

1999

Designing a Better Day: Annotated Bibliography of Adult Day Care Literature, 1990-1998

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Recommended Citation

Alden, Andrew; Betrabet, Gowri; Moore, Keith Diaz; and Weisman, Gerald, "Designing a Better Day: Annotated Bibliography of Adult Day Care Literature, 1990-1998" (1999). *Center for Architecture and Urban Planning Research Books*. 8.
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Designing a Better Day

Annotated Bibliography of Adult Day Care Literature, (1990-1998)

Andrew Alden
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Keith Diaz Moore
Gerald Weisman

ABSTRACT

This monograph contains 56 annotated bibliographies of literature published since 1990 on Adult Day Care facilities. The annotations are organized into five components - organization, staff, family, client, and physical setting - all of which form the dimensions of place for Adult Day Care. A matrix of the annotated bibliographies gives an overview of categories addressed in each publication.

PUBLICATIONS IN ARCHITECTURE AND URBAN PLANNING RESEARCH

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Report: R99-2 / ISBN: 0-938744-98-4
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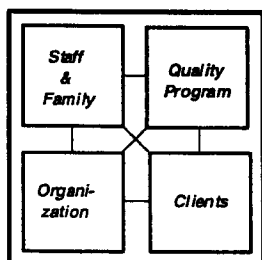


Introduction

Designing a Better Day

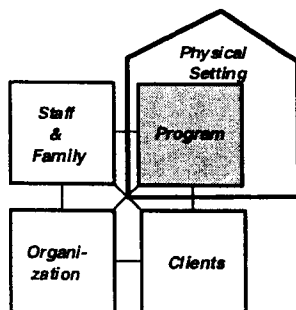
Introduction

What do we mean by "designing a better day" for adult and dementia day care clients and how can we most effectively meet this goal? Many of us are likely to think first of provision of a *quality program* with a rich range of activities and services. Program quality is surely central to our task; however we must also think of what is required to support such programs as well as their intentions and consequences.



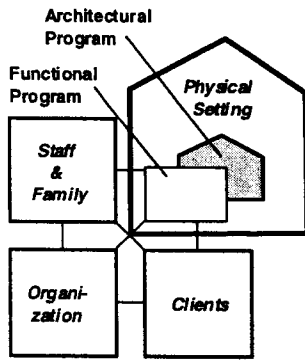
Human Resources

Provision of an effective program requires the marshaling of a range of human resources. First there must be a *knowledgeable and committed staff*, working within the context of a *supportive organization*. It is also essential to remember that "quality" is not an absolute; rather we must ensure that there is a match between that which a program offers and demands and the *desires and capabilities of the clients* that program is designed to serve. And quality care always requires the active involvement of informal as well as formal caregivers -- clients' *families* and friends. Organization, staff, families, and clients together form the human systems of day care.



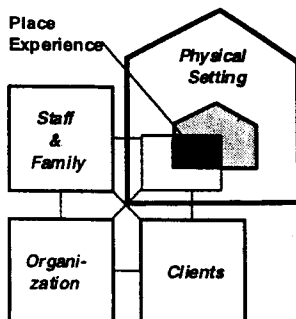
Less often recognized as a resource in our attempts at "designing a better day" is the *physical setting* within which adult and dementia day care services are provided. This omission likely reflects the current circumstances of day care and the necessity of "making do" in borrowed spaces in no way designed or redesigned in response to the needs of frail or cognitively impaired older persons or their caregivers.

It isn't easy for us to image the physical characteristics of a building for adult and dementia day care; we do not yet have a socially shared and sanctioned understanding of what this new place type is "supposed to be." Furthermore, the physical setting tends, for all of us, to be a "background" variable, not consciously considered until the heating fails or the roof leaks.



Thus we need to consciously "program" the spaces of an adult and dementia day care center much as we program the activities to be contained within those spaces. First we need to specify not only who will be doing what, when, and with whom; this is the **functional program**. We must also specify *where* these activities will be taking place and the desired characteristics of such places -- in terms of size, location, sensory properties, furnishings and equipment; this is the **architectural program**. When activity takes place within a physical setting, human experience is created. This makes it important in our planning stages to project the experiences we want to create. Should this place be a place of privacy? Of social interaction? These are attributes of experience and should be identified for each place -- this is the **experiential program**.

Indeed it is likely the case that the physical setting is even more important in adult and dementia day care centers than in most other place types. The physical setting has the potential of serving as a "mnemonic" for the cognitively impaired. This goes way beyond the simple naming of places, overstuffed furniture, personal momentos (so called "clutter"), TV, long curtains with a valence, table lamps, carpeting -- all go into shaping our experience of "Living Room." Clearly understood places -- "den," "dining room," "living room" - can serve to prompt those behaviors deemed appropriate and adaptive in each.



At the point of intersection of human and physical sub-systems -- at their vital center -- is the *experience of place* which they create. Place experience reflects but goes far beyond the program. People's experience of a place surely includes what they do within it-- the activities listed in a functional program -- but it is much more. What aspects of a day care center do its occupants perceive? What are their memories of this place? How do they feel about what they see, hear and do? Is it experienced as a place of privacy or sociability, tranquil or stimulating? What meaning do they attach to a day care center and the life which it engenders?

In short, meeting our overall goal of "designing a better day" requires that we understand and accommodate *all* of the essential sub-systems of day care centers. As we have seen, these sub-systems, or *components of place*, include organization, families, clients, and physical setting. The very term "day care center" -- like school, nursing home, and office -- connotes both people and the physical setting necessary to accommodate them. It is in terms of these multiple systems -- human and physical -- which collectively create adult and dementia day care centers that this annotated bibliography is organized. Each of the annotations in this bibliography is structured so as to highlight all of those components of place -- organization, staff, clients, families, physical setting, outcomes in terms of place experience -- considered in a specific article or book. In only a few instances, we shall discover, does an author deal with all of these sub-

systems in a comprehensive fashion. However, as the Annotated Bibliography reveals, each component of place is addressed somewhere in the Adult Day Care body of literature. Thus it falls to us to gain familiarity with this broad range of issues to ensure that they are fully integrated in the planning, programming and design of facilities. The following matrix provides a summary of all 56 citations included in the bibliography and specifies those components of place addressed in each.

