; Yordy, 1988; McCullough, 1988; O'Connor et al., 1988; Wyszewianski, 1988; Kaplan, Greenfield, & Ware, 1989; Kraft, 1989; Oriol,
The concept of quality of care is a very complex one. However, its complexity seems to arise from the elusive nature of the term "quality" itself. The key dilemma is "who" defines quality for "whom." The problem is also compounded by the measurement difficulty in assessing quality. It seems as though there are two potentially polar views on quality: 1) quality is a very individualized concept, where no standardized measure of quality is adequate to examine the individual cases; and 2) quality is defined by conformity to requirements or to technical criteria of performance and methods; therefore, it can be measured. In assessing the quality of health care, the definition and measurement of quality must be precise (Roberts, 1988). For this reason, it is imperative to explicitly specify the level and scope of concern about quality of care, such as who or what is being considered, what aspect of it is being measured, and how it is being assessed because the aspects of care that require assessment might vary from level to level (Donabedian, 1969; Spiegel & Backhaut, 1980; Friedman, 1988).

Definition of quality in medical contexts.

There are two, sometimes three ways to define quality of care: expert or provider-oriented, client or consumer-oriented, and societal or collective-oriented approaches.
(Kraft, 1989). The provider's view of the definition of quality is the standard level used by health care professionals regarding their credentials, education, training, competency, etc. Also, there are direct measures of their performance. The consumer's view of the definition encompasses the highest level of care based on their expectations and perceptions. The societal view is based on the aggregate net benefit for a given population as measured by such epidemiological measure as mortality rates, incidence rates and life expectancy.

Traditionally, the tendency for assessing the quality of care is geared to the control and ensurance of the credential of the medical staff, which is the provider-oriented approach. The consumer-oriented approach has been long ignored; however, consumers have recently become more involved in the quality of care issues. Recently, several researchers stated that the assessment of quality must focus on patients' perceptions and satisfaction as well as health status (O'Connor et al., 1988; Cleary & McNeil, 1988; Lohr, 1988; Linder-Pelz, 1982).

Technical vs. art-of-care.

In examining the quality of care, there are two components: technical care and art-of-care. Brook (1975) reclassified Donabedian's two major aspects of care, physician behavior (curing) and the client-provider relationship (caring) to technical medical care and art-of-
care. Technical care refers to the adequate use of preventive, diagnostic, and therapeutic procedures and art-of-care refers to the milieu, manner, and behavior of the provider in communicating and delivering care to the patient (Donabedian, 1980; Brook, 1975; Spiegel & Backhaut, 1980; Friedman, 1988). These two components are not assumed to be additive but interact in a complex manner (Brook, 1975).

Until recently, measurement of quality generally emphasized the technical aspects of health care and not art-of-care because it has been relatively easier to measure. Some features of the art-of-care pose significant problems in observing, describing, recording, and measuring (Ellis, 1988). Despite the difficulty in measuring the aspect of art-of-care, recent approaches seem to place more emphasis on the art-of-care (Brook et al, 1979; Spiegel & Backhaut, 1980; Kraft, 1989). Several recent studies indicate that the most important attributes of a physician as perceived by the patient were interpersonal aspects of care, art of care, and not so much the technical skills, or the instrumental aspects of care (Stiles, Putnam, Wolf, & James, 1979; Dimatteo, Taranta, Friedman, & Prince, 1980; Dimatteo & Dante, 1982; Friedman, 1982; Linn & Greenfield, 1982). The quality of the interpersonal care that patients receive seems to influence the outcome of medical treatment significantly. The interpersonal domain, thus, is quite
important in assessing the quality of care as perceived by
the patients.

The development of valid measures of the art-of-care
becomes crucial in assessing the quality of care.
Naturally, the assessment of art-of-care needs a different
approach than measuring technical aspects which are often
based on written administrative and medical records.
Periodic surveys of patient satisfaction that focus on
quality of care or direct observation of interactions
between provider and patient through videotaping or
recording may be needed (Kraft, 1989; Like & Zyzanski,
1987).

Problematic nature of assessment.

The problematic nature of the assessment methodology is
not only limited to the art-of-care. There has been
considerable controversy regarding an appropriate
methodology for assessing quality. In evaluating the
quality of care, three approaches are available: structure,
process, and outcome. Structure refers to the relatively
stable resources of care, human, physical, and financial
that are needed to provide care. Process refers to a set of
activities of care which are explicitly regulated by
professional norms. Outcome refers to the change in a
patient's current mental and health status, attitudes,
including satisfaction, and health related behavior
(Donabedian, 1969). Structure, process, and outcome are not
three distinct and mutually exclusive aspects but they are elements in a chain, bound to one another by causal connections (Wyszewianski, 1988).

Various researchers have extensively examined the quality of care by utilizing these three approaches: structure, process, and outcome (Brook, 1975; Brook et al., 1975, 1976, 1979; Cleary & McNeil, 1988; Lohr, 1988; Donabedian, 1980; Wyszewianski, 1988). The results of these studies, however, raise questions about the extent of the connections between each aspect of care and its role in examining quality of care. The examination of structure is only meaningful if it influences how care is actually delivered (process). Outcome can be an indicator of quality of care only if it is attributable to process and structural elements (Wyszewianski, 1988).

There is no agreement as to what would be the best measure of quality of care among researchers. Nevertheless many studies have been utilizing outcome as the means to measure quality of care. Broadly speaking, there are two types of outcome measurements: physiological (objective) and psychological (subjective). The most common outcome measures are physiological such as death and morbidity. Some of the problems with utilizing physiological indicators, such as death, are: 1) the feasibility of study is very limited due to the infrequency of occurrence, 2) death often occurs so late in the course of treatment that
timely evaluation is impossible, and 3) it is heavily influenced by intervening factors such as genetic makeup, social environment, etc (Brook et al., 1976; Lohr, 1988).

In examining the subjective indicators such as patient satisfaction, the validity, reliability and relevancy of information provided by the patients will most likely be questioned (Henley & Davis, 1967; Locker & Dunt, 1978; Fitzpatrick & Hopkins, 1983; Like & Zyzanski, 1987). Although patient satisfaction is a troublesome variable to measure, patient satisfaction is a crucial "art-of-care" aspect of quality assessment and is the most recognized and widely used measure for gauging the effectiveness of the physician-patient relationship (Brook, 1975; Brook et al., 1979; Kaplan et al., 1989; Friedson, 1979; Patrick, Scrivens, & Charlton, 1983; Kane & Kane, 1988; Lohr, 1988; Linn & Greenfield, 1982; Stamps & Finkelstein, 1981; Ben-Sira, 1976). The rational for utilizing patient satisfaction as a measurement of quality of care has been the importance of knowing how people felt towards the provider's performance, personal courtesy of staff, and administrative stability. Information obtained from the patients provide insight into the realities of the health care system (Spiegel & Backhaut, 1980; Pascoe & Attkinsson, 1983). Locker & Dunt (1978) stated that when the individual is subject to long-term care, the quality of care can become synonymous with the quality of life in general.
Patient satisfaction with medical care, especially with the art of care, enhances their compliance with medical regimens. On the contrary, patient dissatisfaction with the art of care inhibits the establishment of an effective physician-patient relationship and leads to "doctor shopping" (Dimatteo et al., 1980).

**Unit of analysis.**

Another factor needs to be considered in conducting the assessment of quality of care is the unit of analysis. There are four possible units of analysis: 1) the physician-patient interaction, 2) the patient-physician team interaction, 3) the health care organization, and 4) the community. The first is the fundamental interaction in health care. The second examines the network of interaction among multiple practitioners and patient. The third approach examines organizational characteristics. The last examines variations between localities in health care practice patterns (Roberts, 1988).

Most studies so far have examined the physician-patient relationship as the unit of analysis in assessing quality of care (Dimatteo et al., 1980; McCullough, 1988; Kasch, 1985; Svarstad, 1976; Stiles et al., 1979; Linn & Greenfield, 1982; Like & Zyzanski, 1987; Weisman & Teitelbaum, 1985; Fibush & Turnquest, 1970; Bloom, 1963; Kadushin, 1972; Mizio, 1972; Banks, 1971; Zola, 1973; Fisher & Todd, 1983).
The choice of measuring criteria generally reflects: 1) the availability of types of information, 2) the researcher's intended statements concerning quality, and 3) the availability of financial resources to conduct the study (Brook, 1979).

**Structural vs. provider characteristics.**

Based on the review of the literature, another aspect, structural characteristics (institution) vs. provider's characteristics regarding the quality of care, seems to be evident.

From the literature, two competing perspectives on quality of care are evident: 1) quality of care is influenced solely by the organizational and structural characteristics of the institution; and 2) quality of care is influenced by the approach of the administrator and staff personnel based on their ideologies and professionalism at the institutional settings.

The implication of Goffman's work is that the negative effects of institutionalization are due to structural properties which are common to all total institutions and not to the personalities of individual administrators (Bowker, 1982). Goffman (1961) indicated that the total institution creates a particular culture by which people adapt to and modify the formal system of surveillance. Institutional routine is experienced by patients as they often go through a mortification of the self and a stripping
process of former statuses in order to adapt to the institutional situation. The total institution creates dependency and submission of the people.

Similarly, Smith (1979) notes that "the system," the characteristics of institutional structures such as highly technical and administrative procedures, are barriers to quality nursing. He indicated that the focal point of the system is administrative efficiency, to manage with highly specialized technologies and highly specialized large staffs in order to reduce unit costs. Thus, the procedures of the organization often serve as obstacles to justify professional practice.

On the contrary, the role of provider characteristics emphasizes that the quality of care is affected by individual characteristics such as the personality, experience of providers, and the process of interaction between providers and recipients (Kane & Kane, 1988; McCullough, 1988).

Strauss et al. (1964) examined the interplay of institutional, ideological, and professional forces as they affect the practice of psychiatry in different hospitals. The results showed that there were great differences in what was done and how it was done among different institutions. They stated that:

given similar institutional conditions, persons with different ideological positions operate differently, that is,
they emphasize different elements of the possible array of services and organize their working conditions accordingly. ... While a number of institutional conditions may affect professional fate, our data suggest that interaction with other ideology-bearing professionals is critical (Strauss et al., 1964, p. 361).

Although Ryden (1983) indicated in her study that the highly constrained environments of nursing homes did not restrict the autonomy of its residents, in reviewing the available literature, there is no doubt that the institutional structure, or "system" definitely places restrictions on the process or the delivery of services. But, individual characteristics of the professionals also influence the way services are provided. Hence, both factors, structural and individual characteristics, affect the quality of care.

The question is then which factors should be given more weight on the quality of care. If the structural characteristics had more weight, then the quality of care at the community-based residential care facilities may be better than the institutional facilities. If the individual characteristics of the professionals had more weight, there may not be much of a difference conceivably between institutional and community-based facilities. One would assume great variations among different facilities in the individual characteristics of their administrators and other professional caregivers.
Intended Approach to the Study

Purpose and the Rationale for the Selected Approach

Major purpose.

The major purpose of this study is to examine the life experiences of the elderly in the community-based adult residential care facilities in Hawaii and to investigate the issue of quality of care from the consumer's perspective.

In conducting the study, two inter-related sociological issues are considered: the quality of care and the provider-patient relationship. The development of adult residential care facilities was facilitated by the deinstitutionalization movement which emphasized the improvement of the quality of care and the quality of life of people in institutions.

As previously stated, the concept of quality of care is a very complex one. In conducting the study, the concept of quality of care will be specified for the elderly persons needing custodial care in adult residential care homes. Since adult residential care homes are non-medical in orientation and skill, the interpersonal domain, rather than technical performance is assumed to be of primary significance.

The definition of quality of care for this study is:
Quality of care in the context of adult residential care homes, is care that meets the needs of individuals in the following respects: 1) by being available and accessible when necessary; 2) by treating the individuals with respect and dignity; and 3) by providing less restrictive, and safe environment where people can live contentedly and comfortably.

**Consumer-oriented approach.**

Although research on community-based care facilities including the adult residential care facilities on the psychiatric, mentally ill, and developmentally disabled patients are available nationwide (Segal & Aviram, 1978; Newcomer & Grant, 1988; McClave, 1982; Piasecki, 1981; Scheerenberger, 1975; Steinhauer, 1982; Kruzich & Kruzich, 1985; Putten & Spar, 1979; Yutiaoa & Kinzie, 1975; Linn, 1981; White, 1981; Linn & Caffey, Jr., 1977; Ullmann, 1961; Lamb, 1980, 1981; Linn et al., 1980; Benjamin & Newcomer, 1986; Sherwood & Morris, 1983; Mor & Gutkin, 1986; Coulton, Fitch, & Holland, 1985; Blaustein & Viek, 1987; Moos & Igra, 1980; Ryan, 1979; Sherman & Snider, 1981; Sherman & Newman, 1988; Institute of Medicine, 1986), not many investigative studies have been done on the quality of care issues from the resident's perspective, particularly the elderly, at the community-based facilities.

Recently, the consumer's view towards the quality has been increasingly stressed by various researchers (Lohr, 1988; Cleary & McNeil, 1988; Kaplan et al., 1989; Freeman, 1989; Zola, 1981). The consumer's view, particularly
patient satisfaction, plays a pivotal role in examining the interpersonal component of quality. The level of satisfaction may well be a result of provider-patient interactions in a variety of dimensions. No doubt, the perceptions, and opinions of the patient can be regarded as valid measures of care in the interpersonal domain of care. For example, caring encompasses the acceptability of services from the provider's point of view but more so the perceived acceptability of services from the patient's point of view. For the reasons stated above, the emphasis of the study will be placed on the examination of the art-of-care from the consumer's perspective.

For the purpose of the study, the dyadic interaction of care home operators with the elderly residents (provider-patient) is the most suitable unit of analysis, since the relationship constitutes the fundamental interaction at the adult residential care home. Thus, the study will examine various issues regarding this specific type of provider-patient relationship and will utilize existing models of professional-client relationship.

**Selection criteria for the assessment of the study.**

The utilization of three criteria, structure, process, and outcome of quality of care will be attempted since all three aspects are interrelated. The characteristics of care home operators and the care homes will be utilized as structure. The relationships of care home operators and
residents, the ways the services are provided to the residents by the operators, will be utilized for process measurement.

The best outcome variable is said to be the change in physiologic status (Kaplan et al., 1989); however, the utilization of physiologic status in this study is quite difficult because the major purpose of adult residential care facility is to provide custodial care and not medical treatment. In addition, physiologic status may not be the most appropriate measure of quality of care for the chronically ill and disabled (Kane & Kane, 1989). The physical change may occur but it may not be attributable to the care received from care home operators. For this reason, notwithstanding the difficulty of measuring satisfaction, the examination of satisfaction as an outcome variable will be attempted with the support of the idea that client satisfaction with care is an important dimension to examine in cognitively intact residents in long-term care institutions (Kane & Kane, 1988).

Significance.

The significance of the study is multifold. First of all, the investigation of quality of care at adult residential care facilities is imperative for the evaluation of the deinstitutionalization movement and for future policy development. A newly created prospective method of reimbursement system, Diagnostic Related Groups (DRG),
encourages the early discharge of patients. Concomitant with the shortage of skilled/intermediate level nursing homes in Hawaii, quite a number of elderly patients have inadequately been placed into care home facilities. Recently there has been an upgrading of the nursing skills of care home operators. In addition, boarding and care homes have been consolidated with the elimination of the former service. The effectiveness of the delivery of long-term care services of which adult residential care homes are a part for the frail elderly population is crucial since the elderly population, especially the "old-old," has been increasing quite rapidly.

Secondly, the examination of quality issue from the perspective of the consumer has rarely been done. However, consumers can play a pivotal role in advocating for the improvement of quality because they illustrate their assertions with examples from their own experiences. The evidence shows that organized consumer action has resulted in the enactment of statutes establishing residents' rights and has strengthened licensure codes in many states (Freeman, 1989). Moreover, what constitutes quality, technical vs. art of care, from the point of view of the consumer affects the very locus of health care delivery and utilization. As O'Connor et al. (1988) stated, the assessment of quality must focus on patients' perceptions, as well as health status. Success in providing health care
services will greatly depend on how well consumers are satisfied with the services they receive.

Finally, there is a need for developing a model and a tool for assessing quality of care specifically appropriate to the Adult Residential Care Homes.

Plan of Dissertation

This first chapter provides the overview of and the origin of the development of community-care services and facilities focusing on the rising awareness towards the quality of care issue. The concept and the problems of defining quality of care have been reviewed. Based on the review of literature, the intended approach of this study in examining the quality of care, rather than, curing has been described.

The second chapter provides a background descriptive information about the population who utilize the community-based care services in relation to the overall long-term care system in Hawaii. Community-based care such as in adult residential care homes is a part of long-term care system which provides a whole array of assistance to disabled people. Thus, the existence of adult residential care homes is imperative in providing a continuum of care. The detailed information regarding the historical development of adult residential care homes, their
characteristics, the regulatory system, and financial issues will be described. In addition, the specific terminology to clarify the ambiguousness of naming community-based facilities will be provided.

The third chapter reviews models of provider-recipient relationships and presents an elaborated theoretical framework for analyzing the interpersonal climates in adult residential care facilities. The three major theoretical perspectives: system theory, conflict theory, and exchange theory concomitant with recent theoretical approaches in relation to physician-patient relationship will be extensively reviewed.

Based on the postulated theoretical model, several questions are raised. These questions are the core of the analysis which will be provided in chapter seven.

The fourth chapter explains the methodological approach of the study. The study is a cross-sectional analysis utilizing both qualitative and quantitative approaches. The rational of selecting a certain method has been explained together with the advantages and disadvantages of each method. Since studies on the quality of care at the adult residential care homes, particularly examining the elderly residents, are scarce, the purpose of the study is exploratory rather than hypothesis testing. Through several screening procedures, the sample population selected for the study is 38. Consequently, the emphasis is placed more on
the qualitative analysis rather than the quantitative analysis.

The outcomes of the study will be provided in chapters five through seven. In the fifth chapter, the results of the descriptive analysis about the adult residential care home operators and facilities based on qualitative information from interviews will be provided. The descriptive analysis will show the demographic characteristics of the operators, noting changes from the 1982 study done by Sakai. Finally, the development of a typology of care home operators is attempted based on the differences in the orientations toward care.

Chapter six is organized in a similar fashion as chapter five. The characteristics of the elderly residents at the adult residential care homes together with the qualitative information will be presented. In this chapter, the life of the elderly at the adult residential care homes is depicted through the form of a case study. The matters such as how they decided to come to the adult residential care homes, how they feel about the care they receive, how they feel about living conditions, and how they cope with the changes resulting from the relocations, physical decline, etc. are examined.

Chapter seven presents the outcome of the analysis on the quality of care at the adult residential care homes. The integration of both qualitative and quantitative
information is attempted. Both Analysis of Variance (ANOVA) and Multivariate Analysis of Variance (MANOVA) are used to examine the effects of structure and process factors on outcome. Each section of this chapter is organized in such a way as to examine the questions postulated in the chapter on the theoretical issues. Additionally, the brief information in regards to the provider's view on the quality of care is included. The analysis is intended to provide a holistic view towards the complicated nature of the issue of quality at adult residential care homes.

The last chapter briefly summarizes the study. Limitations and weaknesses of the study will be explored and the recommendations for future policy regarding the adult residential care facilities in Hawaii will be offered.
Parallel to the expansion of the elderly population, the incidence and prevalence of chronic diseases have increased over the past several decades. Chronic illnesses require coordinated provision of long-term care services. The adult residential care service has developed as one aspect of long-term care service to meet the needs of chronically ill patients in Hawaii. In order to understand the issues related to the quality of care at the adult residential care facility, we must first examine the circumstances surrounding the current provision of adult residential care services. This chapter provides detailed background information on four aspects of these services: 1) the characteristics of Hawaii's elderly population, 2) the availability, the types and the levels of long-term care services, and its cost, 3) the historical background of adult residential care homes and their characteristics, and 4) the issues relating to the provision of adult residential care services in Hawaii.
Demographic Characteristics of the Elderly

The elderly population.

In the last two decades, the elderly population has increased dramatically. Approximately 31 million Americans were 65 years old and older, which accounted for one out of eight persons in the U.S. in 1989.

Although the proportion of the elderly who are 65 years of age and older in Hawaii is still relatively small compared to the mainland U.S.A., it has been increasing rapidly over the past several years (Jeskey-Lubag, 1984; Executive Office on Aging (EOA), 1985). According to the pamphlet provided by the American Association of Retired Persons (AARP) in 1987, the percentage of the elderly population who were 65 years of age and older in Hawaii was 9.7% of the total state population, compared to 12% of the entire U.S. population in 1986. The total elderly population (65+) in Hawaii was 76,000 in 1980 and is estimated to have increased to 109,000 in 1987 (Department of Business and Economic Development, State of Hawaii, 1988). The percent increase from 1980 to 1986 was 35.8%. It has been predicted that the growth rate of Hawaii's elderly will be two and a half times faster than the national average (EOA, 1988). Furthermore, the elderly
population will comprise nearly 18% of the state's total population by the year 2005. Among the elderly population, the 85-plus are the fastest growing age group and is expected to triple in size between 1980 and 2020 and to increase seven times between 1980 and 2050. The expansion of the "old-old" can be attributed to advanced medical technology, better nutrition and improved disease prevention and health care in general. In Hawaii, the dramatic increase of the elderly, especially those 75 years and above, can be attributed to the longevity of Japanese and Chinese older adult cohorts (EOA, 1988).

**Life expectancy & ethnic composition.**

Life expectancy has dramatically increased since the beginning of the century (Palmore, 1986). The life expectancy in Hawaii is the highest across the U.S. and also internationally. In 1986, the life expectancy at birth for females in Hawaii was 81.5 years whereas the life expectancy for the nation was 77.5 years. For males, the life expectancy was 75 years in Hawaii compared with 70 years nationwide (State Health Planning and Development Agency (SHPDA), 1986; U.S. Senate Special Committee on Aging, 1986). Gardner (1980) indicated that the mortality in Hawaii was among the lowest in the world in 1975. While there were some ethnic differences in mortality rate, the differences among the groups were converging.
Although the problem of classification exists in examining ethnicity, the current ethnic composition of the elderly in Hawaii is 36% Japanese, 28% Caucasian, 17% Filipino, 9% Chinese, 7% Hawaiian and 3% others based on self-classification in the U.S. Census. Among all the ethnic groups residing in Hawaii, the Japanese and Chinese have the highest life expectancy rates both at birth and at age 65. In addition, the Japanese and Chinese have the highest proportion of elderly among their members (Nordyke, Lee, & Gardner, 1984).

**Health status of the elderly.**

Several studies examined the ethnic differences on health status and the factors affecting health status (Gardner, 1980; Rose, Izutsu, & Kagan, 1981; Reed & Benfante, 1985; Peterson, Rose, & McGee, 1985; Benfante, Reed, & Brody, 1985). Among five major ethnic groups in Hawaii (Japanese, Caucasians, Filipinos, Chinese, and Hawaiian/Part Hawaiian), Japanese had the highest life expectancy and the health status of Japanese was better than the Caucasians (Gardner, 1980; Rose et al., 1981). One possible reason for the better health status of Japanese was the importance of ethno-cultural supports in the health maintenance of the elderly (Rose et al., 1981; Peterson et al., 1985).

A comparison of health status between Hawaii and the U.S. as a whole was made by the Executive Office on Aging in
1985. The prevalence of chronic conditions for persons 65+ was basically the same, with a slight difference in ranking. The most prevalent chronic diseases were: arthritis, hypertension, hearing impairments, heart conditions, diabetes, and visual impairments. Accurate comparison of functional disability was not possible because the data are not available on the same age categories; however, 7% of those between 65-74 needed some form of functional assistance in the U.S. and 8% of persons 65 years and older needed functional assistance in Hawaii. The need for functional assistance increases rapidly with increased age. If the proportion of "young-old" and "old-old" categories were known, more accurate comparison of functional assistance could be drawn. Nyman et al., (1989) indicated that the functional disability level, especially the level of Activity of Daily Living (ADL) alone could serve as an predictor of institutionalization for some elderly.

Another study indicated that Hawaii's elderly who were not institutionalized were healthier than the average elderly person for the U.S. as a whole. Hawaii's elderly seemed to be able to delay institutionalization but the resultant disability at later age might be more precipitous and require more health care resources and services (Hayashida, 1986).
Geographic distribution & living arrangements.

According to Nordyke et al. (1984), Honolulu County consists of 79.1 percent of the total state population and has the largest number of the elderly. A few districts of Honolulu such as Waikiki, Diamond Head, Kapiolani, and Ala Moana have the highest concentration of the elderly. This concentration of the elderly in central Honolulu is one of the issues that we need to examine in the delivery of long-term care services. Since a majority of adult residential care homes are located in the outskirts of the Honolulu area, the relocation of the elderly to suburban areas creates a problem. Many elderly are hesitant to move away from their familiar surroundings and their friends. However, in reality, hardly any alternatives are available at this time. The elderly are sometimes forced into moving to areas unfamiliar to them. This creates dissatisfaction, particularly for the immobile elderly, and lowers their quality of life.

According to data provided by the Elderly Affairs Division of the Office of Human Resources in 1984, the elderly concentration in the Kalihi-Palama area is projected to double from approximately 5,900 to 10,000 by the year 2000. The expansion of the elderly in Kalihi-Palama seems to be attributed to the concentrated existence of adult residential care homes in that area.
Contrary to the commonly accepted notion that the majority of the elderly live in institutions, only 5% of the elderly 65 and above are institutionalized (SNF/ICF only). A relatively small percent (4%) of elderly 65 years and older are institutionalized in Hawaii and 75% of non-institutionalized elderly live in family settings (EOA, 1985; Takamura, 1988; Chinen, 1988). Compared to the figures provided in 1982, the living arrangements of the elderly with family members has decreased from 78% to 75%. This is still relatively high compared to the national average (67%). Based on the AARP's information in 1987, approximately 30% of all non-institutionalized elderly in America lived alone and the growth rate seemed to be increasing from 1970 to 1986. In contrast, only 16% of the elderly lived alone in Hawaii (EOA, 1985).

Long-Term Care System in Hawaii

Concept and Definition of Long-Term Care

The question arises as to what is long-term care. The commonly accepted definition is:

a set of health, personal care, and social services delivered over a sustained period of time to persons with chronic physical and/or mental conditions who are functionally limited in that they require assistance in activities for daily living (Kane & Kane, 1987, p.4).
The key to long-term care is the consideration of functional capability; thus, long-term care services refer to the range of services needed to compensate for functional problems (Kane & Kane, 1987; Estores, Boland, & Kamali'i, 1988).