It is our premise that by dealing with adult and dementia day care holistically -- in terms of its purposes, program, setting, and the positive experiences they will hopefully engender -- that we can "design a better day" for those in our care.

Sources consulted for the bibliography:

Ageline electronic database

Avery Index to Architectural Periodicals

Brookdale National Group Respite Program (1998). Bibliography for dementia day programs. Berkeley, CA:
Brookdale.

Medline electronic database

National Alzheimer's Association, Chicago IL

Psych-Lit electronic database

Sociofile electronic database



Matrix

Author / Year	Organization	Staff
Barker, J. C., & Mitteness, L. S., et al. (1991).	Organizational visibility in community network of care options	
Beisecker, A. E., & Wright, L. J., et al. (1996).	Demand for convenient hours, flexibility of use, affordability, stimulating, meaningful activities	
Benzing, P. (1994).	Implementation, funding, and scheduling of fieldwork	Occupational therapy students, fieldwork experience
Berry, G. L., & Zarit, S. H., et al. (1991).	Home care services vs. Adult day care services	
Beyersdorfer, P. S., & Birkenhauer, D. M. (1990).	Pet therapy	
Born, D.G., & Thompson, C.D., et al. (1996).	Adoption of pre-activity methods to increase involvement in activities.	
Bradsher, J. E., & Estes, C. L., et al. (1995).	Social / medical / combination models, and medical, "patchwork" funding, services	Medical model employees twice as many staff as social model
Brawley, E.C. (1997).		
Buelow, J.R., & Conrad, K.J. (1992).	Services offered	Perception of ADC and important components
Burgio, K.L., & Burgio, L.D., et al. (1991).	Intervention programming, verbal / physical cues	Staff role in toileting assistance
Cefalu, C. A., & Ettinger, W. H., et al. (1996).	Medical vs. Social	Skilled nursing (medical) versus social interaction (social)
Cohen, U., & Weisman, G. (1990).	Programming approaches to expand client autonomy	

Family	Client	Physical Setting	Outcomes
			Physicians as "gate-keepers" in use of alternative community care options
Users and non-users of ADC, demographics, perceptions of benefits / barriers		Barriers include unpleasant atmosphere, inadequate space and furniture	Need for increased marketing of ADC and its potential benefits
		Adult Day Care program offered for student practicum on University Campus	Meaningful experience for occupational therapy students and ADC clients
Demographics, activities performed during respite / non-respite, life satisfaction		Time usage and satisfaction	Time usage and satisfaction depending on respite type and caregiver relationship
	Client previous experience with pets, positive affect		Beneficial effects on clients, concerning social interaction, calmness, communication
			Increased social participation from the reading or telling relevant news stories
	Demographics, level of impairment		Increased demand, changing client profiles with lack of equal funding and regulation
ALZ impact on family	Effects of aging, effects of ALZ	Color, pattern, texture, light, acoustics, furniture, finishes, garden design	The formation of 10 therapeutic goals for design implementation, design guidelines
Perception of ADC and important components	Perception of ADC and important components	Interior environment	Staff caring, general morale and interior environ. are significant to client satisfaction
	Incontinence, level of physical and cognitive impairment		Incontinence is associated with cognitive and physical impairment
Demographics, caregiver burden, support options	Demographics, functioning / cognitive levels, continence, ADC stay length, abn behavior		Significant racial differences among client use pattern
	Needs of cognitively impaired, wandering	Design for day/respite center, impairment and environ. design, safety, privacy	Design principles for maximizing autonomy

Author / Year	Organization	Staff
Cohen-Mansfield, J., & Besansky, J., et al. (1994).	Services offered	
Cohen-Mansfield, J., & Taylor, L., et al. (1998).		
Cohen-Mansfield, J., & Werner, P., et al. (1995).	Behavior modification techniques	
Conrad, K.J., & Guttman, R. (1991).	Therapeutic versus maintenance activities, services offered	
Conrad, K.J., & Hanarahan, P., et al. (1990, March).	Organizational and structural issues	Training, staff size, staff client ratio
Conrad, K.J., & Hanarahan, P., et al. (1993).	Medicare funding – ALZ vs. non-ALZ , rural vs. urban, medicare, requirements, services	Medicare requirements, qualifications
Conrad, K.J., & Hughes, S., et al. (1993).	Different model types - medical, social, rehabilitative, services offered, etc...	Staff client ratio
Conrad, K.J., & Hultman, C.I. (1993, September).	Services offered	Training
Cox, N.J., & Reifler, B.V., et al. (1998, May/June).	Reasons for termination, transportation, funding for clients, attendance flux	
Curran, J. (1996).		
Gutkowski, S., & Guttman, F. (1992).	Therapeutic goals of specific spaces	Interactions with patients
Guttman, R.A. (1991).		