Brubaker (1987) indicated that the long-term care system consists of a triadic relationship among the elderly, their family and bureaucratic service organizations. The bureaucratic structure of these organizations determines the type, cost, and clientele of services provided. The family is an important component in this triadic relationship because it is the main source of the provision of continuum of care toward the elderly and the mediator between the elderly and the bureaucratic organizations (Kane & Kane, 1976, 1987; Kane, 1988; Brubaker, 1987).

Since most of the long-term care is provided by the family, the help is relatively unspecialized. It is very labor-intensive but the efforts of the family are often neglected by the policy makers. Recently, the importance of a comprehensive national policy on long-term care has been recognized; however, the implementation of such measures is still far from reality (Branch et al., 1987).

Types and Levels of Long-Term Care Services

Long-term care services include both institutional settings and non-institutional services, social, and health
programs. Kane & Kane (1987), describe the scope of long-term care service as:

The person who is functionally impaired has need for income, housing, health care, recreational and other social goods in common with all citizens. Some approaches to long-term care include one or another of these components (p.8).

Within long-term care institutions, broadly speaking, three levels of care exist: 1) skilled nursing, 2) intermediate care, and 3) custodial care. Skilled nursing requires continued daily nursing care as prescribed by physicians. Intermediate care is similar to skilled nursing but less intense medical care and treatment are provided. Custodial care refers to personal care services such as bathing, feeding, etc. which do not require medical skills.

As facility types are concerned, institutional care occurs in state mental hospitals, rehabilitation hospitals, and skilled nursing and intermediate care facilities. For non-traditional institutional settings, adult residential care homes, half-way houses, group homes, and foster homes are available. In addition, respite care, adult day care and day health programs, congregate meals, community health and mental health centers, protective and legal services, and handi-van transportation services provide care outside the family home at community level. For care within the home, hospice programs, home health programs, personal care services, chore services, meals-on-wheels, telephone
reassurance programs, friendly visitor's programs, and emergency alarm systems may be provided (see Figure 2.1).

**Availability of Long-Term Care Services**

Based on several figures, the existing numbers of nursing home beds in Hawaii were lower than the U.S. average. In 1980, the national average was 57.5 beds per 1,000 population over 65 years of age in comparison to 34.5 in Hawaii. Although the present supply of nursing beds in Hawaii is inadequate, the availability is expected to continue to remain low (SHPDA, 1986; DHS, 1987). Hayashida (1986), cautioned that the shortage of nursing beds in Hawaii may create inappropriate placement, elderly abuse, and inadequate care if alternative long-term care services are not provided efficiently.

According to the inventory conducted by SHPDA in 1986, a total of 33 institutional long-term care facilities provide a total of 621 skilled nursing beds, 959 intermediate care beds, and 1168 combined skilled and intermediate care beds (swing beds) in Hawaii. A majority of these beds are located on the island of Oahu. For community-based facilities, 3,087 adult residential care home beds and 82 foster care homes exist in the state of Hawaii.

In Hawaii, the State Health Planning and Development Agency is responsible for determining statewide needs for health services and facilities. They have the authority to
approve or not to approve the development of health care services and facilities according to needs identified by the agency.

Public and private social service agencies provide other supportive services; however, no statistical information was available regarding the extent of the distribution of these services.

Cost of Long-Term Care Services

The cost of long-term care has risen tremendously over the past several decades. Although the cost of long-term care services varies, the cost for skilled nursing homes in 1989 is approximately $3,000-$4,000 a month. The cost for intermediate care facilities is between $2,000-$3,000, whereas the cost for adult residential care is approximately $900-$1,500 a month.

The range for adult day services cost between $25 a day or $625 a month to $40 a day or $1,000 a month (DSSH, 1987). In Hawaii, recipients of Medicaid residing in adult residential care homes, cannot attend adult day centers simultaneously.

Financing of Long-Term Care Services

Long-term care costs have primarily been financed out-of-pocket on an individual basis concomitant with a variety of federal and other government programs. Currently, not many private health insurance companies underwrite long-term care coverage. Thus, the financing of long-term care services is
one of the most critical issues at this juncture. Federal programs which support both community and institutional long-term care services are: Medicaid, Medicare, Social Services Block Grant, the Older Americans Act, and Supplemental Security Income.

1. Medicaid - is a federal-state matching program which covers the medical costs of eligible low-income persons.

Medicaid was initiated in 1966 in Hawaii. In order to be eligible for Medicaid, people are required to spend down their financial resources until their net income meets Medicaid financial requirements. The Medicaid fund for institutional care accounted for 66.4% (approximately $115 million) of the total Medicaid budget for the fiscal year 1986 in Hawaii. Of this amount, 95 percent of Medicaid was used to maintain the elderly in skilled nursing and intermediate care institutions. Only 5 percent was allocated to community based programs (EOA, 1988).

2. Medicare - is a federally funded health insurance program authorized by Title XVIII of the Social Security Act to pay for medical care for elderly and disabled beneficiaries.

Medicare only covers acute care and short-term stays in skilled nursing care for persons discharged from acute hospitals and recovering from acute conditions. Medicare
does not cover intermediate care services. Medicaid covers both skilled nursing and intermediate care services for only the eligible persons. Thus, Medicare does not cover a majority of long-term care services.

3. Social Services Block Grant - is a federal program which provides funding to pay for social services such as homemaker services and adult day care and day health. In Hawaii, this program has been administered by the Department of Human Services.

4. Older Americans Act - is federal legislation that provides funding to states for development and coordination of services for the elderly 60 years and older. There is no means test for eligibility of these services.

5. Supplemental Security Income (SSI) - is an income eligibility program which provides a guaranteed minimum income for the poor who are aged, blind, or disabled.

In Hawaii, SSI beneficiaries are automatically eligible for Medicaid. The Supplemental Security Income is the major means to finance adult residential care homes for a majority of the chronically ill elderly in Hawaii.

A Long-Term Care Task Force appointed by the Policy Advisory Board for Elderly Affairs and the Hawaii Executive Office on Aging was established in 1988 to examine the current long-term care policies, services, system development and coordination, quality of care, and financing issues. Their findings indicated that Medicaid was the principal public funding source for long-term care services.
in Hawaii. The majority of Medicaid funds were provided for institutional care and not for home or community-based services. Neither Medicare nor Medicaid adequately addressed the social aspects of long-term care due to the overall emphasis on the "Medical Model" of the long-term care system. In addition, the fiscal crisis created by the medical care cost is due to inadequate planning and underprojections of the older adult population in the 1970's.

**Adult Residential Care**

Various terms have been utilized interchangeably to describe community-based care facilities among researchers and administrators. This has created some confusion as to assessing and evaluating these facilities. The definition of terms, particularly those utilized in Hawaii, will be described before preceding further to describe the details of adult residential care services.

**Terminology**

The term, adult residential care facility, adult foster care, homes for the aged, adult homes, geriatric foster care, board and care home, personal care homes, sheltered care, domiciliary care and family care homes have been simultaneously utilized in the United States to describe community-based care facilities (Giovannoni & Ullmann, 1961;
Coulton et al., 1985; Moos & Igra, 1980; Lamb, 1980; Walton & Elliott, 1980; Blaustein & Claudia, 1987; Steinhauer, 1982; Linn & Caffey, 1977; Newcomer, 1988; Linn, 1981; McClave, 1982; Sherwood & Morris, 1983; Benjamin & Newcomer, 1986; Baggett, 1989; Scheerenberger, 1975). Although some of the services and the target groups might differ slightly, they often describe similar services.

Different terminology creates confusion in examining the management and the services of the facilities. According to Linn,

Other terms that float about (such as community residence, boarding homes, rest homes, welfare hotels, skilled-nursing homes, intermediate-care homes, halfway houses, community lodges, and the like) must be nailed down with a definition or else abandoned. Much of the conflicting opinion about how patients managed in the community after hospital release came from a lack of specificity about which aftercare setting was studied (Linn, 1981, p. 45).

For this reason, it is important to clearly define what each term means. In Hawaii, the terms, boarding home, care home, foster home or community care program, adult residential care home, intermediate care facility and skilled nursing facility have been utilized to describe different types of services in the long-term care service system. Although boarding homes and care homes were officially combined as adult residential care homes in 1986, the separate definitions of boarding homes and care homes
will also be mentioned in order to see the differences in services.

Definition

1. Boarding home - is a family home providing, for a fee, 24 hour living accommodations to no more than three adults unrelated to the family, who are in need of minimal "protective oversight care" in their daily living activities. "Protective oversight care" includes, but is not limited to, one or more of the following: 1) daily awareness of the resident's functioning, 2) whereabouts of the resident, 3) ability to intervene if a crisis arises for a resident, and 4) assumes some responsibility for the welfare of the resident including supervision and assistance in areas such as nutrition, maintenance of clothing, medical care and household management (Department of Social Services and Housing, 1980).

2. Care home - is any institution, place or building in which any accommodation is maintained, furnished or offered for 24-hour care to persons in need of personal services, supervision or assistance essential for sustaining the activities of daily living (Department of Human Services, 1978).

3. Adult residential care home - is any facility which provides twenty-four hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, but who do not need the services of an intermediate care facility. It does not include facilities operated by the federal government. There shall be two types of adult residential care homes: 1) Type I home for five or less residents;
and 2) Type II home for six or more residents (Department of Health, 1986).

4. Foster home or community care program - is any facility which provides twenty-four hour supervision, room and board, homemaker services, personal care (assistance with activity of daily living, monitoring of medications, range of motion and other exercises, and in some cases tube feeding, dressing changes, insulin injection, and catheter irrigation), and transportation for medical and social outings. The patient has to be 55 years old or older and certified in need of intermediate care or skilled nursing level of care. This is for less than two residents (Braun & Rose, 1986, 1987).

5. Intermediate care facility (ICF) - an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act. The medical examination by a physician is required once every three months (EOA, 1988).

6. Skilled nursing facility (SNF) - an institution that has a transfer agreement with one or more participating hospitals, and that is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and that meets specific regulatory certification requirements. The medical examination by a physician is required once a month (EOA, 1988).
The Development and the Characteristics of
Adult Residential Care Homes

Development: National Level

Although there is some discrepancy as to exactly when foster care homes developed in the United States, they are generally regarded as being introduced in the late 1970's from Europe (McCoin, 1985; Linn, 1981; Steinhauer, 1982; Segal & Aviram, 1978; Morrissey & Goldman, 1986).

According to Sherman & Newman (1988), adult foster homes for the elderly were developed under the enactment of the Elizabethan Poor Law in England and passed on to the United States. In the United States, the origin of foster care homes, particularly for the elderly, comes from boarding houses in the late nineteenth and early twentieth centuries. An early boarding home for the elderly was developed in California during the 1930s.

The passage of Medicaid in 1966 provided the financial incentives for the development and the expansion of long-term community-based care facilities. The deinstitutionalization movement further facilitated the creation of community based long-term care facilities. By late 1979, thirty-four states had officially-sanctioned adult foster care programs serving not only for the mentally ill but also the mentally retarded and the elderly as well (McCoin, 1985).
Approximately 34,000 residential care facilities with a total of 270,000 beds were available in 1975 and their residents increased to 600,000 by the year 1979 (Mor & Gutkin, 1986). By 1982, there were approximately 300,000 unlicensed boarding homes and 30,000 licensed boarding homes in the United States (Benjamin & Newcomer, 1986). However, as described previously, various terms have been utilized to describe facilities which provide assistance to people who are in need of personal care. Consequently, it is very difficult to determine an accurate estimation of these facilities. In addition, the lack of uniformity poses many problems for the administration and regulation of these facilities.

**Rules and regulations.**

Thirty-four states established some form of regulations by 1979 followed by the Keys Amendment (Section 505d of P.L. 94-566) passed by Congress in 1976. State regulations vary considerably with respect to licensing and regulation activities. More stringent rules and regulations are developed for the facilities for the mentally ill and the mentally retarded. Those for the elderly and/or mixed adult population are minimally regulated (Mccoin, 1985; Benjamin & Newcomer, 1986). Based on the study done by Reichstein & Bergofsky (1983), state regulations governing community-based facilities which did not include medical care lacked a substantial number of important requirements affecting the
health, safety, and civil rights of the residents. Also, very few regulations incorporated enforcement provisions required of the states by the Keys Amendment.

Development: Hawaii

Similar to the U.S. Mainland, the development of community-based care facilities in Hawaii occurred in an unplanned fashion. Seventy independent boarding homes were available on the Island of Oahu in 1975 and these boarding homes had developed as the result of a community need rather than as direct planning of a government agency at that time (Yutiao & Kinzie, 1975).

It is not clear as to which care facilities, foster homes, boarding homes or care homes, were first developed. However, the record indicates that seven care homes were developed on Oahu in 1960. The number had increased to 199 (860 beds) in 1975 and 242 (1221 beds) in 1980. The total number of beds were 1507 statewide (Kamakawiwoole, 1980; DOH, 1986). Under the category of care home, two types of facilities are available: 1) family care home and 2) residential care home. A family care home is a facility operated by a single family which housed not more than four residents at a time. The vast majority of care homes are operated by Filipino women. A residential care home is a facility which provides assistance and supervision of personal care and where more than five residents can be accommodated (Sakai, 1982).
By 1982, 201 licensed boarding homes and 244 care homes including 10 residential care homes were available (DSSH, 1982). The Department of Social Services and Housing, currently renamed the Department of Human Services, provided licensure for boarding homes and the Department of Health provided licensure for care homes as well as health and case management services for the mentally ill and the developmentally disabled who were covered by departmental programs. A task force was established in 1983 to examine the efficacy of the provision of community-based care, particularly boarding homes and care homes due to arising problems related to licensure, reimbursement and case management issues. The overall goals of the task force were: the improvement of quality of care, cost containment, and upgrading the skills of operators (DOH, 1986).

In 1986, the consolidation of both boarding and care homes to adult residential care homes was carried out by the Department of Health and the Department of Human Services. Within the category of adult residential care homes, two types of facilities exist: Type I facilities are licensed for up to 5 residents; and Type II facilities have no limitation on the numbers of residents. Educational and nursing training programs are required for boarding care home operators to run adult residential care facilities. The purpose of the consolidation was to provide a more
uniform and higher level of caregiving, hence the improvement of quality of care.

**Rules and regulations.**

The rules and regulations of adult residential care homes were constructed under the provision of Hawaii Administrative Rules Title 11, Chapter 100 Adult Residential Care Homes by the Department of Health. Since then, adult residential care homes have been regulated by the Department of Health, Hospital and Medical Facilities Branch. The Department of Human Services has primary administrative responsibility for placement, case management, and payment for state assisted residents under the provision of Hawaii Administrative Rules, Department of Human Services Title 17, Chapter 831, Adult Foster Care Services.

A license is good for one year and it can be reissued after an inspection by the staff from the Department of Health every year. The minimum requirements for personnel and staffing are as follows:

1.) be at least eighteen years of age,
2.) be a nurse aide,
3.) have completed adult residential care home teaching modules approved by the department,
4.) have at least one year's experience working full time in an intermediate care facility, skilled nursing facility, home health agency, or hospital,
5.) have no activities outside the facility sufficiently demanding of the licensee's time and energy as to interfere with proper and adequate care of the residents,
6.) have no family responsibilities sufficiently demanding on the licensee's time and energy,
7.) demonstrate sufficient skill in the use of the English language,
8.) have achieved an acceptable level of skills in first aid, nutrition, and cardiopulmonary resuscitation and appropriate nursing and behavior modification techniques as required for care of all residents admitted to the facility,
9.) attend and successfully complete at least two training sessions per year as may be developed or recommended by the department, and
10.) have knowledge of the availability of community services which may be utilized by the residents and operator (DOH, Administrative Rules, Chapter 11-100).

For Type II facilities, business accounting and administrative skills are required in addition to the above requirements.

Characteristics of Adult Residential Care: National-Level

Under the categories of the community-based care facilities in the United States, several variations as to the number of facilities and their residents both nationally and in individual states are evident (Coulton et al., 1985; Newcomer & Grant, 1988; Benjamin & Newcomer, 1986). The state variations are: 1) the total number of licensed beds varies widely from state to state such as 300 beds in Wyoming to over 91,000 in California; and 2) the relative percentage of beds allocated to aged populations varies widely across the states, but in most states, the elderly are the primary clients of these facilities (Mor et al., 1986; Newcomer & Grant, 1988). Based on the 1979 statistics, approximately half of the 355,804 residents
nationwide were elderly (Mor et al., 1986). More than half of the residents receive Supplemental Security Income (SSI) due to age or permanent disability (McClave, 1982; Mor et al., 1986).

The wide variations seem to be influenced by the state regulations on community-based care facilities, nursing home reimbursement, and the provision of income supplementation by the states (Benjamin & Newcomer, 1986). At the same time, there are general similarities noted on the overall operation of the facilities. A majority of these facilities are private and for-profit operations. The facilities range from small family-oriented facilities which consist of one to six beds, mid-size facilities with 7 to 50 residents, and large facilities with more than 50 beds. Recent studies indicate that half of the facilities are family-owned small facilities (Segal & Aviram, 1978).

A majority of the operators are middle-aged and married females who have caretaking skills as a result of raising a family or working as nurses aides (Putten & Spar, 1979; Segal & Aviram, 1978; Linn, 1981; Blaustein & Viek, 1987; Sherman & Newcomer, 1988). Various studies indicate that most of the operators are minorities such as blacks (Segal & Aviram, 1978; Coulton et al., 1985). The educational background of operators varies widely from those having only primary education to those with college degrees (Segal & Aviram, 1978; McClave, 1982; Yutiao & Kinzie, 1975).
The motivational factors to become care home operators seem multiple: companionship, income supplement, personal rewards of helping the needy, and a combination of these reasons. Assessing motives, however, is difficult because the answer of the operators might well be the results of conformation to "socially acceptable norms" (Segal & Aviram, 1978).

The provision of services by the operators usually include room and board, cleaning the residents' rooms, doing their laundry, help with transportation, shopping, supervision of residents' medication, and assistance in obtaining medical and social services. Other services such as assistance with activities of daily living (ADL) are also provided depending on the needs of their residents (Newcomer & Grant, 1988).

Characteristics of Adult Residential Care: Hawaii

Although a systematic comparison of the adult residential care homes between Hawaii and the U.S. Mainland is difficult, similarities are more striking than differences. The provision of services covers the same areas such as supervision of residents and their medication, behavioral management, transportation, assistance with activities of daily living and other medical and social needs, and personal care. The small family-like homes (Type I) outnumber the large institutional types (Type II) and all
of the adult residential homes in Hawaii are operated as private business entities.

As far as the care home operators are concerned, similarities are also noted. A majority of the operators are married, middle-aged women with minority backgrounds. In Hawaii, a majority of care home operators are Filipino females. Eighty-two percent of 208 care home operators surveyed in 1982 immigrated from the Philippines. Most of them have migrated from the northern Ilocano speaking area of the Philippines (Sakai, 1982). Yutiao & Kinzie (1975) indicated that since the majority of Filipino housewives have problems of language, acculturation, and lack of education, they lack opportunities in the mainstream job market. Therefore, they have sought work in the non-competitive boarding home business in order to supplement their family income. In addition, the cultural values of the extended family system coincide with the concept of boarding home care. Admitting unrelated boarders into the household and accepting them as temporary members of their household seem to be a common practice in Philippines (Yutiao & Kinzie, 1975).

Various types of people utilize adult residential care homes such as the mentally ill, the developmentally disabled, the mentally retarded and the elderly. More elderly utilize the facilities than any other group and there are more females in the facilities than males.
According to Kamakawiwoole (1980), the average age of residents at admission is 57 years and they are diagnosed as having about two chronic illnesses each. Approximately 50% of the residents are discharged from hospitals and 18% come from other care homes. Only 12% are discharged from ICF/SNF level nursing home facilities, indicating the jump from the higher level of medical care to the lower level personal care, by-passing the intermediary care level.

Current Issues Concerning Adult Residential Care

Contradictory Forces: Financial vs. Quality

The increase in the cost of health and long-term care services together with the rising federal expenditures for health and long-term care services have been subjected to considerable scrutiny in recent years. Federal and state governments have been enforcing control over the costs of long-term care services, at the same time, suggesting the improvement of in-service training, supervision, etc., which may lead to the provision of quality care. In viewing this phenomenon, the contradictory forces, effort to simultaneously control cost and enhance quality, are pulling in opposite directions (Applebaum, 1989).

At this point, it is imperative to examine the cost and the reimbursement of adult residential care homes to have a clear view of this issue.
Cost of adult residential care homes.

The study of efficacy and cost containment has been the focus of several studies. However, the examination of cost is not a simple task. Many facilities do not adequately measure the costs or expenses incurred in establishing the facilities and their operational costs (Piasecki, 1981; Newcomer & Grant, 1988; Mor et al., 1985; DSSH, 1980; DHS, 1987).

Mor et al. (1985) conducted a study to examine the cost of adult residential care homes in five states examining only operational costs. Four areas of monthly expenses were analyzed: 1) food and other consumable supplies, 2) salaries and wages paid to staff or operators, 3) utilities such as electricity and water, and 4) fixed expenses such as rent and mortgages. The overall cost per resident per month in 1980 was $330 and approximately one-third was attributed to food costs. The larger institutional type facilities had higher staffing costs than the smaller ones. A focus on costs solely for budgetary purposes may ignore the issues of program quality and program effectiveness (Piasecki, 1981).

In Hawaii, the charge for adult residential care home services range from $900 to $1,600 per month depending on the level of care required by the residents. Residents who are publicly assisted must pay room and board charges which are set by the state government. The private residents are forced to pay whatever care home operators wish to charge
them. In a sense, the private residents are very vulnerable high costs of services in part due to cost-shifting from the public pay residents.

**Reimbursement.**

Adult residential care facilities are usually not reimbursed directly by Medicare or Medicaid. The primary source of reimbursement for adult residential care facilities is the Federal Supplemental Security Income (SSI), Title XVI of the Social Security Act. SSI benefits are established and provide uniform payments of $340 nationwide in 1987. In addition, 24 states provide State Supplemental Payments (SSP). The amount varies widely according to state; however, most states utilize a flat-rate prospective payment to operators. Further, the rate varies depending on the type of residents (such as mentally ill and developmentally disabled) and the size of the facilities and the level of care needed for each resident (Newcomer & Grant, 1988).

For example, payments are determined according to the level of care assessed by the social workers at the Department of Human Services in Hawaii. Four levels of care are determined as;

1.) Level I - Ambulatory; independent in self care; able to communicate and manage health related care,

2.) Level II - Assistance to walk, manage self care, manage health needs, resident may have behavioral problems,
3.) Level III - Unable to walk without assistance or wheelchair confined; needs assistance with all personal care; severe behavior problems and difficulty communicating; needs regular assistance to meet health needs, and

4.) Level IV - (Special Care); individuals requiring ICF level of care but residing in residential care homes (SHPDA, 1986).

Based on 1987 figures, the federal base rate for residents was $340 per month. For SSP, four types of supplements were available: $55 per month was allocated to all the publicly assisted residents; $100 per month was allocated to Level IV residents; $108 per month for Level II and Level III in type II facilities; and $79.90 for Level I, $129.90 for Level II, and $191.90 for Level III residents regardless of the size of the facilities (DHS, 1987).

Therefore, the total payment for Level I in type I facilities was $474.90, Level II was $524.90 and Level III was $586.90. Approximately 68% of the residents who were assisted by the Department of Human Services were determined as Level III in 1987 (DHS, 1987).

Since 1987, studies have examined the adequacy of the reimbursement system of adult residential care facilities (DHS, 1987; Research Information Service, 1989). Several problems regarding the reimbursement system were noted and recommendations were submitted to increase the reimbursement rates.
Although the payments for Level III residents in Hawaii were the second highest, after California, when compared nationwide, the studies suggested that an increase would be necessary (DHS, 1987). One reason for an increase is that the residents today have much greater health care needs than they did several years ago. Thus, the reimbursement rates were revised in July 1989. They went up to $602.90 for Level I, $687.90 for Level II, and $789.90 for level III. If residents receive Social Security benefits, $20 is provided as an allowance in addition to $30.00 of monthly allowance (DHS, 1989).

Notwithstanding the increased rates of reimbursement in recent years, the adult residential care home operators and their associations are still claiming that the increased rates of reimbursement are not enough to provide quality care. A majority of them compare their labor cost to that of the nursing home counterparts. One of the major complaints is that the small adult residential care home operator's duty is a 24-hours job whereas the staff of the nursing home is 8-hours a day and their salaries are much higher. With the limited amount of money they receive, they claim that it is very difficult to provide personal attention and quality care. It seems as though the cost constraints are in many ways in direct conflict with efforts to enhance the quality of care.
Figure 2.1
Array of Long-term Care Services in Hawaii

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<th>Most Restrictive setting</th>
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<td>Institution</td>
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<td>Rehabilitation Hospital</td>
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<td>Community</td>
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<td>Foster Care Home</td>
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<td>Hospice</td>
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<td>Adult Residential Care Home</td>
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<td>Half-Way House</td>
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<td>Group Homes</td>
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<tr>
<td>Mental Health and Health Center</td>
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<td>Congregate Meals</td>
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<td>Protective/Legal Services</td>
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<td>Handi-Van Transportation Service</td>
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<td>Home</td>
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<td>Friendly Visit</td>
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<td>Home Delivery Meals</td>
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<td>Emergency Telephone Alarm System</td>
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<th>Least Restrictive setting</th>
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CHAPTER 3
THEORETICAL FRAMEWORK

In an attempt to create a conceptual framework for the provider (care home operator) - consumer (resident) relationship, three major theoretical perspectives on physician-patient relationship\(^1\), will be reviewed in this chapter: system theory, conflict theory and exchange theory.

System Theory

The system theory introduced by Parsons was predominant from the 1930's until the 1960's (Parson, 1954; Bloom and Wilson, 1979). Although several models of system theory exist\(^2\), Talcott Parsons' approach, which is incorporated with his action theory, is very useful in examining the relationship of physicians and patients (Wilson, 1983).

**Basic Elements of the Theory**

The basic focus of system theory is to treat social phenomena as dynamically interdependent processes,


furthermore, the social order rests on shared understandings and shared norms. According to system theorists, even the smallest unit of social life, such as physician-patient relationship, comprises a social system because the building block of social order is not the individual but the bond of double contingency. The behavior of the actor directly shapes and is shaped by the behavior of the other, and the two form a "whole" which is more than the sum of its parts. Thus, the system theory is a way of thinking about connections and inter-dependencies among subsystems and systems. The exchange between subsystems requires a generalized media through which the interchanges take place. The media of exchange link the different subsystems by regulating and integrating the transactions between them. Money, power, influence, and value commitments are all mediums of exchange (Wilson, 1983).

Social behaviors and social relationships are the results of a socialization pattern which is rooted in cultural expectations about the social roles of people. The behavior of physicians and patients is essentially determined by the normative expectations of their society.

The Sick Role Concept

The sick role concept postulated by Parsons (1978, 1985) suggest a framework of social norms for examining the relationship of physicians and patients. There are four aspects of the sick role: 1) The first norm is non-
responsibility of the individual over his/her condition. The sick person is not to be held responsible for his/her condition; 2) The second norm is exemption from normal obligations. To be sick is to legitimately withdrawal from a number of social obligations from work and family duties; 3) The third norm is undesirable nature of sickness. Being sick is a socially undesirable; therefore, the sick individual must want to get well; and 4) The forth norm is seeking out competent help. The sick individual will seek out technically competent health care such as specifically trained physicians. Consequently, the sick role by definition is an undesirable one to be escaped from as quickly as possible with a help of skilled and trained physician. Thus, the sick role becomes the social control mechanism in order to maintain the social system (Turner, 1986; Wolinsky, 1988).

Social Control Agent

The role of the physician is to function as a social control agent to return sick patients to perform their social roles in the society. The physician controls the interaction with the patient.

The institutional patterns of society perform important automatic control functions on at least two different levels, that of ordinary "personal" social relations and of the institutionalization of medical practice... Not only does the physician "control" his patient but, in order to be in a position to do so, he must
himself be controlled, he must adhere sufficiently closely to an institutionalized definition of his role, and to a situation which is enforced overwhelmingly by automatic, informal mechanisms (Parsons, 1954, p. 159).

The use of the prestige and power of the physician's role is achieved by a system of formal controls and sanctions. The physician is normatively constrained by a professional demeanor of functional specificity, affective neutrality, universalism and technical specificity. The physician's authority is limited only with matters of health and it is based on the "technical competence" of the profession. The physician is expected to avoid emotional involvements in dealing with his/her patient; thus, the treatment procedures have to be objective, impersonal and universalistic (Parsons, 1954).

The **Physician-Patient Relationship**

The major assumptions of this theory on the concept of physician-patient relationship are: 1) the rationality of human beings, 2) the social relationship is voluntaristic, 3) the asymmetry of the physician-patient relationship, and 4) the roles of physician and patient are mutually understood and mutually rewarded.

System theorists view health care as a social role relationship between a helping agent and a person needing help. It is an institutionalized role-set in our society (Parsons, 1978; Wolinsky, 1988).
According to Parsons (1978), the asymmetrical relationship of the physician-patient is a necessary one. The physician is distant from the personal relations of the patient, who does not participate in equal reciprocities with him. The power of the physician rests on: 1) professional prestige, 2) the situational authority such as monopolization of treatment, and 3) the situational dependency of patients. However, the physician's superiority is focused on the specific functions of handling people who have some health impairments (Parsons, 1954 & 1978; Wolinsky, 1988).

Although Parsons assumed the asymmetry of the physician-patient relationship, he seemed to recognize that the relationship may change because of the bureaucratic reorganization of medicine and the upgraded knowledge of patients as a whole. Parsons' concept is developed based on a normative practice of an individualistic contract between physicians and patients. His concept has been criticized as being outdated and not relevant to understand the contemporary situation where significant reorganization of health care systems exists (Turner, 1986).

The Revision of Parsons' Concept

The analysis of the relationship of physicians and patients by Parsons rejects the reciprocity of their interaction. In contrast, Szasz and Hollender (1987) consider the relationship of physicians and patients as the
joint participation of the two. They indicate that "relationship" is neither a structure nor a function. It is an abstraction embodying the activities of two interacting systems. They postulated three basic models for the physician-patient relationship: 1) activity-passivity, 2) guidance-cooperation, and 3) mutual participation. The activity-passivity model states that the physician has an authoritative role and the patient assumes a completely helpless role. Treatment takes place irrespective of the patient's contribution. Similar to the activity-passivity model, the guidance-cooperation model is a prototype of the parent and child relationship. In this model, the patient seeks help, thus is willing to cooperate in the treatment process. The third model is mutual participation, which offers a prototype of an adult relationship where equal power, mutual interdependency and mutual gratification existed. In the first two models, the physician knows what is best for the patient so the "agreement" between physician and patient is taken for granted. But the last model differs in that the physician is uncertain about the best therapeutic treatment for the patient. In a sense, the patient's own experience and information enhance the process of negotiating the "agreement" between them. They perceive the relationship of physician and patient as a situation and a process. Consequently, each of the three types of
relationship can be entirely appropriate or inappropriate depending on the circumstances.

**Conflict Theory**

**Basic Elements of the Theory**

In contrast, conflict theory has been utilized to examine the medical care system by Freidson, Mechanic, and Navarro since the late 1960's to challenge the predominant ideology of the system theory.

The central theme of conflict theory is that exploitation and alienation emanate from power relationships. Conflict theorists emphasize that conflict and disagreement are integral parts of peoples' relationships. The distinction between "them" and "us" is intimately connected with unequal distribution of power.

Dahrendorf (1969) stated that:

> The integration theory (system theory) gives us a tool for determining the point of departure of the process. To find the locus of the forces which drive the process and social change is the task of a theory of conflict (p.218).

He stresses the fact that it is very important to produce a proof that a conflict is based on certain social structural arrangements and not to relegate the conflict to psychological variables.
The Physician-Patient Relationship

Power and conflict.

In applying Dahrendorf's notion, Mechanic (1985) noted that any of the underlying ethical issues in health care services are due to inequalities in the power of physicians and the dependency of patients. In contrast to Parsons, Freidson (1960, 1973) stressed that the problematic relationship of physician-patient is based on conflict between the physician and patient over the struggle for control and negotiation over the provision of services. Concomitantly, the interaction between physicians and patients is based on sometimes conflicting sets of norms: the professional and the lay.

Physicians try to use whatever power they have to control that relationship so as to be able to work in the way they think appropriate because patients usually are not sophisticated enough regarding technical knowledge, resource allocations and procedures. Though, what the physicians think appropriate may not be what the patients want, these characteristics themselves make patients more vulnerable to physician's power.

Fundamentally, all professions engaged in providing services to individual clients are prone to have some form of official gatekeeping powers attached to their credentials (Freidson, 1986). Physicians are no exception. They are gatekeepers for access to health care; at the same time,
they are gatekeepers for government disbursements for
disability benefits. It seems as though they have
tremendous power over their clients. However, they are, at
the same time, constricted by the rules and regulations of
the agency or organization in which they belong, in
allocating their resources. Therefore, the conflict between
physicians and medical organizations is also inevitable.

It can be said that the resources
available for doing work inevitably
shape what work is done and how it can
be done. The consequence for clients
may be marked impersonality, long
periods of waiting, lack of information,
and unresponsive categorization of their
problems—what some might call
bureaucracy. Such a consequence stems
from the fact that, while the
professional rank and file have direct
interpersonal power over their
clientele, they lack any direct power as
individuals over the allocation of the
resources they need to do their work the
way they wish or the way their
professional judgement might dictate
(Friedson, 1986, p.177).

Social control.

As far as the agency of social control is concerned,
Friedson (1960) thinks patients also exercise a measure of
social control. The patients can evaluate the physician's
professional ability based on their "lay referral system" ³
and can affect the physician's career success.

³ It is a network of lay consultants based on the local
community and which imposes form on the seeking of help (Friedson,
1960, p.377).
Two types of medical practice or encounter with patients are postulated by Friedson: 1) client-dependent practice, and 2) colleague-dependent practice. Client-dependent practice is represented by primary care especially the "solo practitioner" who operates independently from their professional network. For a physician to survive as an independent practitioner, he/she must be located within a lay referral system. In this case, the physician is least able to resist control by clients and most able to resist control by his colleagues. Colleague-dependent practice is the extreme opposite from client-dependent practice. It is a practice that does not attract its own client but obtain patients through referral from other practices, individual, or organizational. It is most represented by medical specialists. In this case, the physician is most able to resist control by clients and least able to resist control by colleagues or their network. The most extreme dependent practice is often called "organizational practice" which one can observe in hospitals, and clinics (Friedson, 1960). From this analysis, the physicians are not the agents of social control nor are they absolutely free from control by their patients.

Conflict Theory vs. System Theory

Some of the criticisms expressed by conflict theorists towards system theory in relation to the examination of the physician-patient relationship are: 1) the system theory
ignores the presence of intrinsic conflict in human relationships, and 2) the system theory puts too much emphasis on a physician and ignores the expectations of other members who are involved in treatment. They also argue that the content of the interaction between physicians and patients is less significant in itself than the formal structure which is the context of that interaction. The pattern of relationship is influenced independently from the characteristics of the individual participants (Freidson, 1979). Conflict theorists extend their analysis from the dyad relationship of physicians and patients to more organizational characteristics of medical professions which are relevant to our contemporary society. By examining the professionals' relationship to other forces in the political economy, they are trying to analyze the flow of power down to the patient's level.

**Extension of Conflict Theory**

Waitzkin's (1983, 1989) approach of micropolitics to the physician-patient interaction integrates both micro and macro level analysis. He emphasizes that micro-level processes such as medical encounters reinforce macro-level structural patterns of domination and subordination in society. Waitzkin extensively uses the approach of the critical theory of Habermas who emphasizes the importance of
language and communication. He states that physician-patient interactions might convey ideologic messages that legitimize current structures of oppression in society. The communicative pattern of the physician-patient relationship supports the professional's dominance within the encounter. Domination creates distortion in communication. The discourse through which physicians communicate their special knowledge to patients enhances their ability to intervene in and to control their behavior. The distortion of communication becomes greatest when the interaction of physicians and patients of different class backgrounds, sex, or race takes place (Waitzkin, 1983, 1989; Hauser, 1981; Katon & Kleinman, 1981; Coe, 1987). Waitzkin also indicates that similar patterns might appear in encounters between clients and members of other "helping" professions.

The Physician-Patient Relationship

Physicians utilize certain organizing formats such as listening to the patient's complaint, taking medical history, administering physical examinations and diagnosing. During the process of interaction with patients, physicians frequently interrupt patients in order to attempt to cut off story-telling (White & Robillard, 1982). Also, in the process of reaching a diagnosis, a substantial part of a patient's experience, no matter how relevant to the patient, is excluded. Thus, the structure of the clinical setting profoundly affects what is spoken and recorded during
medical encounters. These acts of physicians can be interpreted as gestures of dominance and power by which doctors control the flow of communication. The different class positions of physicians and patients concomitant with their difference in gender, age, and race, ideological patterns, and language in face-to-face interactions as well as medical discourse (Waitzkin, 1989).

Social Control

Social control over patients by professionals in medicine is generally an unintended process perceived by participants in physician-patient encounters. The unintentionality of medical social control is maintained by the physicians education and their socialization. The discourse through which physicians communicate their knowledge enhances their ability to intervene in and to control other's behavior. Thus, by perpetuating, re-enacting and supporting an ideology, medicine acts as an agent of social control (Waitzkin, 1989; Pappas, 1990).

Also, medical social control involves the management of potentially troublesome emotions such as anger, anxiety, depression and other emotional distress. One of the outcomes of medical social control may be the diffusion of socially caused distress in our society (Waitzkin, 1983).
Exchange Theory

Basic Elements of the Theory

Exchange theorists view social relationships as based on the reciprocal giving and receiving of resources or benefits among people. They believe that social relationships are influenced by the individual characteristics of the partners as well as by the social system, but their emphasis is more on the examination of actual exchange of "social goods." Exchange theory is the theoretical analysis based on the calculative rationality of human beings and the motivation to achieve rewards and reduce costs (both material and non-material) characteristics (Emerson, 1981; Bengtson & Dowd, 1980). Thus, it focuses on the flow of benefits, the benefits people obtain from, and contribute to, the process of social interaction.

According to exchange theorists, social relationships require a calculation of own utilities but also the utilities of others. What it means is that they insist on the importance of one's rational choice but also the anticipation of what choices others would make. The rewards are not necessarily monetary or concrete goods and services but also less tangible outcomes. Conformity to norms, respect, admiration, gratification, etc are all considered as rewards (Wilson, 1983; Emerson, 1981).
Based on the exchange theorists, there are four types of social relationships: 1) negotiated transaction which involves mutually contingent contributions to the exchange, with both contributions evolving together in some social process. An example of this relationship is the sale/purchase of goods; 2) reciprocal transactions which is an altruistic act based upon noncontingent context. The other's contribution may or may not occur but if it does occur, then a reciprocal transaction has occurred. An example of this transaction is gift giving; 3) generalized reciprocity which starts out as an altruistic act can become one of a series of such transactions between two long-term partners. The act is performed not in response to any specific benefit received, but rather in honor of the social exchange relation itself; and 4) productive exchange which is based upon a special form of exchange in which separately obtained benefit is not possible. It is a collective gain among people involved in the transaction (Emerson, 1981).

The Physician-Patient Relationship

Bloom (1963) examined the relationship of physicians and patients by utilizing John Spiegel's analysis on the cultural values of Irish-American patients toward physicians. He states that the physician-patient relationship is based on the respective roles played by both

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physician and patient in a transactional social system. A system of transaction is characterized by reciprocal, mutually regulative processes such as adaptation or adjustment. In addition, the system of transaction is affected by the external forces such as class, religion, and ethnicity of the actors.

Utilizing Emerson's typology, the physician-patient interaction could be perceived as a negotiated transaction. The relationship is maintained when actors such as physicians perform valued services for others, and vice versa; and when reciprocal benefits are obtained in the transaction. The actors feel more satisfied with relationships in which equity prevails but are dissatisfied when the transaction is inequitable. The judgement of either equity or inequity by the actors seems to be rooted in the overall satisfaction of their relationship, which is tied to the history of rewards and costs in that relationships and to the partners' respective alternatives outside the relationship (Huston & Burgess, 1979).

Power and conflict.

The relationship of physician and patient can be either symmetrical or asymmetrical depending on the balance in the social exchange. The power is derived from the imbalance of its exchange and it resides implicitly in the other's dependency (Emerson, 1962; Dowd, 1975; Wilson, 1983). In another words, power is based on control of resources which
the other needs. Therefore, if the offered services are highly valued by the receiver, in the case of physician-patient relationship, who usually do not have other alternative means, the power of the physician seems much greater. Also, prerequisite to the exercise of power is the possession of sufficient power resources which include money, knowledge, persuasiveness and social position (Dowd, 1975).

Within the course of an interaction, three major stages are defined: exploration stage, expansion stage, and commitment stage (Scanzoni, 1979). If both parties are equally dependent upon each other, the relation is said to be balanced but if one of the actors has alternative resources outside of their interaction, it influences the bargaining power of the actor in his negotiation. In this case, conflict might occurs between the parties. If the conflict occur during the exploration stage, then the relationship is most likely terminated but if the conflict occurs during expansion or commitment stage, the termination of the relationship becomes more costly. Balancing operations such as withdrawal, extension of power network, emergence of status, and coalition formation may be utilized to equalize the relationship (Dowd, 1975).
Conceptual Framework for
Care Home Operator-Resident Relationships

There is no existing framework for analyzing the relationships or interactions between care home operators and residents. Care home operators differ from physicians in regard to technical knowledge and skill, and the position or status that they acquire in our society. In addition, the task of care home operators is to provide custodial care and not to provide medical care and treatment. Nevertheless, the research on the physician-patient relationship suggests some relevant applications to study the relationships of care home operators and residents.

While the system theory provides the notion that the physician-patient relationship is based on the normative expectations of the society, it cannot provide adequate explanations of the core of the interaction such as power, conflict, and negotiation that takes place in the dyad relationship. For this reason, a triangulation of the above mentioned theoretical perspectives will be attempted to analyze the relationships or interactions between the care home operators and the residents.

Sick Role and the Role of the Provider

First of all, the elderly residents who reside in the adult residential care facilities have at least one or more
chronic conditions which debilitate their functional capacity.

Based on Parson's sick role, being sick is a socially undesirable situation. The sick individual will seek out competent help to escape from that condition; thus, the role of the physician is the mechanism for social control. Different from the sick individual described by Parsons, the elderly in the adult residential care homes cannot escape from the socially undesirable situations no matter how much they desire.

Murphy (1987) describes in his book, The Body Silent, the psychological trauma the disabled person goes through and the dilemma that he feels. He states that there are four far-reaching changes in the consciousness of the disabled: 1) lowered-self esteem, 2) the invasion and occupation of thought by physical deficits, 3) a strong undercurrent of anger, and 4) the acquisition of a new, total and undesirable identity. As he states "the disabled are neither fish nor fowl; they exist in partial isolation from society as undefined, ambiguous people." With added age concomitant with the disabling condition, the elderly in the adult residential care home only await the road to the graveyard. Even though the elderly want to escape from this undesirable condition, they cannot resume a socially defined role as human beings.
Social Expectation of Providers and Residents

One of the crucial elements in the relationship is the nature of the expectations the partners have about their roles, the congruence and mutuality of their role expectations, and their potential for exploring and revising those expectations (Rodin & Irving, 1982).

In examining the relationship with the care home operator, the majority of elderly in adult residential care homes are psychologically and physically dependent on the care home operator, in what can be identified as unreciprocated dependence. The residents who have organic brain syndrome or Alzheimer's Disease and related disorders lack total reciprocity. Murphy states that overdependency and nonreciprocity are considered childish traits in our society, and this is the very reason why the severely disabled and the very old are often treated as children. Aside from the situational uncontrolled dependency, some of the elderly residents have been conditioned to carry on a dependent role because of the traditional cultural expectation that women should be subservient and passive. Because most of the residents are elderly women, many of them have had little experience in managing their financial affairs or making their own decisions. Consequently, it is very difficult for them to change their behaviors in their later life. Thus, they assume a completely helpless role. In this sense, the Szasz and Hollenders' activity-passivity
According to Parsons, the role of the physician is functionally specific. The role of the majority of care home operators (Type I care home operator) is not only limited to one aspect of care, personal care, but has multiple tasks. There are some difference between Type I and Type II care home operators: Type II care home operator assumes only an administrative role which is functionally specific because she/he has many other staff to perform other roles. Nevertheless, the role of the majority of the care home operators are not functionally specific, but diffused, similar to parents in the parent-child relationships. The Type I care home operator as sole provider has economic, social and health responsibilities for the resident twenty-four hours a day. Even the transportation service to physicians, clinics, hospitals and banks is "supposed to be" provided by them which is similar to the parents who have to play the role of chauffeur for their children sometimes.

Paradoxically, however, residents may perceive the role of care home operator as functionally specific. If the care home operators ask questions about the resident's financial background, intimate relationship, etc., which are not relevant to their specific function as custodial care
providers, the residents may well resent them as "prying" into their own private affairs.

Aside from the role performed by the care home operator toward the residents, care home operators have other roles to fulfill, such as wife, mother, and in some cases grandmother. Their services are often provided in their own homes; thus, the simultaneous performances of different roles is imperative. In addition some care home operators hold a part-time job elsewhere. Consequently, the care home operators must carefully assess how many resources (time, money, mental capacity, etc) they have. Naturally, they must allocate their material and non-material resources wisely; otherwise, it would be impossible to manage the care home residents and their other role obligations.

Presumably, the more patients the Type I care home operator has as residents, the fewer resources will be provided to them. This is more apparent in Type I care homes than Type II. This situation may well affect the quality of care at the adult residential care homes. Concomitantly, the residents may perceive this situation as inequitable in the exchange relationships with care home operators. The amount of payment toward the care in contrast to the amount of services provided may create a discrepancy in the mind of residents.
The Negotiation

The concept of equity is quite important in examining interpersonal relationships. When the ratio of inputs to outcomes is equal to the ratio for other people involved in the exchange interaction, a state of equity exists. If the degree of inequity is great, people usually feel unjustly treated and will be dissatisfied. When there are no alternative available, people seek to restore "psychological equity" by altering their perception of respective inputs and outcomes (Huston & Burgess, 1979; Wilson, 1983).

From the social exchange perspective, the patients (residents) can change their course of action, when they perceive that greater utility may be obtained from other alternatives, for example by returning to their own family or moves to another facility. At the same time, residents may continue the course of action even though they are experiencing severe deprivation or dissatisfaction simply because they perceive no alternatives with greater expected utility available to fulfill their needs.

The initial contact between the care home operators and residents, particularly for the Type I adult residential care home, is very similar to Friedson's first type of client-dependant practice, which is modeled on the merchant-customer relationship. Care home operators are entrepreneurs competing with each other for the fees of prospective residents. If the care home operator's practice
is well-established, he/she can refuse services he/she does not want to give. If the care home operator is not yet established, he/she may pay special attention to establishing a good reputation in the community by providing personalized services and quality care. On the other hand, if the patient has some resources, such as money or social and family support, the patient may have some freedom to turn away from the care home services.

One of the ways to examine the relationship of care home operators and residents is to consider the resident as either a consumer or a commodity. Whether one can become a consumer or a commodity depends on the power of control over decision-making in the service process. An empty bed represents an operational loss to the care home operator. Care home operators will accept residents with less money at the beginning in order to fill the empty beds. However, soon after the admission of residents, they may raise the cost of care against the will of residents. Once the elderly client moves into a care home, it is a very difficult and timely process to change the care home. Thus, the operator may see the residents as just a commodity in order to fill the empty bed.

Also, if the care home operators do not want particular residents because of the timely care that the residents require or for any other reasons, they often reshuffle the residents to other care homes with empty beds through their
network system. The residents often have no choice but to accept the care home operator's arrangement. Quite often, a majority of residents can assume a consumer-oriented role only with the supportive efforts of their third-party participants such as social workers, welfare workers, or other service providers (Segal & Aviram, 1978).

Evidence for the negotiating ability of patients with professional services is provided by Friedson (1986). Wealthy or powerful, well-educated people can pretty much dictate the content of physician's service and gain a great deal, of not all of what they want, from them.

The Power and Dependence Relationship

As stated earlier by Friedson, any person engaged in providing services to clients or patients is prone to possess some form of official gatekeeping powers. In addition, the concept of power-dependence relations postulated by Emerson (1962, 1981) may well be applied to examine the motivational aspect of the care home operator-resident relationships. According to Emerson, power is a property of the social relation and not an attribute of the actor. The power resides implicitly in the other's dependency (Emerson, 1962). The services provided by the care home operators become necessary for the resident's survival. Furthermore, the power relationship seems to be much more apparent if the resident does not have any knowledge of available alternative resources. The
availability of family members and their supports seem to be one of the most critical elements in determining the balance of power between care home operators and residents.

The power of one individual over another will be greater if what she offers is highly valued by the other, if the other is willing and able to meet her needs, and if the other cannot resign himself to living without the service she provides (Wilson, 1983, p.29).

In the case of the residents who have organic brain syndrome or Alzheimer's Disease and related disorders, the dependency ratio seems very high. In some cases, they are abandoned by their own families because of the difficulty involved in caring. They don't have any other choices but to be taken care by the care home operators. In this situation, the power of the care home operator seems to be quite formidable and can be conducive to physical force, abuse and/or coercion.

For elderly residents, an additional element may influence the balance of power relation. Often, problems of aging are seen as problems of decreasing power resources and their inability to sustain the balanced exchange relations with others with whom they are in interaction. Compliance may well be the only option that the elderly have in their exchange relationships with providers (Dowd, 1975).
The Ethnicity of Providers and Residents

Another factor which may influence the care home operator-resident relationship is the ethnic factor; inter-ethnic group relationships. Kadushin (1972) examined the case of same-ethnic and different-ethnic professional-patient interactions by examining relationships between Caucasians and Blacks. The results suggest that the problem of ethnic relations in the professional-patient encounter is not clear-cut. Further, the effectiveness of interaction was not so much the question of the ethnicity of professionals or patients, but whether the professionals were competent, warm, and understanding. In Hawaii, the major ethnic groups among the elderly are Japanese, Caucasians, and Filipinos. Among them, the Filipinos, in general, occupy the lower economic and social strata in Hawaii. The median income of employed Filipinos was $6,554 compared to $8,396 for all Oahu residents in 1975 (Ponce, 1980).

The concept of status inconsistency may well be applied in the care home operator-resident relationships. The Filipino care home operator may experience ambiguous feelings as an administrator or an authoritative figure towards ethnic-dominant groups such as Caucasians and Japanese. Although several definitions of status inconsistency are available, it usually refers to the discrepancies in the ranks in the several status dimensions
of one's existence (Wegner, 1964 a. & b.). At the same time, perceived status supremacy of Caucasian residents may affect their relationships if the care providers are the ethnic minority and the recipients are the ethnic majority. The relationship between Filipino care home operator and the Caucasian and Japanese resident may create a conflicting situation. Caucasian and Japanese residents may not feel happy or satisfied with the care compared to other ethnic groups. Thus, the problems of interaction may exist due to conflicting expectations based on the status inconsistent situation.

Ethnicity is also likely to affect the satisfaction of residents because the services provided at the Filipino care homes are more culturally specific to Filipino residents. The values, customs, language and even taste in food of the operators will be more consistent with the Filipino residents. Therefore, the degree of satisfaction may be much higher when the provider and resident are from the same ethnic background. The provision of quality care and the perceived satisfaction level of recipients may well be influenced by these structural and cultural factors.

Conclusion: Statement of Research Questions and Theoretical Model

The purpose of the study is to examine the issue of the quality of care at adult residential care homes by focusing
on the relationship and the interaction between the care
home operators and the residents.

From the above discussion, three major sets of
questions regarding different aspects of the operator-
resident interaction can be identified for investigation:

1) What is the power-dependency relationship between
the care home operator and the resident? What effects
do the resident's resources have on the interaction
between care home operator and resident? Do the
residents with more resources such as money,
availability of formal and informal support, and better
activity of daily living function, receive better
quality of care than the elderly with no or less
resources? Do the residents with resources have better
bargaining power, such as more choices, than the one
without resources? What type of relationship is more
predominant among mentally coherent residents? Do the
newly established care homes provide better care than
the older ones in order to compete in the care home
business?

2) How do the multiple role situation of care home
operators in small family-like care homes affect the
quality of care provided to the residents? Does the
number of residents seem to affect the quality of
interaction? Compared to Type II care home operator,
do they have less time to attend to the needs of the
residents?; and

3) How does the ethnicity of care home operators and
the residents affect each other? Are Caucasian and
Japanese residents less satisfied than Filipino
residents in Filipino operated adult residential care
homes?