Family	Client	Physical Setting	Outcomes
Reasoning for refusal to utilize services, services needed	Demographics, Disability level affecting care options		
	Hallucinations, delusions, pain, agitation, medical info, cognitive function		Clients experienced at least 1 del. / hal. per week, women more likely than men
	Agitated behavior frequency and type at ADC and home		Variance in agitated behaviors occurring at ADC and Home
		Pleasantness, amenities for ADA, safety, location	ALZ ADC - quality of life issues and improvement, Non ALZ ADC - maintenance
	Demographics, services needed	Square footage, location, equipment, amenities for ADA, space	Fiscal survival means intense marketing and over-enroll on a daily basis
			Percentage of ADC which qualify for Medicare
Family involvement	Impairment level in relation to program type		Types- ALZ family care, rehabilitation, high intensity, moderate intensity, low intensity
	Socio-demographics, services needed	Square footage, location, equipment, amenities for ADA, space, pleasantness	Fewer clients, staff, other resources in rural settings
Resistance to program	Behavior problems, medical needs, level of impairment / function		Suggestions made for preventing premature terminations
Family perceptions of clients changing mood and behavior	Clients suffering from Alz or related dementia		ADC had a positive effect on the mood and behavior of 42% of the clientele
		Color, light, boundaries, reception areas	Redefine space - interactive psychotherapeutic environment
Caregiver burden, nature of stress, support groups, institutionalizing issue			Increased caregiver burden = desire to institutionalize, benefits ADC

Author / Year	Organization	Staff
Hasselkus, B.R. (1992).	Organization guiding principles, maintenance (ADL's) vs. therapeutic activities	Staff role in activities including ADL's
Hasselkus, B. R., & Labelle, A. (1998, March).	Discharge criteria, limits of care provision	Staff ideology about good and bad care, perception of termination of services
Hedrick, S., & Johnson, R.J., et al. (1991).		
Henry, M.E., & Capitman, J.A. (1995).	Financial viability, operational choices, services offered	Interaction with clients and family
Hensley, D.A., & Travis, S. (1997).	Organizational philosophies on staff training and continued education	Staff development and training / staff wear many hats based on need
Kirwin, P.M. (1991).	Services offered	
Kirwin, P.M., & Kaye, L.W. (1991).	Services offered to meet needs of family and client	Staff - less technical activities, Contracted - professional / technical services
Kirwin, P.M., & Kaye, L.W. (1993).	Services provided	
Lindeman, D.A., & Corby, N.H., et al. (1991).	Physical / social / cognitive / functional activities, financial management	Qualifications, recruitment, structure / training, retention / burnout, volunteers
Lovering, M. (1990).	Outdoor activities to supplement indoor activities	
Lyman, K.A. (1990).	Medical vs. non-medical	Stress, staff "control" over environment
Lyman, K. A., & Pynoos, J., et al. (1993).		Training intervention to increase knowledge of the effect of physical environment

Family	Client	Physical Setting	Outcomes
	Daily behavior / effects ALZ		Activities concerning ADL's take precedent over rehabilitative or therapeutic goals.
			Termination of client participation was an unsatisfactory experience for ADC staff
Ratings of client IADL's and behavior problems.	Level of physical and cognitive impairment / assistance received		ADHC participants more likely to be recruited from SNF / home care than from hospitals
Needs, preferences, satisfaction	Dementia / non-dementia, demographics, health status		Operational choices influence - affordability, utilization, discharge, but not caregiver well being
			Staff develop. programs constrained by time, budget, coordination, and changing client need
Socio-demographics, family support, caregiver functions, service need/use, satisfaction	Socio-demographics, impairments, length of stay, satisfaction		ADC & family roles more parallel than compliment. IADL's stronger predictor of ADC use than ADL's
longitudinal change in need of services	longitudinal change in need of services		ADC staff most likely to perform toileting, exercise and recreation - in home use declined over time
Services provided			Informal and formal - provide parallel services not complementary
Family needs, caregiver burden, support groups	Intake assessment, orientation, reassessment, behavioral problems	Noise, lighting, chairs, safety & security, wandering, room size and number	
	ALZ clients, wandering behavior, other impairments issues	Outdoor - enclosure, lighting, noise, safety, way-finding, seating arrangement	Design principles for outdoor spaces
	Medical typification of clients		Medical model has lower staff stress but increased infantilization of clients
		Space provision + spatial arrangements, security, personal care facilities, staff private spaces	Occupational stress & caregiving improvements with design modifications.

Author / Year	Organization	Staff
Maynard, M. (1990).	Stress management exercises for clients	
McGadney, B.F., & Madison, A. (1997).	Services offered	
Murphy, M.B. (1993).	Concept of Adult Day Care, administration and organization, services offered	Training techniques and personal care
Newman, S., & Ward, C. (1993).	Planned and structured music activities	
O'Brien, N., & Sainer, J., et al. (1995).	Admin. policies and procedures, organization goals – mission statement, recruitment	Position summaries, professional and volunteer employment
Short-DeGraff, M.A., & Diamond, K. (1996).	Intergenerational activities	
Stevens, A.B., & King, C.A., et al. (1993).	Question asking reading (QAR) as meaningful activity	
Stremmel, A.J., & Travis, S.S., et al. (1994).	ADC and Child Care Center – philosophy on intergenerational exchange	Staffing concerns, training
Teresi, J.A., & Holmes, D., et al. (1998).	Medical Adult Day Care	
Travis, S., & Das, P. (1994).	Medicaid, research, teaching, public service, marketing, intergenerational	Staffing, student volunteers
Twigg, J. (1997).	Boundary between medical / social model concerning provision of bathing services	Psychosocial implications of bathing role
Wallace, S.P., & Snyder, J.L., et al. (1992).	Racial differences in funding sources for clients, racial differences in service needs	

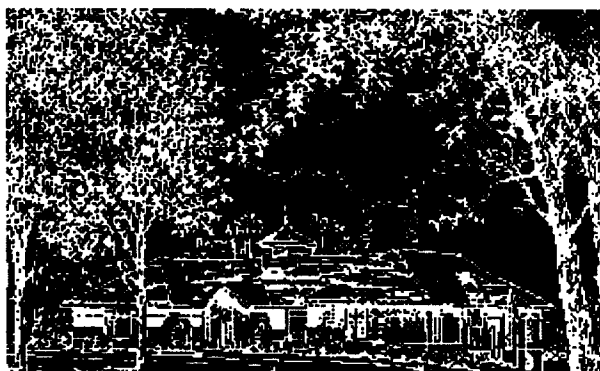
Family	Client	Physical Setting	Outcomes
	Education + physical limitations, stress reduction		Aid adaptation to life stressors
Socio-demographics, attitudes toward ADC and other community resources	African American ADC clients, socio-demographics, services needs		African American caregivers prefer community asst. to family asst. Need asst. w/ IADL's, mostly
	Understanding the ADC client population and individuals with ALZ and dementia		
	ADC clients, physical manifestation of social interaction		Increase in social interaction and physical contact when children present
Caregiver burden, family finances, resistance to use	Client profile, behavior problems, intervention techniques	Design and use of space, sensory stimulation, orientation, environmental barriers	
	Various impairments including dementia (ALZ), behavior, social interaction		Higher social interaction / lower levels of solitary behavior with Intergenerational prog.
	Various impairments including dementia (ALZ), memory skills, social interaction		Higher social interaction and improved memory skills w / Question and Answer Reading
		Different spatial requirements for ADC / CDC programming activities	Benefits exist from intergenerational exchanges, but problems - training, practice policy
	Prevalence of cognitive impairments		Increased prevalence of ADC's serving mildly and moderately cognitively impaired clients
		Adult Day Care as part of University Campus	
Willingness and psychological reaction to bathing assistance	Psychological reaction to loss of ability to perform personal hygiene, social meaning of bath	Home environment vs. public space of ward or nursing home, public vs. private	Trend away from medical toward social results in unclear definition of bathing services
	Socio-demographics, functioning(ADL), cognitive levels		African American clients utilize ADC at twice the rate of older Caucasians.

Author / Year	Organization	Staff
Webb, L.C. (1989).	Activities for sense of control, maximize the functional level, promote independence	Staff orientation, staffing patterns, support staff
Weissert, W.G., & Elston, J.M., et al. (1990).	Licensing / certification, financial aspects, services offered, three models of care	
Weissert, W.G., & Elston, J.M., et al. (1991).	Regulating entities, differences between ADCs according to regulatory status	Staffing requirements
Werner, B.J. (1994).	Medical model, revenue sources, administration methods, programming, therapies	Staffing, staff development, volunteers, students
Wilber, K.H., & Specht, C.V. (1994).		Demographics, burnout, involvement, peer cohesion, autonomy, control, physical comfort
Williams, B., & Roberts, P. (1995).	Segregation on basis of ability, programmed vs. non-programmed time	Staff roles in social interaction of clients
Zarit, S.H., & Stephens, M.A.P., et al. (1998, Sept).		
Zelman, W.M., & Elston, J.M. (1991, Spring).	Funding, operating expenses, financial profile, revenues, expenses	

Abbreviations:

- ADC** = Adult Day Care (Center)
- ADHC** = Adult Day Health Center
- ALZ** = Alzheimer's Disease
- ADA** = Americans with Disabilities Act
- ADL** = Activity of Daily Living
- IADL** = Instrumental Activities of Daily Living
- CDC** = Child Day Care (Center)

Family	Client	Physical Setting	Outcomes
Family resources, recognition of family needs, family involvement	Intake assessment, trial period, activity level, orientation to facility	ADA, site selection and orientation, vestibule, reception area, mnemonic cues, signage	
Socio-demographics	Socio-demographics		Expenses exceed revenues, general high level of client satisfaction with ADC
	Client satisfaction	Facility requirements for regulation	Regulated centers generally have more satisfied clients that unregulated centers
	Cognitively and physically impaired		Various sources of funding necessary to provide range of services demanded of ADHC
			ADC staff experienced lower than average levels of burn-out for health care workers
	Cognitive impairment and participation / social interaction	Staff influence in physical location of clients	Friendship-type interactions enable clients to maintain self-esteem and adjust to social norms
Socio-demographics, caregiver burden, depression, anger	Impairment levels (IADL's and ADL's)		ADCs allow for lower levels of caregiver related stress and better psychological well-being
	Dependence level according to model type		Labor is largest expense, flexible scheduling and part-time employees may help with cost of labor



Annotations

Barker, J. C., & Mitteness, L. S., & Heller, K. S. (1991). Physician's knowledge of adult day health care for the elderly. *Gerontology & Geriatrics Education, 12(1), 1-15.*

OVERVIEW

This study interviewed 216 clients concerning in-home health care use and 54 physicians regarding awareness of adult day health care, a community-based service, and whether they would refer their patients to such care. It was found that only 41% of the physicians were willing to refer their patients to Adult Day Health Care (ADHC) and only 13% had done so. This study highlights the role of doctors as "gatekeepers" with the ability to facilitate or deter the entry of frail elderly into various long-term care services.

NATURE OF INQUIRY

This study interviewed 216 clients of a large Medicare certified urban home health care agency and 54 of their physicians. The physicians were known to routinely refer the use of in-home health care services for the elderly. The questions were; did the doctors who knew and used in-home health care for frail elderly also know about ADHC? Under what circumstances did they refer patients to ADHC? The 10 – 15 minute interviews were conducted by telephone. Most physicians (80%) were male and described themselves as; general internists (56%), non-surgical specialists (30%), and surgeons (15%). None of the doctors specialized in geriatrics although each treated substantial numbers of geriatric patients.

COMPONENTS OF PLACE

Organization This study focused on medically-oriented adult day health care centers in which physicians are identified as an important source of referrals.

Staff

Family

Client The patients who were interviewed had an average age of 77.4 years. A fourth had a low annual income and a fourth were married and living with a spouse. Forty-two percent lived alone. All patients received in-home health care for a median of 22 days (either from a registered nurse or a physical therapist) for existing or new conditions. A little over half the patients were mildly to moderately impaired.