The conceptual framework for the study is depicted in
figure 3.1.
Figure 3.1
Conceptual Framework for the Study of the Quality of Care at the Adult Residential Care Homes

Structure

Stability of operators
- length of time as an operator
- nursing background
- physical type (Type I & II)

Characteristics of residents
- availability of resources
- disability level
- ethnicity

Outcome
Satisfaction towards
- care
- living condition
- cost

Process
The way services are provided
- availability of activities
- availability of choice
- availability of operator
- manner of operator
CHAPTER 4
RESEARCH METHODOLOGY

The emerging importance of adult residential care homes as a context for long-term care suggest significant questions in research in order to better understand the nature of quality of care provided by these homes and their effectiveness in serving various kinds of elderly populations. The present study is an exploratory investigation in regard to some of these questions.

This chapter explains the methodology utilized in conducting the study. The rationale for the methodology of the study, the sample population, administration of survey questionnaires, measurement of variables, and the quantitative and qualitative data analysis are explained in this chapter.

Rationale for Selecting the Method

Quantitative vs. Qualitative Approach

Whether to utilize either a quantitative or a qualitative approach is a major methodological issue. Both approaches have advantages and disadvantages. The major advantage of the quantitative approach is to facilitate comparison and statistical aggregation of the data. It gives generalizable findings. On the other hand, qualitative methods provide more depth and detailed
information through in-depth interviews, direct quotations, observed behaviors, interactions, and situations (Patton, 1987; Taylor & Bogdon, 1984).

The decision was made to utilize both approaches due to the following reasons:

1.) The basic research question is exploratory in nature because not enough research findings on the quality of care issue at the adult residential care level are available;

2.) There was initial uncertainty of the number of elderly residents who would be interviewed. The number might be insufficient for statistical analysis. The number of adult residential care facilities and their bed capacities were available prior to the data collection; however, care homes are utilized not only by the elderly, but also, by the mentally ill and developmentally disabled patients. No statistical information about the breakdown of the resident population was available even at the state department level; and

3.) The study is aimed at the understanding of the meanings of the social and cultural context of social interaction between the care home operators and the elderly residents.

Quantitative approaches such as telephone surveys and closed-ended survey questionnaires were utilized to obtain descriptive information about the care home operators, utilization of care homes by the elderly clients, and the functional disability level of the elderly residents. Qualitative methods, particularly the case study approach,
were utilized to enhance the understanding and the quality of research outcomes.

Longitudinal vs. Cross-sectional Approach

Although there are disadvantages to cross-sectional research in identifying causal processes (Branch & Ku, 1989), the decision was made to utilize the cross-sectional approach because of the following reasons: 1) limited time frame for data collection, 2) the elderly residents are referred to the adult residential care homes from a variety of sources such as hospitals, the social service division of the Department of Human Services, private social service agencies, families, and friends. Thus, it is very difficult to longitudinally track a group of the elderly upon discharge, 3) the outcome measurement used is the satisfaction level towards care and not the change of health status of the elderly. In addition, the resident's records were inaccessible because of the lack of support from the Health Department 5 in conducting the study, 4) the access to adult residential care homes was very difficult because of the tremendous resistance from the care home operators. Some of the reasons for the resistance were: a) too many researchers visiting care homes to conduct various studies, b) negative previous experiences with researchers, and c) anxiety of care home operators to be the target of the study

5 The Department of Health felt that there was noting more that could be learned from the study.
and the investigation. Some of the operators participated only on condition that the visiting time should be less than one hour.

**Plan of Data Collection**

**Procedure**

The study was conducted in three major stages: 1) a descriptive study to examine the characteristics of care home operators and the availability of elderly residents by utilizing the telephone survey method; 2) acquisition of functional disability status of the elderly residents from the care home operators by survey questions, and 3) visit to a sample of adult residential care homes in order to carry out interviews with operators and a sample of cognitively intact residents and to conduct informal observation of the interaction between the care home operators and the elderly residents.

Since the vacancy list of adult residential care homes consisted of only the name of the care homes, telephone numbers, and the availability of beds, additional information such as the name of the care home operators and addresses were obtained from the Department of Health. Based on the information obtained, all of the adult residential care homes (414), which included both Type I and Type II, were contacted by telephone.
The telephone survey consisted of a two-page questionnaire asking ethnicity, socio-economic status, occupational background of the care home operators, the years of operation, licensed capacity, and the availability of elderly residents and their nationality. All of the care home operators could speak and understand English over the telephone; thus, no interpreter was necessary.

After selecting the sample of care homes with elderly residents for the study, letters requesting the cooperation of the care home operators with a possible interview date were mailed out to care home operators. Several follow-up telephone calls were also made to remind the care home operators of the scheduled interview date. Since the majority of care home operators had negative attitudes towards "research projects," several telephone calls were made to explain the purpose of the study and to acquire permission for visitations from them.

For the first part of the second phase of the study, a modified version of the functional disability scale which was developed for the Statewide Adult Day Center Study⁶ was utilized to examine the functional disability level of all of the elderly residents regardless of their mental capacity. The functional assessment scores of the residents

were recorded by the researcher with the cooperation of care home operators or nurses (in the case of Type II facilities).

The purpose of collecting the functional disability level was to select mentally intact residents for a semi-structured interview. The semi-structured interview covered the availability of family and external supports, the daily activities of resident, and the opinion about food, art of care, physical environment of care homes and the cost of care home services. Each interview took approximately 15–20 minutes to complete. It was usually conducted in the privacy of the resident's room.

In order to pursue some issues in more depth, certain residents were selected for an open-ended interview. These interviews provided material for reporting case studies.

All materials from interviews with residents and operators and from the observation of the facility and the interaction between the care home operator and the resident were recorded in field notes immediately after each visit to the care homes.

The analysis of these adult residential care homes also includes information obtained from telephone interviews with social service agencies which deal with consumer advocacy and protection, and from episodes based on my personal experience as a social worker in assisting the elderly residents of adult residential care homes in Hawaii.
Sample Population

The sample populations of this study were: 1) the care home operators, and 2) the elderly residents (65 years old and over) of care homes on the island of Oahu. The Department of Health provides the certification for care home operations; therefore, a master list of licensed care homes exists for the State of Hawaii. The Department of Health compiles a vacancy list twice a month and circulates the information among social service agencies in town. The vacancy list is a list of all the adult residential care homes in Oahu with information about the separate availability of empty beds for men and women at each adult residential care home. The total number of care homes fluctuates quite often because of the termination and/or development of new care homes. According to the March, 1989 vacancy list, there were 414 care homes currently in operation on the island of Oahu, comprising approximately 2000 beds. All of the care home operators (414) constituted the initial sample population.

An initial telephone interview took place to determine which homes provided care to elderly residents. Of the 414, 245 were so identified. Of these, 236 were Type I care homes and 10 were Type II care homes. The study sample was created by taking an approximately 50% random sample of the Type I care homes and all of the Type II care homes. However, due to refusals, only seventy nine out of 127 adult
residential care homes (62%) participated in the second phase of the study (see Figure 4.1).

All of the elderly residents in Type I and twenty percent of the elderly residents in Type II adult residential care homes underwent a functional disability assessment. It was quite difficult to collect the data from all of the elderly residing in Type II facilities because of the inability of the nurses or the administrators to spare their time for the study.

Some of the elderly residents were expected to be severely confused due to symptoms of senile dementia and other mental disorders. Based on the information of the assessment of mental status, only the cognitively intact elderly residents were selected for the interviews to assure that the data collected would be reliable.

A total of 70 elderly residents were selected for interviews. However, thirty-two out of 70 residents were either not home at the time of the interviews or refused to participate. Although the notifications for the interview were mailed to the care home operators, some of the care home operators did not inform the residents to remain in the care homes for the interview or the residents simply forgot about the interview date. Consequently, the sample size for the final stage of the second phase was 38 residents.

Since the sample selection required several steps to identify the target population and only the mentally alert
elderly who were residing at the time of the interview were selected, the representativeness of the sample was in question. For example, the opinions of some of the residents who were still functionally independent and who were unhappy staying around the care homes might be lost from the study.

Duration of Study

The duration of the initial stage of data collection was from May, 1989 to July, 1989. The telephone contacting hours were limited to between 9:00 am and 11:30 am, and 1:00 pm to 4:30 pm in order to minimize the burden on care home operators from their daily workload.

The second stage of data collection, through visitation to each adult residential care home, started immediately after the first phase and continued until November 1989. The visitation hours were also limited to the above mentioned periods. The visitation usually lasted for an hour depending on the availability of cognitively intact elderly residents.
Figure 4.1
Sampling Charts (Quantitative Purpose)

FIRST PHASE

Number of Care Homes
414

Participated
319 homes

Refused
95 homes

Homes w Elderly
245 homes

Homes w/o
74 homes

Type I
235 H

Type II
10 H

SECOND PHASE

Type I
117 homes (50%)

Type II
10 homes (100%)

Refused
44 homes

Actual Sample
73 H 6 H

Refused
4 homes

(Part I)

Type I (100%)
203 Residents

Type II (20%)
53 residents

Others
149 R

Mentally Alert Elderly
54 R 16 R

Others
37 R

(Part II)

Refused/unable
25 R

Interviewed
29 R 9 R

Refused/unable
7 R
Measurement

For the quantitative analysis, certain variables were selected as structure, process and outcomes measures. Both the structure and the process components have direct influence over the outcome; at the same time, the structure has an impact on the process which in turn influences the result of the outcome.

For example, in examining the question of the power and dependency relationship between the care home operator and the resident, whether the care home operator is established in his/her business or not may have a great influence over how she/he interacts with the residents. The balance of the power relationship between the care home operator and the resident may well be influenced by the availability of resources of the residents and/or the level of physical dependency of the residents. Ultimately, the level of the power-dependency relation influences whether the resident is satisfied with the care or not.

Structural variables.

The structural variables include the characteristics of the operators and the characteristics of the homes. Specific variables to be analyzed regarding the individual characteristics of the operator include a) length of operation, and b) educational and occupational background. The length of time of an operation and the background of the care home operator were used to measure the establishment of
the care home operator in his/her business, and the education and occupation as indicators of the experience and the acquired knowledge of the operator.

A second set of structural variables cover the physical characteristics of the homes: the size of the facilities, Type I and Type II. The size of the facility was to measure the characteristic difference of the care home operators between the two types.

**Process variables.**

For the quantitative analysis, the variables for the process component were defined as: a.) the availability of recreational/exercise activities, b.) the availability of personal choice regarding physicians, watching TV and decorating one's room, c.) the availability of care home operator's attention to the resident, and d.) the treatment of the residents with respect and dignity. The availability of activities and the freedom of choice at the care homes were utilized to measure the power of the care home operators toward their residents. The index was also created to measure the aggregate scores on the availability of the resident's choices. In addition, whether the care home operator ate meals together with the residents or not was utilized to measure the home-like atmosphere of the care homes.

To examine the process by utilizing these quantitative variables, however, does not provide an in-depth
understanding of the interaction between the care home operator and the resident. Thus, to examine the process component, the emphasis was placed more on the qualitative data based on the field observations and my past experience dealing with the care home operators and the residents. As anticipated, some of the process components will not be included in the quantitative analysis.

Unlike studies which have carried out systematic observation of the doctor-patient interaction in the clinical setting, the observation of interaction between the care home operator and resident was very difficult and unsystematic. No video-taping nor tape-recording was permitted. Every day activities of care home operators and residents differed greatly depending on the type of residents at each care home, the time of the day, etc. Because of the time constraint imposed by the majority of care home operators, the focus of my observation was mostly limited to how the care home operator would introduce me and how they would approach the residents, such as their manner and tone of voice. The rest of the observations were very situational.

As a matter of fact, very little interaction was observed. The reasons were: 1) the duration of the interview was more or less limited to an hour due to the busy schedule of the care home operators and their unwillingness for the outsiders such as the researcher to
spend time in their care homes, and 2) the interview for both the care home operator and their residents had to be conducted in the short period of time. For these reasons, even the visitation to the care homes and the interview at the time of data collection provides only a limited understanding of the relationship of care home operators and the residents. Thus, previously collected and recorded anecdotal accounts based on my encounters as a social worker in assisting residents of adult residential care homes in Hawaii were also utilized to measure the process component. The social work experience overlaps with the data collection period.

**Outcome variables.**

The variable for the outcome component of quality of care was the satisfaction of the residents toward the care they were receiving. To better understand the resident's satisfaction, multiple dimensional measures were utilized (Pascoe, 1983; Stamps & Finkelstein, 1981). Three dimensions of satisfaction were: the resident's satisfaction with 1) care provided by the operator, 2) living condition, and 3) acceptability of the cost of care home. However, the last item was dropped from the analysis because not many elderly residents knew about the cost.

**Intervening variables.**

The characteristics of the residents such as ethnicity, the availability of financial resources, family support as
measured by the number of family contacts with the residents, formal support by social workers, and the functional disability level of the residents, were utilized to measure the dependency level of the residents toward the care home operators. Some of the above mentioned variables were treated as continuous and others as categorical.

When examining the role of ethnicity, only care homes operated by Filipino were selected, since few care home operators were from other groups. The resident's ethnicity is utilized as an independent variable and the level of satisfaction will be used as dependent variable to examine the differences toward the satisfaction level among three major ethnic groups, Caucasians, Japanese, and Filipinos. To examine the questions regarding the effect of role differences among the care home operators, the care home operator (Type I vs. Type II) will be used as the independent variable and the availability of the operator's attention toward the resident will be used as the dependent variable. In addition, the availability of children in the operator's family will be examined.

Data Analysis

The statistical analysis was conducted utilizing STAT1\textsuperscript{7} and SPSS PC+, a computerized statistical package.\textsuperscript{8}

\textsuperscript{7} Jerry Brennan & Lawrence H. Nitz (1986). Stat 1: A Statistical Toolbox, Honolulu, HI: Sugar Mill Software Corp.

First, descriptive statistics were generated in order to examine the characteristics of care home operators and the residents, the characteristics of facilities, and so forth. Secondly, the comparison of client's characteristics between Type I and II adult residential care homes was conducted by utilizing T-tests. Thirdly, the analysis of the components of structure, process and outcome was generated by utilizing ANOVA, MANOVA, and Multiple Regression.

Several analyses are presented in order to examine the previously stated study objectives and questions in Chapter 3.

Since the number of elderly residents who could participate in the final phase of the study was very small (38), the emphasis in the analysis will be placed upon the analysis of multiple case studies to examine the interaction of structure, process, and outcome.

For the strategies for conducting case-study analysis, the explanation-building technique⁹ will be utilized. The narrative form of individual cases will be presented initially and the cross-case analysis will be followed.

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CHAPTER 5
A PORTRAIT OF CARE HOME OPERATORS AND FACILITIES

Prior to the analysis of quality of care at the residential care home, the characteristics of the care home operators and the facilities on the island of Oahu based on the results of both quantitative and qualitative information will be provided in this chapter. The analysis is based on the results of the survey data, visitations to the facilities, and my own personal encounters with the care home operators as a social worker.

Following the descriptive information which will provide an overview of current situation about the care home operators and the facilities, the development of a typology of care home operators is attempted based on the differences in the orientations toward care.

Some of the questions to be explored in this section are: Are there changes of the characteristics of the care home operators since the last survey done by Sakai in 1982? Has the involvement of other ethnic groups increased in the operation of care home industry? Do the characteristics of the care home operators differ between the two types of adult residential care homes, small-family type (Type I) or large institution type (Type II) care homes?
Care Home Operators

Most of the descriptive information regarding the care home operators was collected by telephone survey. Among 414 licensed adult residential care homes in Oahu, a total of 319 care homes participated in the initial phase done by telephone and 79 care home operators participated in the second phase of the study done by visitation. Table 5.1 presents descriptive information regarding the care home operators. In examining the characteristics of the care home operators in the initial and the second phases in the table, one finds that they are quite comparable. Thus, it can be said that the adult residential care homes which were visited appear to be a representative sample.

Who Are The Care Home Operators?

Based on the initial sample of 319 care homes, a majority (91%) of the adult residential care home operators on Oahu, Hawaii are Filipinos. Among these Filipino operators, 90% are of Ilocano origin, a northern area of the Philippines. Seventy-one percent of the Filipino care home operators migrated to Hawaii after 1965. A majority of them (99%) are operating Type I (small-family type) adult

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10 There are three major phases of Filipino migration to the United States: before 1932, 1933 - 1964, and after 1965. The characteristics of the migrants differ greatly according to the period of migration (See Liu, 1984).
Table 5.1

The Characteristics of Care Home Operators in Hawaii (1989)

<table>
<thead>
<tr>
<th></th>
<th>Initial sample (N=319)</th>
<th>Second sample (N=79)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>49 years old</td>
<td>51</td>
</tr>
<tr>
<td>Maximum age</td>
<td>73 years old</td>
<td>73</td>
</tr>
<tr>
<td>Minimum age</td>
<td>28 years old</td>
<td>29</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Male</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filipinos</td>
<td>91% (90% Ilocano)</td>
<td>86%</td>
</tr>
<tr>
<td>Japanese</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Part-Hawaiian</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Caucasians</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Others</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>93%</td>
<td>97%</td>
</tr>
<tr>
<td>Widow</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Single</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Average Years of Operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type I</td>
<td>11 years</td>
<td>12</td>
</tr>
<tr>
<td>Type II</td>
<td>28 years</td>
<td>24</td>
</tr>
<tr>
<td>Work Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered/Licensed Nurse</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Nurses Aides</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>Other Health Related</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Others (sales, clerk, etc.)</td>
<td>44%</td>
<td>36%</td>
</tr>
<tr>
<td>Educational Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate school</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Technical/College Graduate</td>
<td>49%</td>
<td>47%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>31%</td>
<td>36%</td>
</tr>
<tr>
<td>Others</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Family Size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Family</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>Extended Family</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Single person</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

109
residential care homes. The rest of the care home operators are almost evenly distributed among Japanese (2%), Caucasians (2%), Part-Hawaiian (2%), and others (3%).

Ninety-seven percent of them are female and the average age is 49 years old. The maximum age of the care home operator is 73 years old and the minimum age is 28 years old. A majority of them (93%) are married. Seventy-one percent of them live with children and the average family size is four. Twenty-five percent of them live with parents, siblings, and relatives aside from their own families. Many of the operator's parents, siblings, and relatives act as substitutes for the care home operators in case of emergency. Some of the substitutes also operate their own care homes in close vicinity. The average number of helpers that the operator can tap into in case of emergency is two. They are the important human resources that the Type I adult residential care home operator can rely on.

The average years of operation among Type I care home operator is 11 years and the maximum is 27 years. The oldest Type II adult residential care homes was established in 1917. However, there have been many different administrators since that time.

The educational level of care home operators is quite high. Eighty-four percent of them are high school graduates. In addition, almost half of them have either a
technical or college degrees. A little more than half (56%) have some kind of health and nursing background: 13% registered or licensed nurses, 39% nurses aids, and 4% other health related field. The rest (44%) of the operators do not have any formal experiences in nursing, other than having attended the nurses aides course required by the Department of Health in Hawaii. Some of the operators mentioned that even though they had no formal experience in nursing, they did have experience in taking care of their own aged parents.

Among the care home operators surveyed, their annual income distribution were as follows: 24% between 20,001 - 30,000, 25% between 30,001 - 40,000, and 21% between 40,001 – 50,000. These amounts are the combined income of all the members of each family.

Similarities and Differences Between the Two Types

For both types of adult residential care homes, Filipino operators outnumber those from other ethnic backgrounds: 93% in Type I homes and 40% in Type II homes. However, more Caucasian operators (30%) manage Type II homes. Filipino operators of Type II homes are both owner and administrator of the facilities. By comparison, non-filipino operators are only administrators. As far as the experiences of the operators are concerned, the operators of Type II homes have better qualifications than the Type I homes: 10% are medical doctors (one doctor with a foreign
certificate) and 50% are registered nurses. In contrast, only 12% registered or licensed nurses while 40% nurse aids operate Type I adult residential care homes. This difference reflects the more stringent qualifications required of the care home administrators in Type II adult residential care homes.

**Have There Been Any Changes Since The Early 1980’s?**

Compared with the 1982 study by Sakai\(^\text{11}\), the proportion of Filipino care home operators has increased; however, the characteristics of the adult residential care home operators has not changed much even after the consolidation of boarding homes and care homes in 1986. One major difference is noted in the work experience of the operators. According to Sakai’s study, 29% of the operators didn’t have any prior experience working in a medical or health related field. The proportion of operators without nursing and health backgrounds has increased dramatically since 1982 (from 29% of Sakai’s study to 44% in 1989). The majority of Type I care home operators had been operating care homes for approximately 11 years at the time of data collection. The reasons for the increase of non-nursing oriented operators is not clear. However, it is known that the regulations and the requirements for the previously licensed boarding homes were not as stringent in comparison

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to care homes. The increase in the number of operators with non-nursing background is probably the result of the consolidation of boarding and care homes around 1986.

Another finding is that the proportion of care home operators other than Filipinos has not increased at all since 1982. No other ethnic group, including recent immigrants, such as Koreans, Samoans, or Vietnamese, are interested in establishing adult residential care homes. Thus, the care home industry is still dominated by Filipinos, especially by first generation immigrants. To examine the reasons for this trend is beyond this study; however, it would be quite interesting to find out the possible contributing factors.

Motivational Factors

Although there are many possible reasons to start the care home business, a majority of the care home operators who were interviewed mentioned that they started the business to make additional income, at the same time, to be able to care for their own children at home. Some of them mentioned that there were no other jobs available for them in the market; besides, it was easier for them to launch a care home business since they had been accustomed to taking care of their own family members. Hardly anyone mentioned that the caring of the disadvantaged population was their mission or their first priority. Basically, a majority of the care home operators have been driven by their need to
supplement their family income. This notion is also supported by the statements of some of the care home operators that they will terminate the business as soon as they accomplish their duties of sending their children off to college and into the adult world.

Selection of Clients

Whenever the care home operators have vacancies in their homes, they contact and make their preferences known to the social workers and discharge planners at the hospitals. In most cases, they prefer private clients over publicly assisted ones, since they can charge higher fees and they do not have to complete the lengthy forms required by the Department of Human Services. The best candidate for the care home operators is a private client requiring little care, e.g. with Level-1 conditions.\footnote{See page 60 for the description of Level 1 care.}

Two out of six Type II adult residential care homes in this study do not accept government-assisted patients under their admission criteria due to the level of payment. There are also a few Type I care homes which only accept private residents. Perhaps, it is inevitable for all human beings to think that the less work with more pay or money seems to be the most attractive choices.

Some of the care home operators also have their ethnic preferences. Through my encounters with many operators,
Japanese clients are usually preferred over Caucasians. Some of the reasons are that Japanese complain less, are more appreciative, quieter, and thus, easier to take care of.

Another selection consideration is the desire of operators for specific types of clients, such as the developmentally disabled patients, psychiatric patients, or the elderly clientele. Some operators mentioned that it would be quite difficult to manage clients who have different health and mental conditions. Often times, the developmentally disabled residents attend day care centers for rehabilitation purposes at the expense of the State. If the care home operator only takes care of the developmentally disabled, she/he will have some time off from taking care of her residents during the day. If there is a mixture of elderly residents and the developmentally disabled residents, she/he still has to stay home to attend the needs of the elderly residents. Thus, the selection of clients is in part based on convenience. This consideration is reflected in the fact that 23% of the care homes in Hawaii at the time of this study did not accept the elderly population.

**Behind the Scene**

The experience of two of my clients illustrates the priority of operating an economic enterprise rather than on client care which is typical of many Type I facilities. In
the process of collecting the data, interesting information was revealed to me from two clients of mine. One of them was referred to me as a possible victim of abuse by the care home operator. The other one was referred to me (indirectly) from the care home operator as having a problem of inactivity and of not being willing to participate in outside activities. Coincidentally, both of them happened to live in the same adult residential care home, a facility which refusal to participate in the second phase of my study.

According to these clients, the care home operator accepts more residents than she is licensed for, sometimes two to three additional private-paying residents for a short period of time. One of the complaints of the residents was that not enough care was provided by the care home operator. It seemed that both the care home operator and her husband had additional jobs at night; therefore, only the care home operator's mother, who is herself elderly and doesn't speak nor understand English well, was available for the resident's assistance. According to the clients, the care home operator's mother is the one who cooked for the residents, cleaned the facility, and assisted the residents with their minor requests.

Not all of the care home operators who refuse to participate in the study have similar problems but it is presumed that some of them may have a similar hidden agenda.
Despite the fact that the care home operators are economically motivated, some of the operators have more humanitarian and altruistic reasons than the others. For the general public, it is not an easy task to identify the less caring operators other than by word of mouth perhaps from referring sources. For social workers, it is possible to sort out the more caring operators from the rest by the continuous case management of clients. However, categorizing operators is a very complex classificatory task, since one has to consider various variables such as individual personalities, preferences, personal competence, and so forth. In addition, it takes a long time to really know the situation in the care homes.

In fact, several list of preferred care homes, marginal ones, and homes to avoid have been created by some of the community social workers and circulated among them. The lists have not been created based on objective criteria but rather subjective feelings of the social workers working with the care home operators and their clients.

Before going into the detailed explanation of how the clients are usually placed into adult residential care homes, and what kinds of negotiation will ensue among those involved, it is imperative to present the characteristics of

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13 The case management approach is a micro-oriented approach which the case manager, usually a professional agency worker, attempts to coordinate a variety of public and private services including informal support, and to provide a continued supervision.
the facilities beforehand to have a more comprehensive understanding of the relationship between care home operators, the residents and their families, and the social workers.

Adult Residential Care Facilities

Characteristics of Facilities

Geographical distribution.

The island of Oahu is divided according to the census into Honolulu, Leeward, Windward, Central, and Northshore areas. Among all of the adult residential care homes on Oahu, the majority of them are located in either the Waipahu and Pearl City areas (45%), and Kalihi, Salt Lake, and the Moanalua areas (32%). These are contiguous areas in East Honolulu and Central Oahu on the outskirts of the city.

Table 5.2 indicates the total distribution of adult residential care homes on Oahu and the distribution of the sample facilities.

Seventy-seven percent (245) out of 319 adult residential care homes which were surveyed by telephone, have accepted elderly residents. Among the 79 adult residential care homes visited, 30% were located in the Waipahu and Pearl City area and 37% were in the Kalihi, Salt Lake area.

Although the distribution of the sample of adult residential care homes in the second phase differed slightly
from the total adult residential care homes on Oahu, the
difference does not create a major problem in this study.