Physical Setting

OUTCOME

The results indicate that 71% of the physicians were aware of Adult Day Health Care (ADHC). More doctors who had less than twenty years in practice knew about ADHC services than did physicians with established practices longer than twenty years. More non-surgeons knew about ADHC than surgeons and more physicians who had low-income patients knew about ADHC than those with patients with higher incomes. Physicians were more willing to recommend ADHC services to the minority elderly, those who had three or more children, and those with lower incomes.

Beisecker, A. E., & Wright, L. J., & Chrisman, S. K. & Ashworth, J. (1996). Family caregiver perceptions of benefits and barriers to the use of adult day care for individuals with alzheimer's disease. *Research on Aging*, 18(4), 430-450.

OVERVIEW

Semi-structured telephone interviews were conducted with 104 family caregivers (52 users of Adult Day Care (ADC) and 52 non-users) to determine the perceived benefits and barriers to the use of ADC. A comparative analysis of the qualitative data identified seven categories of benefits and seven categories of barriers. Both groups reported benefits and barriers; more users overcame the barriers to actually use the service.

NATURE OF INQUIRY

The study explores the underuse of ADC's despite the perceived benefits by discovering the barriers to its use. Fifty-two caregivers of individuals with Alzheimer's disease who had used ADC's and fifty-two who had not used ADC's were interviewed. The interview asked about demographic data and about perceived benefits and barriers to the use of ADC programs.

COMPONENTS OF PLACE

Organization ADC programs are perceived in this study to serve the needs of those with Alzheimer's disease providing more socially and behaviorally oriented care and more support for families.

Staff

Family Caregivers were mainly spouses and adult children. Caregivers were predominantly white and had cared for the family member through the course of the illness.

Client

Physical Setting

OUTCOME

Users of Adult Day Care (ADC) mostly expressed benefits of ADC for both caregiver and the patient whereas nonusers were more likely to view the use of ADC as benefiting only the caregiver. The benefits were coded into seven categories; caregiver, patient, staff, program, facility, convenience, and cost.

Caregiver benefits included respite, preservation of physical health and emotional relief. User caregivers were more focused on benefits related to preservation of their emotional and physical health. However non-user caregivers viewed the benefit more from a task orientation perspective – that ADC use afforded them time to work, run errands, and take care of others at home. Patient benefits included stimulation, socialization, safety, physical health, self-esteem and enjoyment. Staff benefits appreciated by ADC users included staff knowledge, qualifications, empathy and sensitivity.

The barriers included seven categories; lack of convenience, cost, patient concerns, caregiver feelings, staff, program and facility. Lack of convenience was related to program availability, hours of operation, location of ADC, access to ADC during times of need and getting the patient to the ADC (transportation). Patient barriers were perceptions about patient unhappiness, behavior, safety, and the like. Caregiver feelings of guilt about using the ADC were coupled with lack of information regarding ADCs. Inadequate ADC programming was also cited as a barrier to its use for example, inadequate nutrition, lack of exercise and stimulating activities. Lack of cleanliness of the facility, inadequate space, unsafe and unpleasant atmosphere and inadequate or inappropriate furnishings were additional causes for concern.

Benzing, P. (1994). The place to be: The development and implementation of an alzheimer's day-care / respite program as a level I fieldwork experience for occupational therapy students. *Educational Gerontology*, 20, 251-263.

OVERVIEW

A one day per week Adult Day Care (ADC) program for individuals suffering from Alzheimer's Disease or other dementia related disorders was started on the campus of Eastern Kentucky State University (EKSU). The goal of the program was to provide students with the opportunities to have practical experience, work with an elderly population, practice communication and other professional characteristics, observe other health care professional, and learn valuable problem-solving skills. This university based ADC program provided an excellent opportunity for students, respite for family caregivers, and meaningful / therapeutic activities for clients.

NATURE OF INQUIRY

This article is an overview of the program and deals with its inception, implementation, and layout of activities and student responsibilities. The occupational therapy students are responsible for patient assessment, program planning, program implementation, and program evaluation. The student first interviews the caregiver to obtain background information and administers evaluation tests to the clients (Parachek Geriatric Rating Scale, Mini-Mental State Exam, and Allen Cognitive Levels-Expanded Test for cognitive disabilities). Next, based on the strengths and weaknesses of the client, the student writes and implements an activity plan. Finally, the student writes two progress reports on the client and one discharge summary at the end of the semester.

COMPONENTS OF PLACE

Organization

This social model ADC program is unlicensed and free of charge to the clients (EKSU funded). The activities include a combination of cognitive (arts and crafts, baking and cooking, memory activities) and physical (gross motor movement games, simple exercises) activities. The exercises are fitted to the client with the appropriate cognitive and physical abilities.

Staff Each student is assigned a client and the program is supervised by the faculty of the occupational therapy department.

Family

Client

Physical Setting This ADC program takes place on the (EKSU) campus, specifically the Baptist Student Center (BSC). The BSC provides a large all-purpose room and attached kitchen with bathroom facilities close at hand.

OUTCOME

This article emphasizes the educational opportunity of organizing Adult Day Care in a university setting. Programs from other health-related fields such as psychology, nursing, and sociology could capitalize on this educational experience, while providing a community service.

Berry, G. L., & Zarit, S. H., & Rabatin, V. X. (1991). Caregiver activity on respite and nonrespite days: A comparison of two service approaches. *The Gerontologist*, 31(6), 830-835.

OVERVIEW

The authors study the effects of respite services, whether home care or respite services (Adult Day Care), on the use of caregivers' time. The study explores whether respite services complement or supplement tasks performed by informal caregivers or instead of informal caregivers. Assessment of caregiver activity during respite and nonrespite days showed significant program differences in the amount of caregiving time. It also showed overall differences in the amount of non-caregiving time. The article discussed the caregivers' satisfaction with various respite program components and their willingness to continue providing care.