Table 5.2

The Distribution of Adult Residential Care Homes in Oahu
(1989)

<table>
<thead>
<tr>
<th>Total</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waipahu/Pearl City/Aiea</td>
<td>45%</td>
</tr>
<tr>
<td>Kalihi/Salt Lake/Moanalua</td>
<td>32</td>
</tr>
<tr>
<td>Other Honolulu areas</td>
<td>6</td>
</tr>
<tr>
<td>Windward:Kaneohe/Kailua</td>
<td>5</td>
</tr>
<tr>
<td>Central:Wahiawa</td>
<td>2</td>
</tr>
<tr>
<td>Northshore</td>
<td>6</td>
</tr>
<tr>
<td>Ewa/Waianae/Nanakuli</td>
<td>4</td>
</tr>
</tbody>
</table>

Physical appearances.

A little more than half of the adult residential care
homes have second-story facilities where the care home
operator and her/his family resides upstairs. Usually, the
resident's rooms or living quarters are connected to the
operator's living quarters by stairs (with or without
doors). The residents usually use bells or buzzers which
are attached to each room or at the bottom of the stairs to
attract the attention of the care home operator. The
residents are not usually allowed to go up to the operator's
living quarters.

The majority of the adult residential care homes are
clean and odorless although some of the Type I homes had a
terrible urine odor. More than half (53%) of the homes have
outdoor areas which residents can freely use, while the rest of the homes utilize the garage as an outdoor area for the residents. Residents sitting on chairs in the garage and looking aimlessly outside is a common scene in many of these adult residential care homes. Some of the elderly residents walk around the house for exercise, but a majority of them are inactive. A little more than half of the homes have a fence around the house. Sixty-eight percent of the homes do not have a place for private conversation. Often, the rooms are shared by two residents. A majority of the homes (77%) have telephones specifically for the residents in their quarters, but some of the care home residents needed the permission of the care home operator to utilize the phone. Usually, the homes which only accept women have more homey, colorful, and attractive appearance in comparison to homes for men. Some of the homes are utilized by both men and women, but the majority of them are only for the same sex.

Overall, there were tremendous differences in the appearances of the facilities: some were very dark and gloomy and others had a very pleasant home-like environment. Some of the care homes covered their couches with plastic to prevent staining. Plastic covers, however added to the impersonal character of these facilities.

**Similarities and Differences Between the Two Types**

Aside from the size of the facilities, the major difference between the Type I and II facilities was the
availability of recreational activities. Only 15% of the adult residential homes provided some kind of recreational activities. A majority of them are Type II adult residential care homes. Only 4% of the Type I care homes provide regular activities such as outings and exercises.

In general, the schedules of daily activities are posted in Type II care homes and the residents can participate if they wish. Some of the recreational activities are games such as Bingo, movies, and outings. Not all of the residents participate in these activities but the option is theirs. In Type I care homes, these activities are simply not provided; however, there are occasional outings possibly once or twice a year in a few Type I care homes.

Although adult residential care homes are established as community-based care facilities, supposedly keeping clients integrated into the community, some of the Type II care homes are very institutional in character, clean and orderly but not homey. Some of the Type II care homes are attempting to make their facilities more "at home," by allowing the residents to bring their own personal belongings. Even among Type I care homes, some looked like mini or semi-institutions. The only available furniture in the bedrooms are beds and a small side table with no personal items. Some of the operators even discourage the residents from bringing their personal belongings.
As far as the occupancy rate is concerned, adult residential care homes in Hawaii are not at present fully utilized. Based on the initial sample of the study, 1,558 residents are residing in the adult residential care homes on Oahu. The licensed capacity for these homes is 1,724. Thus, the occupancy rate is 90%. Some of the adult residential care homes are very popular and have a long waiting-list, but, some of them have great difficulty in achieving their licensed capacities.

In examining the occupancy rate between the two types, Type II had lower occupancy rate than the Type I (86% vs. 91%). One of the contributing factors for this lower occupancy was the self-imposed limitations of the facilities due to the lack of nursing staff. One of the major concerns for the Type II facilities is the recruitment and retention of employees with minimum non-competitive wages.

**Typology of Care Home Operators**

Based on past encounters with the care home operators and the visitation and the observation of the care home operators and their facilities, a typology of the care home operators can be generated. As noted previously, almost all of the care home operators are driven by the profit motive; however, some are more care oriented than others.
Basically, the care home operators can be differentiated into three categories: 1. client-oriented, 2. mixed-motive oriented, and 3. profit-oriented. A majority of the care home operators fall into the second category, which is half way between the client-oriented and the profit-oriented categories. The background experience of the care home operators, professional or non-professional, does not seem to be a determining factor.

Client-Oriented

Client-oriented operators are usually more willing to devote their time for their residents and their concerns. They treat the residents as part of their family and are very much concerned with the likes and dislikes of the residents. They are more concerned about providing a warm and comfortable environment for the residents. In general, the care home has a friendlier atmosphere among the residents and also for the care home operators and their families. Sometimes, the care home operator takes those residents who want to go, out for lunch and shopping. To take the residents on outings requires special effort by the care home operators. One care home operator mentioned that she wants to treat her residents as she wants to be treated when she herself gets old.

The client-oriented facilities are usually clean and tidy. There is hardly any physical dividers or invisible dividers between the operators' families and their
residents. The care home operators allow their residents to bring their personal belongings and let them decorate their rooms as they wish. Or, the operators decorate the rooms for them to make it look cozier.

One such example was found in the home of a 70 year old care home operator. There are currently 6 care home operators whose ages are above 70 years. Although I was initially surprised as to whether an operator this age could provide the necessary care for her residents, my doubts disappeared as soon as I observed the interaction between her and her residents. The positive reactions of the residents confirmed this impression.

According to the residents, both the operator and her husband go on outings, shopping, and exercising together with residents and they treat residents just like their friends or the members of her family. The operator was joking with one of her residents and a lot of touching was observed with one Filipino female resident. Another resident who is much older than the care home operator calls her "mama." He mentioned privately, that he had lived in many different care homes prior to coming to this one, and there is no home better than this care home. It is second best to his own home.

Profit-Oriented

In contrast, the profit-oriented operators are less concerned about the comfort of their residents than seeking
more economic benefits from themselves. They look for means to acquire more money than granted; thus, they charge extra fees for their services. The profit-oriented operators often lack the caring components in dealing with their residents. They spend less time with the residents and provide the absolutely minimum services. Although some of the residents want their privacy and want to be left alone, hardly any empathetic interaction takes place with the residents.

The appearance of these facilities is also substandard. Some of the care homes were dark and gloomy and reminded me of old psychiatric institutions as often depicted in television dramas.

One obvious example of the profit-oriented care homes is the one where Mrs. K resides, who is a 87 year old Japanese widow with difficulty in mobility due to the condition of severe osteoporosis. Although she has been living in Hawaii for more than 60 years, she still has difficulty speaking English and lacks assertiveness in expressing her needs.

According to Mrs. K, the operator charges for every service she provides, for example, $1.00 for cutting her nails, $5.00 for each trip to the doctor, and $10.00 for the use of diapers even though Mrs. K doesn't use them. These services are supposed to be included in the basic fee. The operator also keeps money for the residents when some of
their families bring them allowances, but she usually keeps it for herself since most of her residents have various degrees of dementia and they don't really know what is going on. In the beginning, the operator gave Mrs. K a bath twice a week, but after a short while it was reduced to once a week.

This facility was under construction since the care home operator was expanding her family's living quarters. The five residents, both male and female, shared three rooms and one bathroom downstairs. The comment made by Mrs K was that it has been such a hassle to use the same bathroom with four other residents when everybody's movements are very slow because of their frailty.

**Recent Trends in the Decline of Adult Residential Care Homes**

Since the consolidation of boarding homes and care homes to adult residential care homes in 1986, the number of adult residential care homes has been decreasing (see graph 5.1). Although the number of adult residential care homes fluctuates each month because of the discontinuation of facilities or the development of new facilities, approximately 500 adult residential care homes were available statewide in 1989 and a majority of them (414) were located on the island of Oahu (Hawaii State Department of Health, March 1989 figure). The peak establishment of adult residential care homes was seen around 1987 when there were 633 licensed facilities which had approximately
3,000 beds. It is speculated that the decreasing number of adult residential care homes dates from the time of consolidation and the implementation of new policies with more stringent rules and regulations. Some of the boarding home operators did not want to go through with the training imposed by the Department of Health. Others were unable to pass the required certification examination.

As far as the technical skills of the care home operators are concerned, the consolidation of care homes and boarding homes may have succeeded in screening out incompetent care home operators. However, there is some evidence that some of the care home operators who did not go through the additional training required by the Department of Health or did not passed the examination, are still operating by only accepting private pay resident through their referral network on an unlicensed basis. This involve a relatively few cases but the problem of unqualified operators currently did exists.

A great number of care home operators expressed that they wanted to change their occupation due to 1) the stringent regulations imposed by the Department of Health and the lack of sufficient support from them, and 2) the amount of work involved is not justified by the financial return.

Another difficulty the operators are facing is the antagonistic relationship between the two major care home
associations in Hawaii. Almost all of the operators mentioned that they do not have lobbying power to obtain general improvements of their status and their working conditions because of the lack of unity among them. Some of them mentioned outright that they will terminate their business after they fulfill their obligation of seeing their children finish college. A majority of the operators also mentioned that their children have no intention of continuing their business.

Although the adult residential care homes are not currently fully utilized, considering the declining trend of adult residential care home operations in contrast to the increasing elderly population in Hawaii, we are left with the question of who or which organizations can take care of the ever increasing frail elderly population at the onset of the 21st century.
Graph 5.1

Numbers of Adult Residential Care Homes in Hawaii
(1960-1989)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE HOMES</td>
<td>(6)</td>
<td></td>
<td>(212)</td>
<td>(525)</td>
</tr>
<tr>
<td>BOARDING HOMES</td>
<td></td>
<td>(183)</td>
<td>(315)</td>
<td>(547)</td>
</tr>
</tbody>
</table>

DSSH (1982) Fact Sheet on Domiciliary Care.
DSSH (1985) Final Report and Recommendation of the DOH and the DSSH on Care Needs in Domiciliary Care Facilities.
DHS (1987) Requesting a Study of the Ways in which the State Can Assist the Operations of Adult Residential Care Homes.
O'Donnell (1988) Adult Residential Care Homes: Are They Truly an Alternative to Nursing Home Placement?

* (asterisk) indicates the year of consolidation (1986)

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CHAPTER 6

A PORTRAIT OF THE LIFE OF THE ELDERLY RESIDENTS IN ADULT RESIDENTIAL CARE HOMES

This chapter explores the information about the elderly residents who reside in the adult residential care homes in Hawaii. First, the descriptive information of the elderly residents, such as the demographic characteristics, and the functional and health conditions, will be presented. Secondly, how and why some of the elderly have been placed into adult residential care homes, their reactions, and the life in the adult residential care homes will be explained with the information obtained through interviews with the residents together with my past experience working with them.

The Elderly Residents

The Proportion of the Elderly Residents

Out of 1,558 residents of care homes in Hawaii at the time of this study in 1989, a little more than half (59%) were elderly residents who were 65 years old and older. No breakdown of other categories of residents is available, but the elderly population is certainly the major utilizer of the adult residential care homes.

Based on the initial telephone survey in 1989, a total of at least 912 elderly were utilizing adult residential
care homes on Oahu: 631 elderly in Type I homes and 281 elderly in Type II homes. Seventy-nine out of 127 randomly selected adult residential care homes which serve the elderly population participated in the second phase (62% participation rates). The total elderly sampled in the second stage was 256 and the final stage was 38.

**Ethnic Distribution of the Elderly**

As far as the ethnic distribution of the elderly residents is concerned, proportionally more Japanese and fewer Caucasians seem to utilize adult residential care homes compared to the general ethnic distribution of the elderly (65+) in Hawaii. ¹⁴

The ethnic distribution of care home residents is depicted in Table 6. Forty percent of the elderly residents were Japanese, and they are the largest ethnic group utilizing adult residential care homes. The next group is Caucasians (16%), Hawaiian (11%), Chinese (11%), and Filipinos (9%) respectably. More Japanese and Filipinos utilize Type I, small-family like care homes, whereas more Chinese and Hawaiians seem to utilize Type II homes. The large percentage of Chinese and Hawaiian/Part-Hawaiian in Type II homes is attributed to two homes, Palolo Chinese Home, and Lunalilo Home, which specifically cater to the Chinese and Hawaiian population. The unknown category in

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Table 6.1 is the result of the lack of information from one facility.

The sample in the second phase of this study is similar to the ethnic distribution of Type I homes in the initial sample.

Table 6.1

Ethnic Distribution of the Elderly Residents (65+)
in Adult Residential Care Homes in Hawaii
(Initial Sample, 1989)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total (912)</th>
<th>Type I (N=631)</th>
<th>Type II (N=281)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasians</td>
<td>16%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Japanese</td>
<td>40%</td>
<td>46%</td>
<td>25%</td>
</tr>
<tr>
<td>Filipinos</td>
<td>9%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Chinese</td>
<td>11%</td>
<td>6%</td>
<td>24%</td>
</tr>
<tr>
<td>Korean</td>
<td>2%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Hawaiian/Part</td>
<td>11%</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6%</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Others</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3%</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Characteristics of the Elderly at the Adult Residential Care Home

All of the detailed descriptive information about the residents were collected through visitations to the adult residential care homes. The result of the characteristics of the elderly residents at the second stage and the final stage is depicted in Table 6.2.

The oldest resident was 100 years old and the average age of the residents were 79 years old. The average age of
the final sample population is slightly older than the second phase. Women were more likely to be residents than men in both the second and final stages. This is a reflection of the fact that women live longer than men and more likely to be widowed. Therefore, they are in need of care facility. The distribution of the ethnicity of the residents reveals differences in the second and final stages. More Caucasians and fewer Japanese and Filipinos are included in the final stage. In addition, the method of payment differs slightly: Fifty-eight percent of the elderly residents were assisted by the government, SSI and Hawaii State supplement, whereas forty-seven percent were government-assisted in the final stage. Consequently, the elderly in the final sample had more financial resources. Less than half (44%); however, knew how much they were paying to the adult residential care facility. The government-assisted residents and the residents whose family members handle their financial matters, are uncertain about the cost of care homes and the amount they pay.

The average length of stay at adult residential care homes is approximately 52 months (4 years). The average stay of the final sample shows almost half of that length (27 months).
Table 6.2
Demographic Profiles of the Elderly Residents (65+) in Adult Residential Care Homes in Hawaii (1989)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Second stage (N=256)</th>
<th>Final (N=38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>21%</td>
<td>39%</td>
</tr>
<tr>
<td>Japanese</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>Filipinos</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Chinese</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Korean</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Hawaiian/Part-Hawaiian</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Others</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

| Average Age                | 79 years old         | 82 years old |
| Maximum age                | 100 years old        | 97 years old |

| Sex                        | Female 60%           | 63%          |
|                           | Males 40%            | 37%          |

| Payment                    | Private paying 42%   | 53%          |
|                           | Government Assisted 58% | 47%          |

| Average Length of Stay     | 52 months           | 27 months    |

| Five Major Health problems | 1.) Dementia/Alzheimer | 1.) Hypertension |
|                           | 2.) Hypertension      | 2.) Heart Disease |
|                           | 3.) Heart Disease     | 3.) CVA (Stroke) |
|                           | 4.) Diabetics         | 4.) Osteoporosis |
|                           | 5.) Respiratory Disease | 5.) Diabetics   |

| Common Mental Problems     | 1.) Schizophrenia    | 1.) Schizophrenia |
|                           | 2.) Mental Retardation |               |
The great difference may be attributed to the difference of the sample population. Residents with developmental disabilities, psychiatric problems, who usually tend to stay longer, were not included in the final stage.

Health and Functional Conditions

Elderly residents usually have more than three chronic conditions. The most common chronic conditions among the residents are dementia or Alzheimer related disorders, hypertension, heart disease, diabetes, and respiratory disease. In addition, other common mental problems include schizophrenia and mental retardation.

As far as their functional disabilities are concerned, a majority of them can more or less independently carry out the activities of daily living (ADL), except bathing (see table 6.3). The average score for bathing was 3.11 on a 6 point scale which means the residents are often assisted by the care home operator when they take a shower or bath. This doesn't mean that the residents are necessarily incapable of taking a bath themselves, but rather, it seems to reflect a concern for safety by the care home operators. The majority of the operators noted that they don't want to take a risk of the residents falling in the bathroom and being held liable.

In addition, the administration of medication was often assisted by the operators. The operators usually keep
the medication in a locked cabinet and dispense the medicine
to the residents according to the prescription of their
physicians. Very few residents keep their own medication
with them.

The mean score for the usage of telephone is 3.29 on a
6 point scale, which means the residents are often assisted
by the care home operator when they use telephone. Again,
this is not due to an inability of the residents to dial the
number, rather phones are not accessible to the residents
other than asking for the operator's permission or the
residents simply request the operator to dial the number for
them.

The mean score for hearing and vision are 1.64 and 1.72
respectively on 5 and 6 point scales. The score 1 indicates
normal or no problem. As far as mental status is concerned,
the mean score is 2.25 on a 5 point scale. The score of 2
indicates mild impairment but the ability to carry out most
activities independently. The score of 3 indicates moderate
impairment and the need for frequent orientation and
reminders. The score of 5 indicates total unresponsiveness
of the residents. The behavioral problems are scored on a 4
point scale with 4 equals unresponsive to maximum staff
intervention. The mean scores for depression, wandering,
physically abusive and delusion are 1.93, 1.51, 1.36, and
1.67 respectively. This indicates that the residents show
less behavioral problems.
Table 6.3

Mean Scores for Functional Disability Levels of the Elderly Residents (65+) in Adult Residential Care Homes in Hawaii (1989)

<table>
<thead>
<tr>
<th></th>
<th>Total (N=256)</th>
<th>Final (N=38)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity of Daily Living (ADL)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>1.47</td>
<td>1.16</td>
</tr>
<tr>
<td>Bathing</td>
<td>3.11</td>
<td>2.79</td>
</tr>
<tr>
<td>Dressing</td>
<td>2.30</td>
<td>1.95</td>
</tr>
<tr>
<td>Transferring</td>
<td>1.69</td>
<td>1.53</td>
</tr>
<tr>
<td>Mobility</td>
<td>2.21</td>
<td>2.47</td>
</tr>
<tr>
<td><strong>Instrumental Activity of Daily Living (IADL)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adm.</td>
<td>2.08</td>
<td>1.82</td>
</tr>
<tr>
<td>Telephone</td>
<td>3.29</td>
<td>1.78</td>
</tr>
<tr>
<td><strong>Physical &amp; Mental Impairments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>1.64</td>
<td>1.55</td>
</tr>
<tr>
<td>Vision</td>
<td>1.72</td>
<td>1.97</td>
</tr>
<tr>
<td>Continence -urine</td>
<td>2.33</td>
<td>1.50</td>
</tr>
<tr>
<td>Continence -bowel</td>
<td>2.15</td>
<td>1.58</td>
</tr>
<tr>
<td>Mental Status</td>
<td>2.25</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Behaviors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1.93</td>
<td>1.58</td>
</tr>
<tr>
<td>Wandering</td>
<td>1.51</td>
<td>1.00</td>
</tr>
<tr>
<td>Physically Abuse</td>
<td>1.36</td>
<td>1.13</td>
</tr>
<tr>
<td>Delusional</td>
<td>1.67</td>
<td>1.11</td>
</tr>
<tr>
<td>Group Participation</td>
<td>2.27</td>
<td>1.33</td>
</tr>
</tbody>
</table>

* ADL and IADL scores range from 1 to 6 with 1=most independent.
* Mental Status scores range from 1 to 5 with 1=oriented, intact memory.
* Continence scores range from 1 to 6 with 1=most independent.
* Hearing and Vision scores range from 1 to 4 with 1=normal.
* Behavior scales range from 1 to 4 with 1=no problem.
In comparing the functional disability levels of the residents between the second stage and the final stage, several differences are noted other than the mental status. The scores of ADL (activities of daily living), IADL (instrumental activity of daily living), physical, mental, and behavior problems of the residents at the final stage are better than the second stage except in regard to mobility and vision. The lower mobility and vision in the final sample is understandable, because if the residents are quite mobile, they wouldn't stay around in the adult residential care homes all the time. As shown in Figure 4.1, almost half of the mentally alert residents were either unable to be interviewed or refused. There were only a few refused cases but the majority of them were simply unable to be interviewed because of their absence from the care homes.

More detailed information regarding the residents' families and their activities were collected at the final stage. Among the residents interviewed, thirteen percent of them could still take a bus and go shopping by themselves. Although the majority of the adult residential homes do not provide any recreational activities, 56% of the residents indicated that they had enough things to do all the time. 18% of them mentioned that they wanted to do more things but they could not.

Seventy-one percent of the elderly interviewed have family members living in Hawaii. Among them, 74% had
someone close among their family members, such as children, brothers, and sisters. Naturally for them, the family members frequently (every week) visit them at the adult residential care homes. In some cases, the residents visit their families' homes and stay overnight during weekends. Only 19% of the residents with family members in Hawaii had absolutely no contact with their families either by visit or telephone. Only 36% of the residents have direct contact with social workers. Overall, ninety-two percent of the residents have someone who visit and provide some forms of supports.

As previously mentioned, the functional disability scale utilized for this study has been previously utilized to examine the functional disability level of adult day center and intermediate care patients. In comparing the mean score between the previous study and this study, the scores for the activity of daily living of the residents of adult residential care homes were much better than for the adult day center population. In addition, the majority of the elderly residents interviewed in this study had close relationships with their family members and had frequent contact with them. It is beyond this study but it would be very interesting to investigate what factors affect the admission of the elderly to adult residential care homes.

\[15\] See Appendix II-D, p. II-39.
rather than taking care of the elderly at home by their family members.

**Similarities and Differences in the Two Types**

The demographic characteristics of the residents between Type I and Type II indicate two major differences: the method of payment and the average length of stay. Table 6.4 shows the result of these comparisons. There are more private residents (62%) in Type II homes than Type I homes (37%). The average length of stay at Type II homes is shorter (43 months) than the Type I (55 months). This may be attributed to the admission policy of the two large Type II care homes which do not accept government-assisted residents. When the savings of some of the residents depreciate and they are unable to pay the private fee, the residents have to move to cheaper facilities, which is usually the Type I care homes.

In examining the functional disability level of the residents in both homes, no significant differences are noted (see Table 6.5).
Table 6.4

The Comparison of the Elderly Residents (65+)
Between Type I and II Care Homes
(1989)

<table>
<thead>
<tr>
<th></th>
<th>Type I (N=202)</th>
<th>Type II (N=53)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum age</td>
<td>78 years</td>
<td>82 years</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>60%</td>
<td>59%</td>
</tr>
<tr>
<td>Males</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td>Japanese</td>
<td>44%</td>
<td>57%</td>
</tr>
<tr>
<td>Filipino</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td>Chinese</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Korean</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Hawaiian/Part</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Others</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private pay</td>
<td>37%</td>
<td>62%</td>
</tr>
<tr>
<td>Government Assisted</td>
<td>63%</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Average Length of Stay</strong></td>
<td>55 mo.</td>
<td>43 mo.</td>
</tr>
</tbody>
</table>
Table 6.5
The Result of the Functional Disability Scale (1989)

<table>
<thead>
<tr>
<th></th>
<th>Type I (N=202)</th>
<th>Type II (N=53)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity of Daily Living (ADL)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>1.48</td>
<td>1.42</td>
</tr>
<tr>
<td>Bathing</td>
<td>3.10</td>
<td>3.04</td>
</tr>
<tr>
<td>Dressing</td>
<td>2.31</td>
<td>2.13</td>
</tr>
<tr>
<td>Transferring</td>
<td>1.65</td>
<td>1.85</td>
</tr>
<tr>
<td>Mobility</td>
<td>2.19</td>
<td>2.30</td>
</tr>
<tr>
<td><strong>Instrumental Activity of Daily Living (IADL)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Adm.</td>
<td>1.99</td>
<td>2.42</td>
</tr>
<tr>
<td>Telephone</td>
<td>3.28</td>
<td>3.31</td>
</tr>
<tr>
<td><strong>Physical &amp; Mental Impairments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>1.71</td>
<td>1.43</td>
</tr>
<tr>
<td>Vision</td>
<td>1.79</td>
<td>1.64</td>
</tr>
<tr>
<td>Continence -urine</td>
<td>2.39</td>
<td>2.09</td>
</tr>
<tr>
<td>Continence -bowel</td>
<td>2.19</td>
<td>2.02</td>
</tr>
<tr>
<td>Mental Status</td>
<td>2.24</td>
<td>2.28</td>
</tr>
<tr>
<td><strong>Behaviors</strong></td>
<td></td>
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<tr>
<td>Depression</td>
<td>2.11</td>
<td>1.81</td>
</tr>
<tr>
<td>Wandering</td>
<td>1.53</td>
<td>1.49</td>
</tr>
<tr>
<td>Physically Abuse</td>
<td>1.42</td>
<td>1.23</td>
</tr>
<tr>
<td>Delusional</td>
<td>1.78</td>
<td>1.57</td>
</tr>
<tr>
<td>Group Participation</td>
<td>2.34</td>
<td>1.98</td>
</tr>
</tbody>
</table>

* ADL and IADL scores range from 1 to 6 with 1=most independent.
* Mental Status scores range from 1 to 5 with 1=oriented, intact memory.
* Continence scores range from 1 to 6 with 1=most independent.
* Hearing and Vision scores range from 1 to 4 with 1=normal.
* Behavior scales range from 1 to 4 with 1=no problem.
There are at least two Type II homes which do not accept government assisted elderly.
Life Experience of The Elderly

On the Way to the Care Homes

Admission process.

There are basically two ways to be admitted into the adult residential care homes: through the formal system such as being referred by a professional, such as community and the State social workers or discharge planners at the hospital, or being referred by the informal channels, such as through the resident's families or friends. Although there are no detailed data available as to what percentage of the people have been admitted through the informal system, it is generally believed that majority of the residents have been placed through the formal system.

The process of placing the client into adult residential care homes is not a simple one. First of all, the source of the request, whether the family or the client him/herself, makes a big difference. For example, the easiest placement is when the client made his/her decision to go into the adult residential care homes. Although each social worker has his/her own way of handling the cases, the social worker usually explains the availability of adult residential care homes, the pros and cons of the Type I and II care homes, the types of services that the care home provides, and so forth.
Then, the social worker examines the financial capability of the client and determines whether the client is eligible for welfare or not. If the client is eligible, the state social worker usually becomes responsible for placing the client. If the client is not eligible, then the community social worker will assist the client. Each social worker has a list of vacant adult residential care homes which is distributed by the Department of Health twice a month. The social worker makes several phone calls to the care homes based on the preference of the clients regarding the types and the location of the care homes. After calling several care homes to see whether they still have a vacancy or not, the social worker will select three or four homes depending on the availability. The social worker usually takes the client to visit the care homes, so the client has an opportunity to see the place, and at the same time, the care home operator examines the client. If both the client and the care home operator are mutually acceptable, then the placement takes place.