NATURE OF INQUIRY

Two stages of data collection were used, face to face interviews with forty female caregivers in the San Francisco Bay area and a series of five subsequent telephone interviews. The face to face interviews consisted of socio-demographic and health related questions such as, extent of service, caregiver program satisfaction, and willingness to continue providing care. The subsequent interviews included the 'Yesterday' interview, which is a detailed time budget to outline activities chronologically from wake-up time to bedtime. This information was collected on three days when home or adult day care services were used (respite days) and three days when there was no use (non-respite days).

COMPONENTS OF PLACE

Organization Respite services including ADC and home care are discussed.

Staff

Family

The caregivers in this study were the wives and daughters of individuals diagnosed as having a form of dementia. They received respite services a minimum of three times per month.

Client

Physical Setting

OUTCOME

Those who used home care showed higher life satisfaction ratings than those who used day care services. A content analysis of activities engaged in during respite days showed the greatest amount of respite time spent on paid employment followed by running errands or household maintenance. However, respite's capacity to reduce caregiving time was apparent only for the home care users. Those who used day care services spent more time performing caregiving activities on respite days (such as preparing for the out-of-home visit) than on non-respite days. The study suggests that respite may be most useful for those caregivers with specific, competing responsibilities (e.g. work/family) and those who are neither frail nor overwhelmed by continuous caregiving.

Beyersdorfer, P. S. & Birkenhauer, D. M. (1990). The therapeutic use of pets on an alzheimer's unit. *The American Journal of Alzheimer's Care and Related Disorders & Research*. 1(2), 13-17.

OVERVIEW

This article documents the research results of pet therapy sessions at an Alzheimer's care unit. Two adult golden retrievers participated in half-hour therapy sessions interacting with residents for five consecutive weeks. The importance of pet therapy in providing entertainment, encouraging social interaction and enhancing self-esteem is underscored in the research team's observations and feedback from the staff and the residents. Social interaction among the patients on the unit and between patients and staff improved during the sessions.

NATURE OF INQUIRY

Three simple objectives were set for the therapy sessions – to provide entertainment, encourage social interaction, and to enhance self-esteem. Five to ten minutes before and after each session were used to prepare the residents or to discuss what had occurred. During each session, residents participated in brushing, feeding the dogs, or walking the dogs up and down the hallway on a leash.

COMPONENTS OF PLACE

Organization

Pet therapy is recognized as a holistic approach to health providing both physiological and psychological benefits to individuals of all ages. The study shows that with cooperation from the staff and

management, and compliance with state health laws, institutional regulations and availability of physical space (e.g. a hallway) pet therapy sessions (in this case, visits by two adult golden retrievers) were easy to adapt to the specific context.

Staff

Family

Client

Participants in the unit were between the ages of 65 and 95 years old. The study assumed that if the residents had owned pets in the past, they might respond positively to interactions with the dogs. It draws parallels between non-verbal communication aspects common to the residents and pets – responsiveness to touch, facial expression, voice, tone, and posture. Moreover, the sessions are also conceptualized as potential reminiscence therapy – talking about pets owned.

Physical Setting

A nationally recognized Alzheimer’s care unit within a multi-level care nursing home in a large metropolitan area was the study site. The unit had some prior experience with pet visitation programs. The hallway was chosen as a suitable setting for the pet therapy activity because it was used frequently by the residents.

OUTCOME

The residents were found to enjoy the visits and hugged, stroked and talked with the dogs. Social behaviors (eye opening and eye contact, leaning towards the dogs) were noticed in those patients with more advanced dementia. Increased social interactions among the staff and patients and among the patients themselves were also recorded. The staff reported that the patients were calmer during and just after the sessions.

Born, D.G. & Thompson, C.D. & Hitchcock, J.K. (1996). Increased participation in adult day programs: An experimental analysis of increased news participation. *Activities, Adaptation & Aging, 20(4), 47-59.*

OVERVIEW

This study examined the social behavioral patterns of with 22 Adult Day Care (ADC) clients. It was hypothesized that positive social behaviors could be elicited from the clients by participation in a current news discussion. The clients showed the greatest increase in social participation during the “telling” of selected interesting current news stories.

NATURE OF INQUIRY

The experimental model was composed of four treatment conditions: reading selected news stories (RS), reading unselected news stories (RU), telling selected news stories (TS), telling unselected news stories (TU). Each experimental condition was observed at intervals of one

minute for a total of ten minutes, by an independent observer. During each interval the number of active responses (more than two words) from the clients were recorded.

The two primary experimental variables are the selection / nonselection of articles and the reading / telling of the articles. The selected / nonselected component involved the discussion leader (staff) selecting or not selecting articles which would be of interest to the discussion group. The telling and reading component involved the method by which the news was relayed to the discussion group. The telling method required the discussion leader (staff) provide a summary to the discussion group. The reading method required the discussion leader (staff) to read the news articles directly from the newspaper to the discussion group.

COMPONENTS OF PLACE

<i>Organization</i>	This study focused on the discussion of current news. A discussion of current events is believed to help keep clients oriented with respect to space and time. The discussion of current events provided both an arena where clients could practice social discourse and a selection of topics which may be used for discussion and interaction with family and friends.
<i>Staff</i>	Staff led the discussion group and selected interesting stories based on their personal knowledge of the clientele.
<i>Family</i>	
<i>Client</i>	The number of clients who participated in the daily current events discussion varied from seven to twelve, each of who suffered from one or more mental or physical deficits.
<i>Physical Setting</i>	Participants gathered around a 4m by 1m table and were seated on upright, padded, metal chairs with armrests. The group discussion leader sat at or near one end of the table.