Meanwhile, the social worker tries to negotiate with the care home operator regarding the care home fees. Many of the private residents who are referred to the community social service agencies are in the "gap-group." They do not qualify for welfare assistance yet they do not have enough money to pay $900 - $1200 a month. If the care home operator is experienced, he or she may actively negotiate
for the fee, depending on the level of care the residents may require, but if the care home operator is still new and has many vacant beds, then the care home operator usually accepts the offer made by the social worker without much resistance.

For the client whose family wants to pursue the placement, the process becomes very difficult. Frequently, the client does not know that the family is seeking assistance from the social worker. The social worker needs to provide psychological counseling for both the family members and the client. After examining all the possible alternatives to the care home placement and if they are unsuccessful, then the care home placement takes place. This is a very traumatic experience for both the client and his/her family members. If the client does not fully accept the idea of the placement, he/she feels resentful and a sense of rejection from his/her family regardless of counseling. The adjustment to the way of living in the care homes takes much longer and is more difficult than the client who made his/her own decision to come. Some of the examples will be provided in the case report format.

The Emotional Status of the Elderly

Case report 1.

Mr. I, is an 80 year old Japanese divorced male. Mr. I was born in a plantation worker's home in Hawaii. He is the oldest of 3 children. He worked as a construction worker
until he retired. He married when he was 28 years old but got divorced after 6 years of marriage. Since then, he has been living alone in a tiny apartment in the downtown area until he came to the adult residential care home in 1988. He has a son approximately 45 years old but they never lived together after his divorce.

Mr. I was placed into a care home by his brother because he was an alcoholic and it became intolerable for the manager of the apartment in which he lived to handle him. Mr. I's brother was very concerned after receiving an eviction notice and persuaded Mr. I to go into a care home.

After assigning Mr. I's son the power of attorney, his son cashed most of Mr. I's savings and told him not to contact him anymore. His son accuses Mr. I of abandoning him by never taking care of him nor providing any emotional support while he was growing up. On the other hand, Mr. I feels his son's accusation is unfair because he provided enough financial support for him so his son could finish his school. Therefore, Mr. I's relationship with his son has been very unsatisfactory. Mr. I often thinks about committing suicide by throwing himself out in front of a car because of his aggravating situation caused by his current living arrangement and the deteriorating relationship with his son. Furthermore, he is not happy with the services the care home operator provides. Even while we were talking, he made a gesture of shaking and shivering of his body and said
his body reacts that way because of his outrage toward his current situation. He still wants to live by himself but he cannot see any other alternatives and feels hopeless and helpless.

Mr I has telephone contact with his brothers approximately once a month but they rarely visit him at the adult residential care home.

Case report 2.

Mrs. M is a 96 years old Japanese widow from Japan who came to Hawaii 75 years ago as a picture bride. She married twice but doesn't have her own children. She has been living in Hawaii for a long time but she hardly speaks nor understands English. She and her late husband lived in their house alone but after her step-son passed away because of an accident, they lived with their daughter-in-law and their grandchildren. Mrs. M was placed in a care home by her daughter-in-law approximately four months ago. Mrs. M has a slow progressing cancer and goes for radiation therapy every week; however, she is not bedridden. She walks around the house and can manage her activities of daily living (ADL & IADL) independently.

Mrs. M feels neglected and very resentful toward her daughter-in-law because Mrs. M took care of her daughter-in-law and her children when they were stranded and in a state of despair by losing her husband. Eventually, the daughter-in-law found a full-time job so Mrs. M almost raised her
grandchildren all by herself. Since her daughter-in-law works full time and there is no one to attend to the needs of Mrs. M at home, she was pressured by her daughter-in-law to go into a care home. Mrs. M said, "Watashi wa Kakugo wa Dekite ita demo totemo yome no shiuchi ga kuchi oshi," which means she somewhat expected that this might happen some day but she at the same time had hoped that her daughter-in-law would take care of her at home until she died. So when it happened, she felt that her daughter-in-law was not appreciative enough for all the work she had done for her and her children. While we were talking, her tears came through many times and I had to hand out a tissue paper for her. Although Mrs. M's relationship with this daughter-in-law is poor, she has a very close relationship with her other step-son. He often visits her and takes her to see the doctor.

Case report 3.

Mrs. K is an 87 year old Japanese widow who was born in Japan. She came to Hawaii when she was 18 years old and married a man who was 18 years her senior. Her husband passed away when she was 41 years old. She never remarried and raised her only son by herself. She used to live with her son and his family until she was hospitalized due to her severe osteoporosis condition. She was discharged to an adult residential care home from the hospital with a help of a discharge planner in 1988 without her clear knowledge of a
permanent placement. Mrs. K said she really did not know what was going on when she was discharged from the hospital. She later realized that her son and his wife arranged for her to stay permanently in the care home. She started crying and told me that her daughter-in-law does not want to take care of her. She mentioned that she worked very hard and sacrificed her own life in order to raise her son after her husband died but all of her efforts were nil at this point. Her son and his wife did not provide enough filial piety to her.

Although she did not mention about her son's current situation, I later found out that her son who is in his mid-sixties is also disabled due to a stroke. His wife still works because their children are still in college; therefore, it is too much for his wife to take care of both of them at home. Mrs. K's son feels sorry and apologetic but there is no other alternatives available to them.

The interesting phenomenon found after interviewing the elderly residents in the care homes was that more Japanese elderly expressed the feelings of resentfulness toward their families than the Caucasians. This is most likely attributed to the cultural differences between the two ethnic groups. The idea of filial piety, an obligation towards the parents, is a very unique concept among various oriental families but it has been rapidly disappearing among the young Japanese-American families in Hawaii. However,
most of the elderly who were interviewed were either first or second generation Japanese and the idea of filial piety is inseparable from their upbringing. Yet, their children who have been exposed to the American value of independence have a more clear cut approach to their family relationships. Thus, the process of acculturation has produced a big generation gap between the current elderly Japanese and the younger generations.

The Life in the Adult Residential Care Home

A majority of the residents were placed into the adult residential care homes as a last resort. However, some of them have adjusted themselves very well into the care home life style and are quite satisfied being there. However, others have not. Whether they are quite happy with the life in the adult residential care homes or not is pretty much influenced by various factors such as the individual's psychological makeup, the family relationships, the relationships with the care home operators, and the quality of the services provided by the care home.

How the elderly residents interact with the care home operators, how they spend their time, and how they feel towards the services they receive can be viewed from some of the case reports.

Case report 1.

Mr. I (previously mentioned) is staying in a small Type I care home where four other residents, both males and
females, are residing. It is a very small but clean care
home. The care home operator is a 32 year old Ilocano
female who has a registered nursing degree from Hawaii. She
has a son who is approximately two years old. When I
visited the care home, Mr. I was walking around outside of
the house but later came and peeked in the living room where
I was interviewing the care home operator. The operator
looked at him with an evil eye and said "I have a visitor
now. I will talk to you later." The operator kept giving
him the evil eye so Mr. I said "Ok, Ok, I will go before
you give me trouble" and left. The operator said, "He is
the one who is difficult."

After the interview with the operator, the operator
called Mr. I saying "I san, she wants to ask you some
questions." He came walking with crutches toward me so I
explained the purpose of my visit. He agreed to be
interviewed. The interview took place in the corridor of
the living room. The care home operator left us alone but
she was standing in the kitchen right next to the corridor.

As soon as the operator left, Mr. I made a remark that
it was the very first time that the operator used san, a
term of respect in Japanese language, to him. He thought
the operator used the word because of my presence. He often
whispered because he said the operator always listens to all
the conversations the residents have.
Mr. I is not satisfied with the operator nor happy living at this adult residential care home, but he mentioned that he does not have any other choice. As far as his opinion about the care home operator, he said that once he complained to the operator, although he did not say what the complaint was, she threw all of his belongings on the street and told him to move out. He told me that "it is not a human thing to do even though she was very angry." He made a gesture of making a fist and whispering to me and said "She does this to me and yells at me. Every time I complain, she gets back at me. Maybe, I will get a licking from her again." Mr. I bluntly said, "She doesn't like me because I complain too much. She prefers people who can't talk."

He feels the operator is not treating the other residents well either. He feels sorry for one resident who is mentally sick and immobile because the operator won't help her exercise or rotate her position, so this person sits at the same position with same posture all day long. According to him, the operator screams at this mentally ill resident when she makes a mess. He mentioned that his brother is a well known person in this community and is advocating for improving the wages of nurses and improving nursing care, but that the word care has to be re-examined. The State should inspect and constantly check the care home operators and nurses. Mr. I feels the operator is very lazy
because the operator's mother does almost everything while the operator often takes a nap.

He also mentioned that the operator is licensed for only four residents but she has one more resident who pays her privately. The operator keeps him in another section of her house. He feels the operator is only after money and does not provide good care.

As previously mentioned Mr. I has lots of accumulated frustrations not only toward the operator but also towards his son. There are no recreational activities offered by the facility and he does not belong to any senior groups or activity groups; therefore, it is very difficult for him not to think about his predicament all the time. He seldom has any visitors so most of his time is spent watching TV, reading books, walking around the care home, and thinking.

At the end of our conversation, he thanked me for listening and said "I feel relieved, thank you." The care home operator came out from the kitchen and said "So, his case is very complicated," as if she was listening to our entire conversation.

Case report 2.

Mrs. M (previously mentioned) resides in a very spacious Type I care home where the care home operator is also a young Ilocano female from the Philippines. She also has a registered nurse degree and opened her care home two
years ago. The facility is quite new and the layout of the house is very open and spacious.

The entire interview with Mrs. M was conducted in Japanese because Mrs. M hardly spoke English. When the operator called Mrs. M, she used the word "Ba san." In Japanese culture, addressing some one as Ba san without using 0 in front of Ba is very impolite and has a disparaging meaning. When I asked Mrs. M how she feels about being called Ba san, she said she takes it as a term of endearment because the care home operator is from a different culture, besides the operator is trying to be nice to her. She feels Arigatai, very thankful, for keeping her. The way the care home operator takes care of her is fine but she said she doesn't ask her for much assistance. Mrs. M said the operator is very courteous and kind. She doesn't have any complaints about the care home except about the food situation.

According to Mrs. M, the foods are always greasy and there are not enough fresh vegetables. She misses eating Japanese food and speaking Japanese language. After being at the adult residential care home for 4 months, Mrs. M finally asked the operator to take her to the Japanese grocery store despite her feeling that she should not be too selective. The operator agreed and she arranged to take Mrs. M to the store the day of my visit.
After talking to Mrs. M for approximately 30 minutes, the care home operator came to us and informed me that she had to take Mrs. M to the store before she started cooking lunch for her residents. So the interview ended but Mrs. M asked me to visit her again because she enjoyed talking to me in Japanese.

Case report 3.

Mrs. S is a 90 years old Caucasian widow who has lived in Hawaii since 1941 after moving from the Mainland. She married twice but does not have her own children. She worked as a substitute teacher at an elementary school and also taught piano. After her husband passed away, she continued to live in her own house until she was hospitalized due to her bad eyesight. With the recommendation of a hospital discharge planner, Mrs. S sold her house and decided to move into an adult residential care home.

Mrs. S is now residing in a small Type I care home where four other female residents reside. The operator is a 54 years old Ilocano woman from the Philippines with a nurses aide background. When I visited, the operator had forgotten about my appointment and was very defensive and hesitant but later she let me in rather reluctantly.

When I interviewed Mrs. S, she mentioned that the availability of the operator for her needs is adequate but there are a lot of things she is not satisfied with: 1. too
much greasy food and no variety of vegetables, 2. too inquisitive about her personal matter and her finances, and 3. too sexy. I asked her what she meant by sexy. According to Mrs. S, the operator and her husband sometimes bring a man and try to arrange for him to have sex with the residents. Mrs. S said she never had a sexual relationship after her husband died so she does not want anything to do with it. She said, "My roommate does but I am not that kind of a person." While talking, Mrs. S got very excited and started crying. A couple of residents walked into her room and asked who I was. I said I am a social worker then they left. As soon as they left, Mrs. S said, "That's why I don't have any privacy. That's none of their business." So the conversation about sex ended.

Mrs. S also mentioned that the operator somehow found out about the price of the house Mrs. S sold and told her that if she gives all of her money, they will take good care of her. She feels the operator and her husband are greedy because they raise her room charge quite often. She pays $1100 a month. She mentioned to one of a social worker at the hospital about her problem when she visited the hospital, but the social worker discouraged her to look for another care home because it would be very difficult to start all over again adjusting herself to a new environment. She feels helpless because she doesn't know any other care homes. Besides, there would be no guarantee that the other
care home operator would take good care of her. She said, "I am very dissatisfied but I will stick with it."

Although the operator discouraged her and other residents to go outside, saying that it was not safe, Mrs. S wanted to join some activities outside the care home and asked me to arrange it for her. Her activities are limited to listening to the radio with her better ear, talking to some other residents, reading books and walking around the house. There is hardly any contact with the outside world other than to visit her doctor once in a while. She feels rather restricted. I followed up with the referred agency later but they seemed to have difficulty in contacting Mrs. S. The social worker said every time when she called, the operator informed her that Mrs. S was asleep.

Case report 4.

Mrs. T is an 88 years old Caucasian widow. She does not have her own children but her sister and her husband live in Hawaii and they are very close to each other. She has osteoporosis but still can manage ADL and IADL independently. She moved into an adult residential care home upon discharge from the hospital and it was her own decision.

Mrs. T now lives in a spacious Type I care home and shares the facility with three other female residents. The operator is a Filipino with a Hispanic background from the Philippines who used to work as a executive secretary before
she became a care home operator. She does not have any nursing or nurses aide background other than the required training course by the Department of Health. The operator only takes private paying residents but she commented that her motto is to treat the residents as part of her family and let them feel as comfortable as possible.

When I asked Mrs. T what she thinks about the operator and how she feels about living in this care home, she mentioned that the operator is very nice and kind. She said, "It is an exceptionally good care home." Although the care home is far away from where she used to live and her friends cannot visit her often, she does not want to move anywhere else. Mrs. T visits her doctor with the handi-van but the operator always offers her a ride and assures her that if she needs a ride back, she can call the care home anytime. The operator provides excellent meals and sometimes takes them out to lunch to different restaurants for a change. Also, her friend can visit her anytime without notifying the operator. She loves to read books in her comfortable rocking chair in her room which she shares with another Caucasian female resident. She is a little bit annoyed about her roommate because she smokes constantly, but other than that she has no complaints at all.

Mrs. T's remark was that this care home is the next best place other than her own home. She pays $1200 a month but feels its a bargain to stay here compared to a nursing home.
Conceivable Problems

Living in the adult residential care homes can be comfortable and rewarding; however, the process of finding compassionate and considerate care home operators is not an easy task. As previously mentioned, if the admission policy of the care home is to accept only the private paying residents, no matter how much the residents feel comfortable and happy there, he/she has to move out if and when the savings run out.

There were several cases which fit the above conditions while I was working as a social worker. For example, $50,000 savings can only last less than 3 years of stay in some of the Type I and II adult residential care homes. Even with using both the savings and the social security money which comes in every month, there is no guarantee that the residents can stay at the adult residential care home until they die. Relocation from one place to another in late life is very difficult because of the need to readjust, physically and mentally, to new environments.

Another phenomenon which occurs quite frequently is the misunderstanding between the care home operators and the residents due to the lack of ability to communicate fully in a common language. Misunderstanding leads to a building up of frustrations for both the care home operators and the residents, and eventually leads to the conception of victimization. The cause of the misunderstanding is not
necessarily due solely to the language differences per se but also the cultural differences of the care home operators and the residents. Sometimes, the communication breakdown will also occur among the care home operators, the residents and their family members. For example, if some arrangement, particularly the financial arrangement, is made between the care home operator and the resident's family without clearly explaining what is happening to the residents, the residents may make accusations of some kind. If the residents have some kind of dementia or Alzheimer's disease, the problem is frequently worse.

In regards to other financial matters, quite a number of the elderly residents who reside in the care homes are very vulnerable and they do not know how to manage their finances. It is mostly the result of their upbringing in the olden days when the role of the husband was the breadwinner and the manager of the business and household expenses and the role of the wife was to take care of their children and manage the household tasks other than the financial matters. Some of the elderly do not know how to write checks and they are easily confused with the bank statements, etc. When their husband dies, they are pretty much at sea, particularly the elderly without children, so they tend to trust people who seem nice to them. For example, the residents without their family members often arrange the joint bank account with the care home.
operator because the Social Security and the SSI (Supplemental Security Income) checks are sent to the residents directly or direct deposit to the resident's bank account. If the residents are bedridden and unable to go to the bank or if the residents have dementia, somebody has to pay the care home operators for their services. If the residents have a court-appointed legal guardian, there is no problem; but if not, there will be a possible problem of financial abuse due to the conflict of interest. In the case of Alzheimer's disease patients, the problems are often more complicated and difficult to deal with. Even if the residents are coherent and independent, the problems such as mentioned above may frequently occur.

One of the Japanese care home operators whom I know quite well explained to me about the difficulty she is having in taking care of one of her residents, Mrs. O, who has dementia. Mrs. O was placed into her care home with the assistance of a state social worker because of the possible physical abuse by her family members. I happened to assist Mrs. O and her family initially before the case was sent to the Department of Human Services because of their eligibility for State's assistance. Mrs. O has a severe condition of dementia and she is also incontinent. She hates diapers and took them off as soon as her daughter-in-law tried to put them on. So, her daughter-in-law, who lived with her and her husband who was also
frail, had to follow her around to clean up her messes. Being Japanese, the daughter-in-law felt the importance of filial piety and she took care of her parents-in-law for approximately one year without any help from anybody. She felt embarrassed, at the same time, felt shame to expose her family problems to other people. She didn't and couldn't go out other than going out for a grocery shopping for a short while for almost a year. The claim for the possible abuse by the daughter-in-law was due to an accumulated psychological and physical pressure of attending to the needs of her mother-in-law. When I met Mrs. O's daughter-in-law, she was on the verge of killing her mother-in-law. If there was one more incident which irritated her, she might have done what she needed to do to release herself from the accumulated pressures and frustrations.

Even after Mrs. O was placed into the care home, she accused the care home operator of physically abusing her and not feeding her. When the care home operator is not watching, she goes outside without any clothes and screams and tells whoever comes around that the people at the care home are abusing her. The care home operator had to explain to her neighbors about her resident, at the same time, the care home operator had to lock Mrs. O's door to prevent her from going out while she is busy attending to other housework. The care home operator also had to lock the bathroom door because Mrs. O keeps flushing the toilet. The
care home operator is also about to give up taking care of Mrs. O.

Where else can Mrs. O go? Who else is willing to provide continuous care for her? Throughout my experience, there were several cases where demented residents were locked in their own small rooms. One of the major reasons for doing that, is to protect these residents from wandering out and being lost or getting into an accident. A second reason is to protect the care home operators from possible accusations in case of accident. The human rights of the demented residents are severely violated and they are treated as if they were prisoners; however, can we criticize and blame the care home operators from doing so? The operators have to attend to the needs of other residents and cannot watch only one resident all the time; besides, they have other daily tasks to do. It is a very difficult situation in which no clear solution is available.

Another frequently occurring problem is the favoritism of a certain resident by the care home operator. Sometimes it is very obvious and sometimes it is very subtle. But the residents themselves feel the discrimination and uneven treatment. For example, Mrs. P was complaining that the care home operator acts very nice to one resident and also gives her much larger portions of food. Sometimes the favored resident is given late night snacks but not the others. For many of the residents, food is their major
concern because they do not have anything else to look forward to in their daily lives other than food. How can you control the problems of favoritism?

The possible problems that the elderly residents encounter in the adult residential care homes can be insurmountable. However, it is avoidable to a certain extent by identifying a genuine, caring care home operator who puts more emphasis on the client's well being. Moreover, it is very important to provide information and to educate the care home operator about the importance of psychological effects in dealing with others. Communication techniques and human psychology should be included in the training curriculum.
CHAPTER 7
THE ANALYSIS OF QUALITY OF CARE

Subsequent to the description of the characteristics of
the care home operators and the life of the elderly in the
adult residential care homes, this chapter explores the
issues concerning quality of care at the adult residential
care homes in Hawaii by examining the relationships among
various variables which might affect the response of the
elderly residents regarding the care that they receive.

The analysis is based on the theoretical model
postulated in Chapter 3. By examining the relationship
among structure, process and outcome components, this
chapter tries to answer the research questions raised
earlier:

1) Is there a power-dependency relationship that
exists between the care home operator and the
resident? What effects do the resident's
resources have on the interaction between the care
home operator and resident? Do the residents with
more resources, such as money, availability of
formal and informal support, and better activity
of daily living functions, receive better quality
of care than the elderly with fewer resources? Do
the residents with resources have better
bargaining power, such as more choices, than those without resources? Do the newly established care homes provide better care than the older ones in order to build their care home business?

2) How do the multiple roles of care home operators in small family-like care homes affect the quality of care provided for the residents? Compared to Type II care home operators, do they have less time to attend to the needs of the residents?

3) How does the ethnicity of care home operators and the residents affect each other?

All these questions will be examined in this chapter. In addition, the question of whether community-based adult residential care homes provide the much needed family-like atmosphere for residents and provide better care than institutional care will be analyzed.

Initially, the definition of quality at the adult residential care homes and the conceptual framework for the analysis will be reiterated prior to the presentation of the results of the study.
Reflection

Definition.

As previously mentioned, the term "quality" is very elusive and has different meanings to different people depending on "who" defines for "whom."

The definition of the quality of care in the context of adult residential care homes, which provide long-term custodial care, should be different from the acute medical context. The purpose of the majority of the adult residential care homes is to provide an alternative living arrangement for people under the supervision of the trained care home operator, who no longer are able to care for themselves or whose family cannot provide necessary assistance. Although the technical aspect of care should not be neglected, more emphasis should be placed on art-of-care which is the milieu, manner, and behavior of the provider in communicating and delivering care to the residents. Thus, the perception of the residents towards how the care home operator is communicating and treating them becomes a very important component in assessing the quality of care.

The definition of quality for this study is:

Quality of care in the context of adult residential care homes is care that meets the needs of individuals by being available and accessible when necessary;
by treating individuals with respect and dignity; by providing a less restrictive, and safe environment where people can live contentedly and comfortably.

**The model of analysis.**

The first analysis is based on the above stated theoretical model in examining the process, structure and outcome in relation to the interaction with the residents (Figure 3.1). In examining the first model, only the Type I adult residential care homes will be examined for some of the questions, since some of the responses of the residents at Type II adult residential care homes did not specifically relate to the care home operator per se.

Structural components are the stable characteristics of the care home operators. For example, the examination of the establishment of the care home operator is measured by the length of operation. The technical qualification is measured by the background experience of the care home operator. Process components are the set of activities and the interactions between the care home operators and their residents. The process is measured by the availability of care home operator, the availability of recreational activities, the availability of choices such as doctor selection, watching TV anytime, eating together with the operator and his/her family, and decorating their own room. Based on the interviews, none of the residents ate with the care home operators and their families; thus, it was deleted.
from the analysis. However, the manner of the operators toward their residents, whether they treat the residents with respect and dignity or not, is included. Using the characteristics of the resident as a control factor, the analysis will be able to examine how the structure and process variables affect client's satisfaction.

Outcome indicators are the degree of the satisfaction of the residents toward care and the comfortableness of living. In addition, the effects of the characteristics of the residents such as ethnicity, the availability of resources and the functional disability level (ADL) were also considered.
Figure 7.1
Model 1: The Relationship Among Structure, Process and Outcome

**Structure**
- Stability of Operators
  - length of time as an operator
  - nursing background
- Characteristics of residents
  - availability of resources
  - disability level
  - ethnicity

**Process**
The way services are provided
- availability of activities
- availability of choice
- availability of operator
- manner of operator

**Outcome**
Satisfaction towards
- care
- living conditions

The second major analysis is based on the issue of deinstitutionalization mentioned in the first chapter. One of the questions which was raised earlier is whether the type of facilities, small home-like and large institution-like, had any effects on the perception of the residents.

Although there were many reasons, the rationale for the development of community-based alternative care was to create a more home-like atmosphere for chronically ill patients in order to eliminate the negative aspects of
institutionalization. It was assumed that smaller facilities could resemble a home-like atmosphere; consequently, they could provide better care and it would be more beneficial to the patients. More precisely, it is expected that the small adult residential care homes (Type-1) provide a more home-like atmosphere and better care than the institution-like Type-II care homes. Figure 7.2 shows the second conceptual model.

Figure 7.2

Model 2: The Effect of the Types of Facility on the Satisfaction Level of the Residents

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of facility</td>
<td>Satisfaction towards</td>
</tr>
<tr>
<td></td>
<td>- Care</td>
</tr>
<tr>
<td></td>
<td>- Living conditions</td>
</tr>
</tbody>
</table>

The Analysis of the First Model

The Effect of Structural Components

Length of the operation.

Does the length of operation, whether the care home operator is new in the business or established, affect the satisfaction level of the residents toward care and living condition? This question stems from the understanding that
the care home business is quite a competitive industry. If
the operator is still new in the business, he/she may put in
extra efforts such as providing better care in order to
create a better reputation to attract potential customers.
Often, the care home operator has borrowed money from their
families, relatives and friends or has loaned money from the
bank to start the business. If they are newly established,
the payment on the loan might be very high compared to the
older, established adult residential care homes. Therefore,
it is very crucial for the care home operator to have a 100% occu-
pancy rate. It is assumed that the newly established
care home operators are less selective than the established
ones. They may have more publicly-assisted residents and
more functionally dependent residents. The cut off point
for classifying whether a care home is newly established or
not, was made at three years, because it usually takes at
least three years for any business to become profitable.
Tables 7.1 and 7.2 show the results of the statistical
analysis.

Table 7.1

The Difference on the Characteristics of Clients Between
Newly-established and Established Care Homes
(N=29)

<table>
<thead>
<tr>
<th></th>
<th>Private-pay</th>
<th>Publicly-assisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly-established Homes(4)</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Established Homes(19)</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Contrary to expectations, the results of the analysis indicate that the newly established adult residential care homes have more private pay and more functionally independent residents. This indicates that the newly established care homes are much more selective about their residents.