OUTCOME

The least effective experimental model was reading unselected articles to the discussion group. The data illustrated that the greatest increase in participation was achieved by selecting articles that are of interest to the clients and relating the news in a less formal, more personal manner. Possible reasons behind the increased participation of Adult Day Care clients may involve personal aspects of telling the story instead of reading directly from the newspaper. When the story was "told" to the discussion group, the news director maintained higher levels of eye contact, instead of constantly staring at the newspaper to read the article. The discussion group may not want to interrupt the news director while he/she is reading from the paper; whereas the "telling" of the story allows for a more informal atmosphere. The "telling" of the story may also promote discussion due to the fact that "telling" instead of "reading" takes less time and allows more time for discussion.

The positive influences of increased news participation can also promote "behavioral momentum". Behavioral momentum is described as a positive or negative behavioral effect that can carry over from one activity to another. The staff noted that clients who participated in the experimental models that elicited increased participation in discussion were more active in the exercise session that followed the news group discussion.

Bradsher, J. E. & Estes, C. L. & Stuart, M. H. (1995). Adult day care: A fragmented system of policy and funding streams. *Journal of Aging & Social Policy*, 7(1), 17-38.

OVERVIEW

This study examined the policy and funding environment of Adult Day Care Centers (ADC's) with a focus on funding strategies, client characteristics, and type of clients refusing services. The services available at ADC's in California, Florida, Pennsylvania, Texas & Washington were studied in order to clarify issues regarding development of and access to ADC's and to link funding issues to the classification of ADC's. Findings indicated an increasing demand for ADC's and a changing client profile.

NATURE OF INQUIRY

This study used a sampling frame utilized in two previous studies to choose 92 Adult Day Care Centers (ADC's) for a telephone survey which covered organizational structure, funding, services, staffing, client characteristics, barriers to care, and policy context. The aim of this study was to examine differences among ADC's by model type and how the differences relate to reimbursement. Respondents were asked to classify their program as a health model (more likely to provide nursing care, medical assessments, rehabilitative services and health monitoring), social model (less likely to provide medically oriented programs and focus on client socialization), or social/health model (a combination but more oriented toward health).

COMPONENTS OF PLACE

Organization The ADC environment is characterized as fluid and dynamic – shaped by the delivery of services, relationships with local, state and federal agencies, funding streams, perceived need / demand and consumer preference, which makes it difficult to quantify medical and social models. However, in this study, respondents classify themselves into social, health and social/health models.

Staff The number of staff in the health models were twice that of the social models. The health model staff consisted of nurses, social workers and volunteers. Physical and occupation therapists were contracted on a regular basis.

Family

Client In general, clients were significantly impaired, were more likely to be chronic care rather than post-acute patients and were mostly women. Clients also exhibited different levels of Activities of Daily Living (ADL) limitations – with only 25% of the ADC's reporting no clients with ADL limitations.

Physical Setting

OUTCOME

The findings indicated the following six key issues:

- 6) Eighty-seven percent of ADC's surveyed were nonprofit although there is a trend towards more profit driven centers.
- 2) Financing is from a 'patchwork of sources' such as client fees, city and county funds, state matching grants, United Way funds, Medicaid, etc. Social models received their highest revenue from client fees, none from Medicaid. Health models on the other hand received 51% of revenue from Medicaid, State and OAA funding than the Social models. Combination models received revenue from a variety of sources with almost equal participation by state funding and client fees.
- 3) Health models employed twice the number of staff as social models. The centers had an average of 11 members and maintained a 1:3 staff client ratio. Physical and occupation therapists were contracted on a regular basis.
- 4) Clients were significantly impaired, more likely to be chronic care rather than post-acute patients and were mostly women. Health and social/health models had a higher percentage of low-income and minority clients while social models had higher proportions of women and clients over age 65.
- 5) Barriers to care were most prominent for abusive clients, clients needing specialized therapy, wanderers and developmentally disabled clients – who were refused services by both social and health models. Reasons for refusal included staffing limitations, facility / environmental limitations and behavioral problems.
- 6) Changes in funding policies affected the ability of ADCs to deliver services – e.g., funding freezes, domestic spending cuts, and increased taxes. Other influences in the type of services delivered were regulatory policy, certification / licensing requirements and standards of care.

Brawley, E.C. (1997). *Designing for Alzheimer's disease: strategies for creating better care environments*. New York: John Wiley & Sons.

OVERVIEW

This book is a general reference source for developing better care environments for long-term and assisted living facilities. Ideas are presented for the improvement or initial development of better physical settings. Attention is given to issues of lighting and interior finishes. The design of the physical environment is presented with specific concern for an aged population.

NATURE OF INQUIRY

The author synthesizes information gathered from current sources on topics such as lighting, behavioral issues of the elderly, Alzheimer's disease, effects of aging, and acoustics. The information is used to form design guidelines. This book examines issues important for dealing with an aged population, especially when the natural aging process may be exacerbated by a dementia condition such as Alzheimer's disease or other disorders.

COMPONENTS OF PLACE

Organization

Staff

Family The study discussed the impact of Alzheimer's disease on the family, based on the personal experience of the author. It also discussed the benefits of a "therapeutic" or "homelike" care environment for family, as well as resident.

Client Discussed are the physiological and mental health changes that occur due to the natural aging process. Specific detail was directed towards the accelerated decline in sensory ability associated with Alzheimer's disease.

Physical Setting This book provided guidelines for both the interior and exterior physical environment. The guidelines covered both general physical structure and internal finishes and furnishings. The interior finishes guidelines cover topics on lighting styles, acoustics, pattern/textures, color options, furniture/fabrics, floor coverings, wayfinding, and window treatments. Exterior topics include the design of therapeutic gardens and outdoor activity spaces.

OUTCOME

The therapeutic goals formed from the synthesis of research are as follows:

- Ensure Safety and Security
- Support Functional Ability Through Meaningful Activity
- Provide Heightened Awareness and Orientation
- Provide Appropriate Environmental Stimulation and Challenge
- Develop a Positive Social Milieu
- Maximize Autonomy and Control
- Adapt to Changing Needs
- Establish Links to the Healthy and Familiar
- Respect the Need for Privacy
- Encourage Family Involvement

These goals should guide policy programming and design decisions.