Table 7.2

The Difference on the ADL Levels of Clients Between Newly-established and Established Care Homes (N=29)

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Moderate</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly-established Homes</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Established Homes</td>
<td>54%</td>
<td>21%</td>
<td>25%</td>
</tr>
</tbody>
</table>

In this analysis, the lengths of stay of the residents at adult residential care homes are not included. This might affect the results of the study since many of the private residents were not actually affluent people but were marginal ones. A majority of the elderly residents had some savings which often became an obstacle for initially acquiring the eligibility for welfare services. They may have started out as private-pay residents but their financial resources eventually depreciate. Thus, the longer they stayed at the adult residential care home, the more impoverished they became.
The statistical results shown in Table 7.3 indicate no differences in the degree of satisfaction towards care and living conditions among the residents between the newly established and the established care home operators.

Table 7.3

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction with care</th>
<th>Satisfaction with living condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Mean</td>
</tr>
<tr>
<td>Newly Established (4)</td>
<td>3.80</td>
<td>4.00</td>
</tr>
<tr>
<td>Established (19)</td>
<td>3.83</td>
<td>4.17</td>
</tr>
<tr>
<td>T-test</td>
<td>0.06</td>
<td>0.36</td>
</tr>
<tr>
<td>Statistical significance</td>
<td>.05 level</td>
<td></td>
</tr>
</tbody>
</table>

Table 7.4 shows the effects of the length of operation on the way services are provided are examined. Only the availability of recreational activities is affected. The provision of recreational activities is more evident in the newly established adult residential care homes than the established ones. This finding indicates that the newly established adult residential care homes are putting some extra effort into their services, although it does not seem to affect the perception of the residents so much. Also no difference is noted on the participation of the activities by the residents.
When the availability of choices of the residents at the adult residential care home is examined by using the index, the combined score of three variables, such as watching TV, decorating one's own room and selecting physicians, many of the elderly have moderate degree of choices. Also, the residents feel that the availability of the care home operator is rather sufficient (5 = very sufficient). The residents in the established care homes have higher mean score than the newly-established care homes. When the manner of the care home operator toward the residents, such as treat the resident with respect and dignity, is examined, the majority of the residents feel that the operator treat the residents with slight politeness.

Table 7.4
The Difference of Availability of Activity, Choice, Operator, and the Manner Between Newly-established and Established Care Homes (N=29)

<table>
<thead>
<tr>
<th>Availability of Care Homes</th>
<th>Newly-established Care Homes</th>
<th>Established Care Homes</th>
<th>Test of Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational Activities</td>
<td>40%</td>
<td>8%</td>
<td>4.19 *</td>
</tr>
<tr>
<td>Choice of residents (index)</td>
<td></td>
<td></td>
<td>0.57 NS</td>
</tr>
<tr>
<td>less</td>
<td>20%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>moderate</td>
<td>80%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>more</td>
<td>0%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Availability of operator (means)</td>
<td>3.80</td>
<td>4.29</td>
<td>1.40 NS</td>
</tr>
<tr>
<td>Operator politeness (means)</td>
<td>3.60</td>
<td>3.88</td>
<td>0.47 NS</td>
</tr>
<tr>
<td>Chi square = 4.19</td>
<td>P&gt;0.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Nursing background of care home operators.

The qualifications of the staff are often considered as one of the important factors in examining the quality of care. Is it also an important factor from the point of view of the residents in adult residential care homes?

Sixty-two percent of the operators who were interviewed had some type of nursing or health background aside from the nurses aide training required by the Department of Health. However, Table 7.5 shows no statistically significant differences in the level of satisfaction toward care and living conditions between the residents who resided with the operator with or without the nursing background. As a matter of fact, the satisfaction levels of the residents toward care and the living condition were slightly higher for the operator without nursing background.

Table 7.5

The Effect of the Nursing Background of the Operator on the Satisfaction Level of Residents (N=29)

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction w/ care (Means)</th>
<th>Satisfaction w/ living condition (Means)</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Nursing Background</td>
<td>3.72</td>
<td>3.94</td>
</tr>
<tr>
<td>Without Nursing Background</td>
<td>4.00</td>
<td>4.45</td>
</tr>
<tr>
<td>T-test</td>
<td>0.61</td>
<td>1.49</td>
</tr>
<tr>
<td>Statistically not significant at 0.5 level</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Results of in-depth interviews with residents who were functionally dependent and required more assistance from the care home operator also suggest that the acquisition of nursing skills does not affect the satisfaction levels of the residents. Functionally dependent residents also tended to express their opinions based on the personality of the care home operators and how the operator treated them as persons. Such as in the case of Mrs. K and Mr. I, the technical knowledge of the care home operator did not seem important to them. The residents often stressed the importance of caring attitudes. Therefore, the acquisition of more technical nursing skills per se did not seem to make much difference in the perception of how well the residents were cared for by the care home operators in adult residential care homes.

Table 7.6 reports the effects of the nursing background of the operator on the manner of the operator toward the residents and the availability of choice, recreational activities, and the operator's responsiveness towards the need of the resident. No significant differences are found in these results.
**Table 7.6**

The Effects of Nursing Background of the Operator on the Availability of Operator, Activity, choice, and the Manner (N=29)

<table>
<thead>
<tr>
<th></th>
<th>With Nursing Background</th>
<th>Without Nursing Background</th>
<th>Test of Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability of</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreational Activities</td>
<td>25%</td>
<td>75%</td>
<td>2.70 NS</td>
</tr>
<tr>
<td>Choice of resident (Mean)</td>
<td>2.00</td>
<td>1.80</td>
<td>1.06 NS</td>
</tr>
<tr>
<td>Operator responsiveness</td>
<td>4.17</td>
<td>4.27</td>
<td>0.38 NS</td>
</tr>
<tr>
<td><strong>Manner</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operator politeness</td>
<td>3.74</td>
<td>4.00</td>
<td>0.61 NS</td>
</tr>
</tbody>
</table>

Statistically not significant at 0.5 level

When the combined effect of structural variables is analyzed by utilizing the Multiple Regression, no statistically significant differences are found. Table 7.7 shows the result of the analysis.
Table 7.7

The Effect of Structure on Outcome Variables
(N = 29)

<table>
<thead>
<tr>
<th></th>
<th>Standard Estimate</th>
<th>Standard Error</th>
<th>T for Ho: Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction Toward Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Operation</td>
<td>0.12</td>
<td>0.04</td>
<td>0.60</td>
</tr>
<tr>
<td>Nursing Background</td>
<td>0.09</td>
<td>0.13</td>
<td>0.46</td>
</tr>
<tr>
<td>F = 0.27, R-square = 0.02, Mean = 3.83, P &lt; 0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Toward Living Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Operation</td>
<td>0.08</td>
<td>0.03</td>
<td>0.44</td>
</tr>
<tr>
<td>Nursing Background</td>
<td>0.24</td>
<td>0.10</td>
<td>1.25</td>
</tr>
<tr>
<td>F = 0.84, R-square = 0.06, Mean = 4.14, P &lt; 0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Effect of Process Components

Recreational activities.

As previously noted, there was a significant difference in the availability of recreational activities between the established and non-established care homes. Although no overall difference was found in satisfaction between two types of care homes, the results shown in Table 7.7 indicate that the mean satisfaction scores of residents with activities are higher than for residents without activities.
Table 7.8
The Effect of the Availability of Activities on Satisfaction (N=29)

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction w/ Care (Mean)</th>
<th>Satisfaction w/ Living Condition (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Activities</td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Without Activities</td>
<td>3.64</td>
<td>4.00</td>
</tr>
<tr>
<td>T-test</td>
<td>2.33</td>
<td>2.16</td>
</tr>
</tbody>
</table>

Statistically not significant at 0.5 level

Quite often, the issue of the provision of recreational and rehabilitation activities in the nursing homes is raised among health professionals. It is assumed that the recreational and rehabilitational activities will add the touch of quality of life in the nursing home. How do the residents in the adult residential care home perceive it?

In examining the daily life of the residents, they may appear very bored and monotonous to outsiders. However, more than half (56%) of the residents indicated that there are enough things to do and it is not dull. Watching television or listening to the radio were the most common activities of the residents. Only 10% of them indicated that they were bored and wanted to join some activities outside the adult residential care homes. The rest of them indicated the physical inability to do so, even though they wanted to participate in some activities. Some of them
seemed to have self-imposed limitations, that is, to have lost their will to be more active. Rather, they seemed to simply accept their current situation. Possibly, the provision of recreational activities per se is not an important factor but the availability of choice to participate in the activities provided by the adult residential care home may be an important factor.

When interviewed, some of the publicly assisted residents mentioned that they wanted to join outside activities. However, in reality, the options for them are very limited. The publicly assisted elderly residents who reside in the adult residential care homes cannot attend outside activities which are provided by private organizations such as adult day care/health programs. The reasons are two-fold: 1) the government cannot afford to pay for both residential care services and adult day/health services, which often provide rehabilitative activities, 2) the priority of the adult day/health programs is for the frail elderly who live alone in the community.

The functionally independent elderly residents can still participate in senior citizen's clubs and senior centers but those clubs and centers cannot and do not have the capability to provide services for the functionally dependent elderly. Thus, the residents who are publicly assisted and functionally dependent have little opportunity to participate in outside activities.
The case of Mr. H will illustrate the problems that publicly-assisted residents face. After 2 months of an initial hospitalization, Mr. H had to give up his apartment and to move to a very nice Type II adult residential care home which only accepted private residents. However, after 7 months, he had to be relocated again to a less attractive care home because his savings depreciated and he could no longer pay the private fee. He was very depressed because of his compounded problems, such as his lowered financial status, lowered self-esteem, loss of his friends from the other care home, etc. Worse yet, a majority of the residents at the new care home had demented conditions so he hardly had anyone to talk to nor anything to do since no recreational activities were provided. Although he was functionally dependent, he was mentally very alert; thus, the predicament he was in made him feel trapped, hopeless, and helpless.

Notwithstanding his physical condition, one of the senior centers in town approved him to spend some time at the center because one of the volunteers at the center agreed to take care of him while he was at the center. He was extremely happy and appreciative of the arrangement but he only visited the center once a month. The reason for not coming to the center more often was financial. Mr. H said that while joining the programs at the center was free, the round-trip fee by the handi-van from the adult residential
care home to the center cost him $2.00 and so he couldn't afford to go more often. Nevertheless, he felt much better because he had the option to go outside of the adult residential care home. Although the state provides a $30.00 allowance per month for the publicly-assisted residents, the residents have to be very careful about how to utilize that money because adult residential care homes do not provide personal items such as diapers, tooth paste, etc.

However, the fact that Mr. H had at least some choices, his outlook greatly improved. This leads to the next analysis of the availability of choice.

**Availability of choice.**

Based on my experience, the selection of a doctor often becomes one of the issues in selecting the care home. In the case of the elderly residents who have to move to the adult residential homes in suburban areas from downtown Honolulu, not many care home operators are willing to take the residents to see their physicians in town. The operator usually requests the residents to change their doctor unless there is someone who can transport them to the physician's office. If the residents do not have anyone, then she/he has to give up their personal physician.

The matter of choice is one of the important issues manifesting power-dependency in the operator-resident relationship. If the choices are not available, then the
residents may be coerced into something which they do not want or are not happy with. In examining the matter of choices, the results from the survey indicate that a majority of the residents have choices regarding the selection of doctors, watching television, and decorating their rooms. Some of the residents had their own television in their rooms; so they could watch whenever they wanted to without getting the permission from the operator. When I visited the adult residential care homes, many of the residents were watching TV. Or to put it differently, they were sitting on chairs facing toward the TV but some of them were not really watching the program but dozing in front of the TV. Table 7.9 shows the result of survey towards choice.

Table 7.9
The Result of Survey Towards Choice
(N=38)

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Don't care (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watch TV</td>
<td>79%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Decorate own room</td>
<td>79%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Select doctor</td>
<td>76%</td>
<td>24%</td>
<td></td>
</tr>
</tbody>
</table>

In considering the selection of physicians, some of the residents surveyed belonged to HMOs, such as Kaiser, and did not have their own physician. Therefore, changing physicians didn't seem to matter to them. In addition, the residents who preferred maintaining their own physicians did
not select the care home which did not allow them to do in the first place.

The effect of choice on the satisfaction of the residents toward care and living condition is separately analyzed in Table 7.10. However, no statistical difference is found.

Table 7.10

The Effect of Choice on the Satisfaction with Care and Living Condition (N=36)

<table>
<thead>
<tr>
<th></th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction w/ care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>1.91</td>
<td>1</td>
<td>1.91</td>
<td>1.46</td>
</tr>
<tr>
<td>Error</td>
<td>44.40</td>
<td>34</td>
<td>1.31</td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>46.31</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction w/ living condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>2.66</td>
<td>1</td>
<td>2.66</td>
<td>3.13</td>
</tr>
<tr>
<td>Error</td>
<td>28.89</td>
<td>34</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>31.56</td>
<td>35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statistically not significant at 0.05 level

Although the issue regarding food is not included in the major analysis, the majority of the residents (74%) are satisfied with the food the care home operator provided. Among people who were not satisfied, the most often heard complaints about the food were taste, no choice, and the lack of variety of fresh vegetables.
**Availability of care home operator.**

Another process indicator of quality is the availability of staff towards the needs of the residents. Eighty three percent of the residents who were surveyed at Type I Care Homes indicated that the availability of care home operator was adequate or very adequate.

According to the results of the ANOVA reported in Table 7.11, the availability of the care home operator had significant effects on both the satisfaction of the residents toward care and toward their living conditions at Type I adult residential care homes. Therefore, the availability of care home operator toward the needs of the residents makes substantial difference in the satisfaction level of the residents at adult residential care homes.
Table 7.11

The Effect of the Availability of Care Home Operator on Satisfaction toward Care
(N=29)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction w/ care</td>
<td>Model</td>
<td>19.66</td>
<td>1</td>
<td>19.66</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>18.48</td>
<td>27</td>
<td>.68</td>
</tr>
<tr>
<td></td>
<td>Corrected total</td>
<td>38.14</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Satisfaction s/ living condition</td>
<td>Model</td>
<td>8.46</td>
<td>1</td>
<td>8.46</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>14.99</td>
<td>27</td>
<td>.56</td>
</tr>
<tr>
<td></td>
<td>Corrected total</td>
<td>23.45</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

* Significant at .01 level

The availability of care home operators may be influenced by the several roles which the care home operator play during their working hours, particularly for the Type I care home operators. Thus it leads to the next question of whether the multiple roles of Type I care home operators have any effect on the satisfaction level of the residents.

The effect of multiple roles of the operator.

Through my experience, I saw many Type I care home operators with small children or the operators were baby sitting their grandchildren. It made me think that caring for five residents who had various mental and physical conditions was hard enough for one person to manage but taking care of small children simultaneously was beyond my
understanding. Thus, the question of the effect of the multiple role of the operator has been raised.

Within Type I care homes, the operators are divided into those with or without children and the effect of the multiple-role is examined. Operators with children have parental roles which require their time and energy, whereas operator without children do not have those demands.

The statistical test (t-test) does not indicate that the residents of the operators with children are less satisfied with the availability of the care home operators than those in homes run by operators without children. Unfortunately the age of the children was not taken into consideration when the questionnaire was made. Possibly, the age of the children may have been a determining factor. If the children were old enough, they could also assist their mother in taking care of the residents. Also, the majority of the residents who were interviewed were more or less functionally independent. Therefore, the availability of the care home operator was not an important factor for them.

In examining the case reports, two of the operators had small children. The family composition for one of the operators was three and the other was eight, including the operator's parents and sisters. The comments of the residents in the two adult residential care homes were that they didn't need much assistance so it didn't matter. One
of them had high functional dependency, but even her response was that she didn't ask much assistance from the care home operator except for bathing. She could still walk, although very slowly, to the toilet by herself.

However, the comments of Mr. I concerning the other residents in his care home, provide some insight into the adequacy of operator's attentions to the residents. One of the residents who was mentally and physically disabled had been scolded by the operator because she made a mess on the floor. This example indicated that the operator did not periodically check the condition of the residents unless something happens. Also, the operator did not seem to spend time with residents in assisting with rehabilitation exercises or rotating the position of bedridden residents. Through my own experience working with the care home operators, minimum contact with residents seems to be a common phenomenon. The operators usually close the door which divides their living quarters from the care home facilities and only respond if the residents ring their bells or ask for assistance.

Similar interactions were noted when I visited one of the Type II care homes, several residents who were confined to their beds were calling for the attention of the staff. There were a couple of nurse aides working in the area where I was interviewing some of the residents; however, neither of the nurse aides paid any attention to the residents. One
of the female residents who was confined to a chair, was crying and asking the staff to take her to the bathroom. It took nearly 10 minutes for one of the nurse aides to respond to her request.

Originally, the statistical comparison of Type I and Type II care home operators in regards to their role differences and their effect on the satisfaction level of the residents was planned. However, this analysis could not be carried out since the answers to the survey questions by the residents at Type II adult residential care homes were not targeted to the care home operators. However, based on observations, the care home operators at Type II adult residential care homes, unlike hospital administrators, were also engaging in multiple roles. Particularly, Filipino Type II care home operators seemed to assume more roles than just the administrative role, because that was their business and they were not hired by someone to become the administrator. One of the Filipino Type II care home operators mentioned to me that grocery shopping for her residents was also her responsibility in order to control and to manage the cost of the care home operation. The other ethnic Type II care home operators were hired by the owner of the care home operator.

The manner of the care home operator.

Based on the literature review, the manner of the provider is very important in providing quality of care.
The manner in this study is measured as using the indicator of whether the residents feel they are treated with respect and dignity or not. The result of the statistical analysis indicates that the residents who feel they are treated with respect and dignity tend to be more satisfied with the care they receive at the adult residential care homes. Table 7.12 shows the result of the Multivariate Test of Significance.

Table 7.12
The Effect of the Politeness of the Operator on the Satisfaction Level (N=29)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction w/ care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>28.79</td>
<td>1</td>
<td>28.79</td>
<td>83.20 *</td>
</tr>
<tr>
<td>Error</td>
<td>9.34</td>
<td>27</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>38.14</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction w/ living condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>9.16</td>
<td>1</td>
<td>9.16</td>
<td>17.31 *</td>
</tr>
<tr>
<td>Error</td>
<td>14.29</td>
<td>27</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>23.45</td>
<td>28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Statistically significance at .001 level

Although the majority of the residents indicated that they had been treated with respect and dignity, to my knowledge, there were several cases in which the operators were not treating their residents in that manner,
particularly the demented residents. Some care home operators made very degrading and humiliating comments, not to the mentally alert residents, but to the demented residents in front of other residents. For example, I noticed three female residents were sitting on hard uncomfortable chairs at the corner of the living room at one of the adult residential care homes. The operator started explaining about who they were, why they came to her place, and so on. Suddenly, she said "you never married, right? You were a teacher but you don't remember, right? What is your name?" in a loud voice to one of the residents with dementia. When she couldn't respond, she told me "see, she doesn't understand anything." Then, the operator put her hand on the resident's head and shook her head with her fingers as if she was a little child. There was no way of knowing how the resident felt, if she had any consciousness left, but treating her like a child certainly made me feel very uncomfortable. I could see that the other slightly demented residents responded with a disgusting facial expression. This illustrates Murphy's (1987) comments on the childish treatment typically shown towards the highly dependent patients.

As previously stated, the most important factor affecting the satisfaction of the residents in the adult residential care homes is not the qualification of the care
home operators but how the operators treat the residents in every day life situations.

When all the combined effect of process variables is analyzed by utilizing the Multiple Regression, only the degree of satisfaction toward care is statistically significant and it is affected by the process variables, particularly the way the operator treats the residents. The Table 7.13 shows the results of this analysis.

Although the validity of the statistical analysis is questionable because of the small sample size and the violation of the assumption of the Multivariate analysis, it does support the qualitative findings.

The effects of resources on the relationship.

As stated earlier, the availability of resources of the residents was determined by examining the availability of formal support (social worker), family support (frequency of visit), and the financial ability (method of payment) for adult residential care homes.
Table 7.13
The Effect of Process on Outcome Variables (N=29)

<table>
<thead>
<tr>
<th>Standards Estimates Error</th>
<th>Satisfaction Toward Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of:</td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td>-0.19 0.23 -2.05 0.05</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>0.06 0.06 0.59 0.56</td>
</tr>
<tr>
<td>Operator responsiveness</td>
<td>-0.04 0.28 -0.23 0.82</td>
</tr>
<tr>
<td>Manner:</td>
<td></td>
</tr>
<tr>
<td>Operator politeness</td>
<td>0.93 0.28 5.55 0.00</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>F = 28.25, R-square = 0.84, Mean = 3.85, P &lt; 0.01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Estimates Error</th>
<th>Satisfaction Toward Living Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of:</td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td>-0.29 0.32 -1.78 0.09</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>0.02 0.14 0.12 0.90</td>
</tr>
<tr>
<td>Operator responsiveness</td>
<td>0.40 0.39 1.29 0.20</td>
</tr>
<tr>
<td>Manner:</td>
<td></td>
</tr>
<tr>
<td>Operator politeness</td>
<td>0.31 0.23 1.05 0.30</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>F = 5.19, R-square = 0.48, Mean = 4.14, P &lt; 0.01</td>
<td></td>
</tr>
</tbody>
</table>

194
Among the 38 elderly residents surveyed, a majority of the residents (71%) had some member of their families living in Hawaii, but they didn't necessarily all receive support from them. In examining the case reports, three of these resident had no children of their own and two of them had their own children but their relationship did not seem to be supportive. The most important indicator of family support seems to be the frequency of the family's visit to the adult residential care homes. In some cases, the members of the family alternately visit the resident so that the resident sees some relative every week. In other cases, family members visit only for special occasions, such as birthdays or Christmas.

Only 36% of them had access to formal support system such as social workers. However, the frequency of the contact with a social worker was approximately two or three times a year. The involvement of a social worker is often limited until the adjustment of the resident and the arrangement of financial assistance are made, which takes approximately two to three months. The workload of social workers in the community agencies and the government agencies is so high (sometimes 50 to 60 cases a month), it is quite difficult to monitor or provide case management for the entire duration of the resident's stay at the adult residential care homes.
A little more than half (53%) were private pay residents. Quite contrary to the study of Newman (1985), no difference in satisfaction level of the residents was noted between private pay and publicly assisted residents. Newman specifically examined the difference between the residents of private pay and public pay homes. In Hawaii, some of the private pay residents in Type I adult residential care home did not have their own room. They often shared the room with one other resident. Monetary resources themselves do not guarantee better accommodation. When the effect of the resources of the residents toward the availability of the care home operator and the way the operator treated the residents were examined, the availability of resources of the residents did not affect the availability of the care home operator nor the manner of the care home operator (F=0.38 and F=2.18 respectively. Mean score is 4.20 and 3.83 respectively). Also, there was no effect of the availability of resources of the residents on their level of satisfaction with care and the living conditions (F=1.28 and F=4.98). Thus, even those residents who had more resources, do not seem to have negotiating power in the Type I adult residential care home.

Theoretically, the more resources one has, the more leverage one has over the negotiation. However, this may not be the case in the adult residential care homes. In examining the psychological makeup of the residents, the
majority of them expressed the feeling that there were no alternatives available for them. No matter how much informal and formal supports are available to them, the fact is that the adult residential care home is the last resort for them and their families. As Wilson (1983) stated people seek to restore psychological equity by altering their perception of respective inputs and outcomes when there were no alternatives available. Therefore, the residents at adult residential care homes may well have altered their psychological perception and expectations.

The effect of ethnicity.

One of the questions raised earlier was the issue of ethnicity. In examining the inter-ethnic relationship, only the residents in the Filipino care homes were selected in the analysis since the number of other ethnic care homes was very small. Among 29 cases, there were only two Filipino residents. Two of them were very satisfied with the care they had been receiving and they felt very comfortable staying at their adult residential care home.
Table 7.14
The Difference in Mean Satisfaction Level
Between Caucasians and Japanese
(N=30)

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction w/ care</th>
<th>Satisfaction w/ living condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian (15)</td>
<td>3.87</td>
<td>4.07</td>
</tr>
<tr>
<td>Japanese (15)</td>
<td>3.60</td>
<td>3.93</td>
</tr>
<tr>
<td>T-test</td>
<td>0.60</td>
<td>0.38</td>
</tr>
</tbody>
</table>

Statistically not significant at 0.5 level

In examining the Caucasian and Japanese residents, Caucasian are slightly more satisfied with the care and feeling comfortable than Japanese residents. Based on the statistical analysis of 29 cases, ethnicity itself does not affect the satisfaction level of the residents toward care and the living conditions (F-value= 0.69 and 1.22). The results of the qualitative analysis also indicate that ethnicity itself does not seem to be a determining factor for the level of satisfaction toward care and living conditions.

Nevertheless, there is a difference in expression between Caucasians and Japanese, particularly the first-generation Japanese, who are satisfied with the care: Japanese tend to express their feelings by saying they are very thankful or appreciative that someone is able to take care of them, whereas Caucasians tend to express their feelings by saying the operator is a nice person and they
don't give them a hard time so they are satisfied with the care and the living arrangements. The judgement of Caucasian seems to be based upon the character of the operator in relation to their compatibility, acceptability, and accountability. For Japanese, even if they are not compatible or acceptable according to their standards, being thankful and being Gaman, self-sacrificing, they could make themselves happy and satisfied. Also, Enryo, the concept of modesty or self-reservation, which is part of Jicho, self-discipline, is more prevalent among the Japanese residents. They don't want to make too many problems and demands for the operator when they are already burdening the care home operator by being in their house.

Ruth Benedict (1954), the prominent anthropologist who studied the pattern of Japanese culture, explained the concept of On and Jicho in great detail in her book\(^\text{16}\). The Japanese feel on, obligation, towards the care home operator, who has no blood relation but nevertheless provides care in their own residence; therefore, Japanese feel that they should not consider their own personal desires. As Benedict points out, the Japanese appraise their own lives by judging that a person is weak if he/she pays attention to his/her personal desires when they conflict with the code of obligations. That is why Japanese

express the feeling of Gaman and Enryo towards the care home operator. However, when Issei, first generation Japanese, and Nisei, second generation Japanese, are compared, the feelings of On, Gaman, and Enryo were not apparent among Nisei residents.

The Analysis of the Second Model

Family-Like Type I vs. Institution-Like Type II Care Homes

The results of the statistical analysis indicate no difference about the satisfaction towards care and living conditions of the residents between the two facilities. The residents in both Type I and II are rather satisfied towards the care and living conditions. Table 7.15 reports the result of the analysis.

Table 7.15

The Difference of Satisfaction Level Between Type I and II Adult Residential Care Homes

<table>
<thead>
<tr>
<th></th>
<th>Type I Care Home (N=29)</th>
<th>Type II Care Home (N=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>3.82</td>
<td>3.88</td>
</tr>
<tr>
<td>Living condition</td>
<td>4.13</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Statistically not significant at 0.5 level
In another study, Lamb (1981) noted that some patients did well in a small family-like care home where there was interaction with other residents and the operator of the facility, but others seemed to do poorly with too much interaction with nurturing persons and did better in a large facility. Perhaps the results of this study support Lamb's notion that the size of the facility shouldn't be too much of an issue because there is a difference of individual preference about the size of the facility.

Whether the residents are treated as one of the family members or not, is often measured by the indicator of whether the care home operator and the residents eat together or not. However, in this sample, none of the residents indicated that they ate meals with the operator and his/her families. Among 38 residents surveyed, only two residents, who lived in the same Type I adult residential care home, mentioned that the operator treated them as part of her family and felt very close to the care home operator, even though they didn't eat together. Often, the residents themselves did not perceive the operator's family as their surrogate family. The majority of the residents did not share in family activities together with the operator nor did the operators provide recreational activities for them.

Although adult residential care homes are different from Goffman's notion of the total institution, they are still one type of institution which is established to care
for people who are incapable of managing and maintaining their life. Based on the observation of both types of facilities, many of the adult residential care homes had similar characteristics to total institutions such as locked doors and gates, restriction of visiting hours, off limit areas (the operator's living quarters), etc. The residents in Type I care homes did not eat together with the care home operators and their families nor did they share the activities of daily life together. The residents were the mere occupants of the rooms and they were treated as "outsiders" and not as "insiders."

The residents in family-like Type I care homes did not necessarily have more involvement and integration into the community than the Type II homes. It may be possible to treat one or two residents as part of the care home operator's family. It would be very difficult to treat four to five residents as family members and to include them in family activities. In considering the size of the facilities, the change in the physical structure of institutions, large to small, will not guarantee more integration and family-like atmosphere.

**Provider's View on Quality of Care**

Although the major emphasis of the analysis has been placed on the analysis of quality of care from the point of
view of the residents at the adult residential care homes, some of the concerns of the adult residential care home operators regarding the quality of issues are included in this section.

Concerns Relating to the Issue of Quality

There are several common concerns among the operators of the 79 adult residential care homes visited regarding the quality of care issues. The major concern seems to be the exorbitant amount of paperwork imposed by the Department of Health. Many operators mentioned that they have been overwhelmed by the detailed reporting system, especially the nutrition section, of the State Health Department. They have to spend so much of their time figuring out the requirements, they feel they are spending less time with their residents.

The Department of Health and Department of Human Services emphasizes the importance of quality of care, but when the inspectors visited each adult residential care home once a year to inspect for relicensing, their major concern seems to be whether the operators have been following the rules and regulations of the department and with the physical features of the facilities. No attention is given to how the residents are doing at the care home. The inspectors hardly talk to the residents so they don't really know whether the residents are happy or their health status is improving or not.
While many of the operators stressed the demanding paperwork, some of the operators offered a different opinion. They said that while there was a great deal of paperwork, that was part of their job requirement as the administrator and the operator of their own business. As long as they did not accumulate the work, it was not bad at all.

In viewing the inspection materials from the Department of Health, a majority of categories to be inspected were allocated to staff requirements, admission and operational policies, medications and record keeping. Less than half a page was allocated to the section of the Plan of Care. Under the Plan of Care, five categories needed to be inspected: 1) care including skin, nails, hair, teeth, and other therapeutic regimen, 2) residents were taught and encouraged to perform ADL, 3) toilet-training was carried out based on doctor's orders, 4) incontinent residents were bathed and cleaned promptly, and 5) residents were dressed appropriately at all times (DOH, Adult Residential Care Homes, Chapter 11-100, Hawaii Administrative Rules, 1986). There was no section regarding how the care should be delivered i.e. manner. As one of the residents stated, we may need to re-examine the meaning of "care."

A second problem is that the Department of Health and the Department of Human Services place high demand on the care home operators but do not provide enough support for
them. The attitudes of the inspectors and the social workers are often appalling, and the operators feel terrified when the time for the inspection period came. One of the operators commented that the inspectors treated them as if they were criminals who exploited other's money. The underlying issue seems to have been the financing of adult residential care homes in conjunction with the tremendous demands imposed by the government: the government insists on quality but not enough tangible and intangible support such as monetary and emotional support are provided to the adult residential care home operators. Many of the operators stated that they work 24 hours-on-duty but their pay is less than that of a nurse aides in long-term care institutions. They want to buy good quality and to offer a variety of food for the residents, but there is not enough money to do so.

Another financial issue concerns liability insurance. If something happens to the residents, the operators are held liable even though it isn't their fault. The cost of the liability insurance is quite high and they feel they can hardly afford to buy it with the amount of money they make. If something happens to the residents, their families and the public often accuse them of neglecting or abusing the residents. The operators feel that they can't be with the residents 24 hours a day so it's a catch 22 situation. The operators stated that they were trying hard to serve the
needs of the community by taking care of the disadvantaged people whose families did not want to take care of them. Hardly anyone seemed to appreciate their work. Instead the family and the public are often critical of them by saying they are not providing quality care. One of the care home operators commented that placing the elderly parents into adult residential care homes was a form of abandonment by the family members. But the family felt they have every right to know exactly what was going on at the adult residential care homes. If they see some bruise on their parents body, they sometimes sue the care home operators. She noted that the elderly often fall even in their own homes and, she resented being blamed by the family members.

The residents are not the only the victims of physical abuse. There are not so many problems with the elderly residents, but there are occasional cases, particularly young male residents with mental problems, who physically abuse the care home operators.

Another concern seemed to be inadequate respite for the care home operator. Many operators mentioned that they haven't had any vacations since they started their business because there was no respite services for the care home operators. If the operator wanted to take a week or two vacation, she has to find a vacant care home by herself and make an arrangement with the owner. She has to relocate her residents to different care homes if the care home can't
accommodate all of her residents. If the care home operator has adequate support from her family members or has a qualified substitute, then it is not so bad. But for the operator without the help of qualified substitutes, it seems very difficult to have respite time. Many of the operators mentioned that they feel stressed out sometimes and frustrated with the current approach of the Department of Health with no emotional and financial support.

Among the Type II operators (large institution-like adult residential care homes), other concerns seemed to be more apparent. The recruitment of nurse aides seemed to be very difficult because of the recent stringent regulations regarding the recertification of nurse aides and their qualifications imposed by the Department of Health. This will affect the staff-resident ratio. One of the operators mentioned that she can only afford to pay them $5.00 an hour considering the costs incurred in the operation of the care home. Even a fast food restaurant pays $5.00 per hour now-a-days for people who don't have any qualifications. People tend to find easier jobs with better pay, so there are not enough nurse aides to actually carry out the personal care tasks which directly affect the quality of care at adult residential care homes.

The issue of quality of care is very complex and there are no easy answers nor easy solutions. No easy solutions can be derived by examining the isolated occurrences. To
examine the issue of quality of care, one needs to approach it from all different aspects, macro, micro, and their interconnectedness.
CHAPTER 8
CONCLUSION

This chapter summarize the issue of quality of care and the limitations encountered in the study. The recommendations for the provision of adult residential care home services in the future are also presented in this chapter.

Summary

Knowing that cost containment and cost-effectiveness are the major issues in providing health care services in recent years, the adult residential care home plays a very important role in reducing the high costs of long-term care services. However, obsessed by the notion of cost-effectiveness, we tend to set aside the issue of quality of care. The quality of care at the adult residential care homes should be of particularly importance not only for the service providers but also for the consumers. Similar to nursing homes, the adult residential care homes are perceived as the last resort and the last home for the majority of the elderly residents. The memory that most of the elderly residents can take with them will be often influenced by the experience they had at the adult residential care homes. At the last end of the continuum of
human existence in this world, the best gift for the passing people is the meaning of human interaction and the feeling of satisfaction that comes out from that interaction. Thus, the quality of care at the residential care homes should be considered as one of the most important factors in providing long-term care services.

Although the results of this study are not nearly comprehensive nor representative of the residents in other geographical areas, the analysis provides an understanding of some of the life of the elderly residents in the adult residential care homes in Hawaii and their interaction with their care home operators.

Based on the analysis of quantitative methods, a majority of the elderly residents who are mentally alert are satisfied with the care they receive. Whether their responses were affected by the reluctance of the elderly residents to freely express their feelings due possibly to fears of repercussion or low expectations, is not clear. As in the case of Mrs. K, a survey response indicated that she was very satisfied with the care. However, with the indepth-interview, one can better understand the psychology of why she responded the way she did.

Through three years of my experience as a community social worker and the observation of the care home operators in the study, there were no care home operators who intentionally abused or neglected their residents. However,
lack of support from the Department of Health, the Department of Human Services, and other private agencies, lack of knowledge about the availability and the accessibility of community services, and possibly lowered self-esteem due to lack of recognition and appreciation by the community, the care home operators themselves may be stressed out, which may lead to the neglect of their residents.

There were three cases of negligence of human rights under the name of protection during my professional experience as a social worker: the severe Alzheimer's patients were locked in or confined into chairs, etc. The care home operators could not keep an eye on them all the time thus they had to lock the residents in their own small rooms. Otherwise, if the residents wandered away and got lost, the care home operators would be held liable. Therefore, the most common reason for the use of restraints or confinement was protection of the residents from falling and wandering. The utilization of restraining devices or confinement is not a simple matter. The care home must be run for the benefit of the residents and not to suit the convenience of the care home operator. Are physical restraints or confinements applied for the benefit of the residents or the convenience of the operator?
Although physical abuses by the care home operator are rare, there are occasional verbal and financial abuses of the elderly residents by the care home operators.

According to Mr. Ron Iwai from the Adult Protective Services, Department of Human Services, DHS receive approximately 10-12 complaints a year from the community. However, only a small number of them relate to care home operators, three cases in 1989. The most common form of abuse was the financial exploitation of the residents by the care home operators.

Another agency which handles consumer protection is the Office on Aging. Based on a telephone interview with Ms. Sandy Rongitsch, the Office on Aging, they handled approximately 50 cases of complaints from the community toward adult residential care homes last year. No statistical data was available. Some of the complaints were:

1) Violation of privacy such as the care home operators listening to the telephone conversation of the residents, and opening the door of the residents without knocking, and the visitation rights. The care home operators often restrict the time of visitation by the families and friends,

2) Psychological and verbal abuse by yelling at the residents, favoritism, etc.,
3) Financial exploitation such as opening a joint account with residents and withdrawing money without telling the residents, or not informing the residents about new changes of allowance amounts. For example, the elderly residents who are publicly-assisted and receive social security benefits get $50.00 monthly allowance. However, the care home operator only gives them $30.00 and they keep $20.00 for themselves because a majority of the elderly are unaware of the changes.

4) Sexual exploitation. There were a few case of sexual exploitation involving the young mentally retarded residents with the family members of the care home operators. Ms. Rongitsch thinks many cases of sexual exploitations do not surface, but she suspects there are many potential cases.

Some of these complaints were noted among the elderly residents interviewed in the study.

Limitation of the Study

There were several limitations to the study. The first limitation was the minimal cooperation received from the care home operators. The care home operators have been bombarded with visitations by different researchers, and
their cooperation has been minimal. As far as I know, there were four separate studies on adult residential care homes within the last year and two other studies were conducted at the exact same time when this study was conducted.17 Two of the studies were also examining the issue of quality of care at the residential care homes, particularly for the developmentally disabled population. Many operators were hesitant to be visited and even if they allowed visitation, they requested to finish the visitation within one hour or less. They just couldn't understand why suddenly so many researchers visited and asked similar questions. They felt that whoever was studying adult residential care homes, the information should be shared among them. They took the purpose of the study very personally and feared that they were the target of inspection and interrogation by the


public and thus were very suspicious and defensive of outsiders visiting them. There was no opportunity for me to stay long enough to really observe the various interactions between the care home operators and the residents at adult residential care homes at the time of the interview.

Secondly, this study was limited by the lack of access to other data sources, such as the operator and the resident's records, to enhance the validity of the information because of the confidentiality of the individual records. The Department of Health was unwilling to provide information on the care home operators and the care home operators were unable to provide the resident's records.

Thirdly, there were a methodological limitations due to being a cross-sectional study and the small sample size. Since the data were collected only from the mentally coherent elderly residents together with a small sample size, it is not a representative sample and the results are not generalizable. As a matter of fact, the number of mentally coherent elderly residents might be much greater, but because of the language barriers between some of the care home operators and the residents, or preconceived ideas about the elderly in general, some of the elderly are rated as having mental problems.
Recommendations

There are several factors to be considered when recommending some strategies for the provision of future adult residential care home services: 1) the mixture of different resident populations, 2) the licensed capacity of residents at each adult residential care home, 3) the respite service for the care home operators, and 4) the training curriculum of the care home operators. Although numerous factors affect the quality of care, the above mentioned factors were very important in the improvement of quality of care at the residential care homes.

1. The Mixture of Different Population

Although there are pros and cons about the mixing of different disabled populations, such as elderly, mentally retarded, and developmentally disabled, it is better not to mix them at the adult residential care home level, particularly at Type I adult residential care homes. Concomitantly, it is better not to mix the Alzheimer's disease and related disorder patients with the other elderly population.

The reasons for this recommendation are two-fold. First, it is too much for the care home operator to meet the needs of each resident population without the much needed support and resources. For example, the mentally retarded and the developmentally disabled may require much more
rehabilitative activities than the elderly population. Secondly, the mixture of the Alzheimer patients with the other residents restricts the activities and the behaviors of the other residents. Often, the care home operators lock the bathroom doors, refrigerators, etc in order to protect themselves from over-usage by the confused residents. This restrains the other peoples' freedom of their movement; thus it will affect the quality of life of the people at the adult residential care homes.

2. The Licensed Capacity of Residents at Each Facility

The current regulation which states the maximum number as five is fine if the resident's care level is defined as Level I. However, it is recommended to have up to two residents if the level of care that the resident requires is Level III for Type I adult residential care homes. In a larger facility, such as Type II adult residential care homes, staff roles are differentiated (e.g., meal preparation, laundry, nursing care, etc.). However, in Type I care home, the care home operator has to perform multiple roles, thus it is impossible to provide personalized quality of care to more than two Level III residents. A study of psychiatric patients in foster care homes done by Linn also stated that two patients or fewer was associated with improved patient outcomes (Linn, 1980, 1981).
3. **Respite Service for the Care Home Operator**

A majority of the care home operators work throughout the year without any breaks because of the difficulty in finding substitutes while they are gone. If they cannot find anyone to come into their home and provide continuous service to their residents, they have to find another care home, often not only one but several, who are willing to accept their residents. Making such arrangement often proves to be impossible. Since no formalized support services are available to the care home operators, they become highly stressed or burnt out. Consequently, the quality of care they provide also goes down.

Several researcher stated that the relationship of licensing agencies and board/care homes are often more adversarial than supportive (Blaustein & Viek, 1987; White, 1981). In Hawaii, a majority of care home operators offered the same opinion. Although there is no easy solution, the state might provide temporary space for adult residential care home operators to utilize as respite service for their residents within, say, Maluhia hospital, on rotational basis. In addition, the state might provide technical support, such as providing in-service training for management and supervision of their residents, coping skills, etc.
4. **Training Curriculum for the Care Home Operator**

In the curriculum, technical skills are important; however, more emphasis should be placed on the psychology of aging and the patient population, the ethical issues which includes patient's rights, and communication skills.

In addition, continuous in-service training should be provided for the adult residential care home operators. Moreover, the contents of the in-service should not be limited to technical matters but should include subject such as cooking classes which could teach preparation of a variety of foods to suit the needs of different ethnic groups. A provider training would benefit both the care home operators and the residents.

By providing interpersonal skills to the adult residential care home operators, the quality of care at the adult residential care homes could be greatly enhanced. A majority of the care home operators are Filipino immigrants; thus their value systems may be different from that of their residents. This may also affect the provision of care at the adult residential care level. Consequently, the training curriculum needs to be re-examined in order to facilitate improved care at the adult residential care homes.

5. **The Provision of Case Management**

Although the case management has gradually been emphasized, it is a very important concept in order to
protect the people from being placed into less caring, profit-oriented adult residential care homes, or identifying such care homes. The case management approach is not only beneficial to the residents but also for the care home operators. The purpose of the case manager is to coordinate and to link the formal and informal services and resources to provide the maximum cohesion and coherence (Biegel et al., 1984). Often times, not only the residents and their family members but also the care home operators do not know the existing and available resources which they can tap into. Moreover, the provision of various welfare and support services, especially state-operated services, are quite complex and usually fragmented. The care home operators most likely operate their care homes in rather isolated circumstances, which may lead to a stressful situation, thus creating a vicious cycle.

A majority of the care home operators have a sense of pride in operating care homes and are willing to acquire new skills and knowledge. By screening out care home operators who are only profit-oriented, a better system of community care services such as adult residential care homes can be created.

As stated previously, the adult residential care services as a community-based program serve a very important role in the continuum of long-term care services in Hawaii. The strict rules and regulations to insure the quality of
care is important. However, some of the rules and regulations should be re-examined to make sure that they are relevant to the level of care that the adult residential care homes provide.

The role of the state should not only be the regulating agency but also to provide much needed support to adult residential care home operators. Only through the collaboration of efforts by the state agencies and the adult residential care home operators, will the quality of care of the residents at the adult residential care homes be assured.

In sum, it is my hope that the results of this study will stimulate activity in addressing some of the issues raised and thus lead to policies to insure quality of care at the adult residential care homes.
APPENDIX 1

Telephone Survey Questionnaire

I. Care Home Operator's Information

Q1. Sex: 1. Male 2. Female

Q2. How old are you?

   5. Filipino

Q4. If you are Filipino, please answer the followings
   C. Migration period: 1. Before 1932
      2. 1933-1964
      3. After 1965

Q5. What kinds of work experiences have you had before you became an operator?
   1. R.N. or L.P.N.
   2. Nurse's Aide
   3. Other medically related work
   4. Social service work
   5. Others

Q6. What year did you open your care home?

   3. Divorced/separated 4. Widowed

Q8. Annual Household Income: 1. 20,000 or less
   2. 20,001 - 30,000
   3. 30,001 - 40,000
   4. 40,001 - 50,000
   5. 50,001 - 60,000
   6. 60,001 and above

Q9. How many years did you go to school?
   1. less than 6 years
   2. 7-8 (Junior High School)
   3. 9-12 (Senior High School)
   4. 13-17 (Technical/College)
   5. 18 and above
Q10. Who is living with you besides your residents?
   1. Spouse
   2. Parent(s)/step-parent(s)/in-law(s)
   3. Child(ren)/step-child(ren)
   4. Brother(s)/sister(s)/step-siblings
   5. Grandchild(ren)
   6. Relatives
   7. Others

Q11. Total number of people living besides your residents?

Q12. How many helpers do you have in case of your absence?

II. Client's Information

Q13. How many residents can you legally care for?

Q14. How many residents do you have now?

Q15. How many elderly clients do you have?

Q16. What is your client's ethnicity? and How many each?
   1. Caucasian   6. Hispanic
   5. Filipino
APPENDIX 2

Functional Disability Scale

Part I

1. Client's ethnicity
2. Age
3. Sex: 1. male 2. female
4. Admission date: mo/year
5. Major medical diagnosis 1.
   2.
   3.
6. Method of payment: 1. private
   2. Government assisted

Part II

Code: MH= mechanical help (cane, bedpan, wheelchair, prosthesis, etc.)
HH=human help
Minimal HH= 1 person assist
Moderate HH= 2 person assist

7. Eating
   1. Independent
   2. MH only
   3. Minimal HH only
   4. Moderate HH only
   5. MH and HH
   6. Dependent
   9. Unable to assess
8. Bathing
   1. Independent
   2. MH only
   3. Minimal HH only
   4. Moderate HH only
   5. MH and HH
   6. Dependent
   9. Unable to assess

9. Dressing
   1. Independent
   2. MH only
   3. Minimal HH only
   4. Moderate HH only
   5. MH and HH
   6. Dependent
   9. Unable to assess

10. Transferring
    1. Independent
    2. MH only
    3. Minimal HH only
    4. Moderate HH only
    5. MH and HH
    6. Dependent
    9. Unable to assess

11. Mobility
    1. Independent
    2. MH only
    3. Minimal HH only
    4. Moderate HH only
    5. MH and HH
    6. Dependent
    9. Unable to assess

12. Continence: Bladder
    1. Independent
    2. MH only
    3. Minimal HH only
    4. Moderate HH only
    5. MH and HH
    6. Dependent
    9. Unable to assess
   1. Independent  1. Independent
   2. MH only  2. MH only
   3. Minimal HH only  3. Minimal HH only
   4. Moderate HH only  4. Moderate HH only
   5. MH and HH  5. MH and HH
   6. Dependent  6. Dependent
   9. Unable to assess  9. Unable to assess

15. Telephone Use  16. Group Participation
   1. Independent  1. Independent
   2. MH only  2. MH only
   3. Minimal HH only  3. Minimal HH only
   4. Moderate HH only  4. Moderate HH only
   5. MH and HH  5. MH and HH
   6. Dependent  6. Dependent
   9. Unable to assess  9. Unable to assess

17. Hearing (with aid if used):
   1. Normal: no problems
   2. Hears when diction clear; volume raised
   3. Hears with difficulty; many misunderstandings;
      can't hear in noisy setting
   4. Hears gross sounds with no meaning
   5. Deaf
   6. Unable to assess

18. Vision (with aid if used):
   1. Normal; no problems
   2. Minimal; large print; glasses
   3. Rt. or Lf. field vision blind
   4. Limited vision (peripheral; tunnel)
   5. Aware of lights/shadows
   6. Blind; no vision
   7. Unable to assess

   1. No problem
   2. Present but requires little or no intervention
   3. Present, requires and responds to staff
      intervention
   4. Present, unresponsive to maximum staff
      intervention
   5. Unable to assess
20. Behavior: physically abusive
   1. No problem
   2. Present but requires little or no intervention
   3. Present, requires and responds to staff intervention
   4. Present, unresponsive to maximum staff intervention
   5. Unable to assess

   1. No problem
   2. Present but requires little or no intervention
   3. Present, requires and responds to staff intervention
   4. Present, unresponsive to maximum staff intervention
   5. Unable to assess

22. Behavior: Delusional
   1. No problem
   2. Present but requires little or no intervention
   3. Present, requires and responds to staff intervention
   4. Present, unresponsive to maximum staff intervention
   5. Unable to assess

23. Mental Status
   1. No problem; normal; intact memory; oriented
   2. Mild impairment; mild memory loss; adequate orientation; can carry out most activities independently
   3. Moderate impairment; memory loss; poor judgment; needs frequent orientation and reminders; needs protected environment
   4. Severe impairment; severe memory loss
   5. Totally unresponsive
APPENDIX 3

Checklist for Observation

Structure/Layout

1. Are there places for private conversations with visitors?
   1. yes  2. no

2. Is there an outdoor area that residents can use?
   1. yes  2. no

3. Is there a telephone available to the residents?
   1. yes  2. no

4. Is the care home a second-storied house or flat?
   1. flat  2. second-storied

5. Is there any structural barriers for access to the operator?
   1. yes  2. no
   What is the barrier?

6. Is the home clean and orderly?
   1. yes  2. no

7. Is the home reasonably free of unpleasant odors?
   1. yes  2. no

8. Is there fence? 1. yes  2. no

Sincerity of Care Home Operator Towards Resident

1. knock the door to inform
2. Use polite words
3. Gentle touch
4. Facial expression
APPENDIX 4

Interview Questions with Elderly Residents

Family and External Support

1. Do you have family in Hawaii? 1. yes 2. no
2. How often does your family visit you? 1. often 2. sometimes 3. occasionally 4. rarely 5. none
3. Do you contact them by telephone? 1. yes 2. no
4. Do you have a social worker? 1. yes 2. no

Transportation

1. Do you have a handi-van pass? 1. yes 2. no
2. Can you go out for shopping, visit physicians, etc by yourself? 1. yes 2. no
   If not,
   2a. Does the operator provide transportation to see your physicians? 1. yes 2. no
   2b. How often? 1. often 2. sometimes 3. occasionally 4. rarely 5. none
   2c. Did you have to change physicians because it was too far from where you live? 1. yes 2. no
   2d. Does the operator provide any transportation service other than to the physician's office? 1. yes 2. no

Activities

1. How do you spend most of your time?
2. Do you think there are enough things to do all the time?
3. Does care home operator provide any activities? 1. yes 2. no
4. If there is, how often do you participate? 1. often 2. sometimes 3. occasionally 4. rarely 5. none
5. Can you watch TV whenever you want to? 1. yes 2. no
Food

1. Do you have a good appetite?
   1. very good 2. good 3. neither 4. not so good 5. no appetite

2. Are you satisfied with the food provided?
   1. very satisfied 2. satisfied 3. neither 4. dissatisfied 5. very dissatisfied.

   2a. If you are dissatisfied with the food, what is it that makes you feel that way?
      1. taste 2. quantity 3. quality 4. no choice 5. others

3. Do you have someone who can sometimes bring the food you like? 1. yes 2. no

4. Do you eat with the care home operator and his/her family? 1. yes 2. no

Art of Care

1. Is the operator available to you whenever you need her/him?
   1. very adequate 2. adequate 3. neither 5. inadequate

2. Does the operator treat you with respect and dignity?
   1. strongly agree 2. agree 3. neither 4. disagree 5. strongly disagree

3. Are you satisfied the way the operator care for you?
   1. very satisfied 2. satisfied 3. neither 4. dissatisfied 5. very dissatisfied

4. Do you feel that you need more nursing care or treatment beyond what you are presently receiving?
   1. yes 2. no

Physical Environment

1. Do you feel comfortable living here?
   1. strongly agree 2. agree 3. neither 4. disagree

2. Do you have enough privacy from the other residents?
   1. very adequate 2. adequate 3. neither 4. inadequate 5. very inadequate
3. Can you decorate your room as you like?
   1. yes  2. no

4. How often do you feel you want to move somewhere else?
   1. often  2. sometimes  3. occasionally  4. rarely  5. none

Cost

1. Do you know how much you pay to the care home now?
   1. yes  2. no
   If so,
   1a. What do you think about the cost of the care home?
      1. very adequate  2. adequate  3. neither  4. inadequate  5. very inadequate

   1b. Is the cost of the care home acceptable to you?
      1. very acceptable  2. acceptable  3. neither  4. unacceptable  5. very unacceptable

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