The final chapter provides an outline for the suggested design process

Buelow, J.R., & Conrad, K.J. (1992). Assessing the influence of adult day care on client satisfaction. *Journal of Aging and Health*, 4(2), 303-321.

OVERVIEW

This study attempted to measure Adult Day Care (ADC) environmental and program characteristics as perceived by four groups (clients, caregivers, staff, and administrators) as predictors of client satisfaction. This study concentrated on 3 research questions: (1) according to the clients, which ADC program characteristics contribute the most toward client satisfaction? (2) Do the perceptions of the ADC's program characteristics resulting in client satisfaction, correlate between administration, staff, and caregivers? (3) Are the ADC program characteristics that influence client satisfaction the same for clients, staff, administration, and caregivers? The data collected indicated that clients consider staff caring, general morale, and the interior environment to be predictive of satisfaction. Secondly, administration, staff and caregiver perceptions were not considered significant predictors of client satisfaction. Lastly, the perception of characteristics that influence satisfaction differed between all four groups.

NATURE OF INQUIRY

This study gathered data from 74 ADC's located throughout the United States. The respondent pool was composed of four groups of individuals: clients (N=228), caregivers (N=90), staff (N=101), and administrators (N=49). There were two independent variables (structure and process) and one dependent variable (client satisfaction) in this study. The independent variable "structure" was composed of level of lighting, number of windows, and general attractiveness of the main activity room. The second independent variable "process" was also composed of three topics: staff caring, general morale, and communication. Individual client characteristics (age, gender, marital status, and self-rated health) were also collected as a co-variant to account for confounding variables.

The "structure and process" characteristics were obtained using modified versions of the Adult Day Care Assessment Procedure (ADCAP). The questionnaires were modified to be appropriate for each respondent group

The client satisfaction scale combined four statements from the Ware's Patient Satisfaction Questionnaire and nine additional statements developed for this study.

COMPONENTS OF PLACE

<i>Organization</i>	This study examined several organizational and service related characteristics such as counseling services, soci-recreational services, rehabilitation services, health services, and general morale.
<i>Staff</i>	The study included 101 ADC paid staff and 49 administrators. Issues of staff caring and client / staff communication were analyzed.
<i>Family</i>	The perceptions of 90 family caregivers were also analyzed for client satisfaction.

Client

The clients in the study (N=228) did not have any serious memory problems or signs of dementia. They also were oriented to time, person, and place (lucid).

Physical Setting

The 74 ADC's selected for this study were distributed across the United States, with 32 in the North Central region, 9 in the Northeastern region, 20 in the Western region, and 13 in the Southern region. This study also examined aspects of the interior environment, such as level of lighting, number of windows, and general attractiveness of the main activity room.

OUTCOME

The data showed that six of the eight program characteristics; staff caring (.56), general morale (.42), interior environment (.40), rehabilitation services (.14), social-recreational services (.27), counseling services (.16) and three of the four client characteristics (age, marital status, gender) were correlated with client satisfaction. When the data obtained from the correlation analysis was examined via general linear regression, only three program characteristics were found to be significant: staff caring (.39), general morale (.25), and interior environment (.21). The clients consider staff caring, general morale, and the interior environment to be predictive of client satisfaction.

The second research question concerned the perceptions of administration, staff members, and caregiver with respect to client satisfaction. According to analysis by general linear regression, none of the eight program characteristics were found to be significant in relation to client satisfaction. According to the data, staff members, administration, and caregivers are not good evaluators of client satisfaction with ADC's.

The final research question involved the relationship between the perceptions of the four groups concerning ADC program characteristics in relation to client satisfaction. The results of the analysis indicated significant correlation concerning interior environment (structure) between clients and administrators (.53), clients and staff members (.52), staff members and administrators (.68), and clients and caregivers (.16). There was also significant correlation between caregivers and administrators (.26), and clients and caregivers (.26) concerning staff caring.

Burgio, K.L., & Burgio, L.D., & McCormick, K.A., & Engel, B.T. (1991). Assessing toileting skills and habits in an adult day care center. *Journal of Gerontological Nursing, 17*(12), 32-35.

OVERVIEW

The purposes of this study is to analyze the toileting habits of both continent and incontinent Adult Day Care (ADC) clients and compare three characteristics thought to be associated with continence: frequency of urination, mobility, and cognitive status. Results of this study indicate that incontinence is associated with mental and/or physical impairment.

NATURE OF INQUIRY

The study population was composed of forty-two clients who attended a hospital-based ADC program for homebound individuals with medical problems. Clients were considered incontinent if they wore a urine collection device or experienced two or more incontinent episodes in the previous month.

The first stage of the study (Frequency of Toileting) involved observation of the toileting habits of 26 clients (15 continent, 11 incontinent) for a period of 20 days. Each time a client entered the bathroom an observer recorded the following information: time of day, if the toileting was self-initiated, initiated by another client, staff initiated, unassisted, accompanied by another client, or staff assisted.

The next stage of the study (Mobility and Toileting skills) involved the assessment by direct observation of a toileting sequence. A total of 32 clients (19 continent and 13 incontinent – 9 men and 23 women) participated in this portion of the study. The observers recorded the amount of time that was needed for the clients to move 15 feet to the toilet, undress, and position for voiding. The observers repeated the instructions if the client failed to move for 15 seconds and also provided physical guidance if the client went in the wrong direction. The assessment was terminated if the client failed to achieve “positioning to void” even after verbal and physical prompts.

Lastly the clients were administered a Mini-Mental State exam, which assessed orientation, memory, attention, concentration, and visual-motor coordination.

COMPONENTS OF PLACE

Organization

<i>Staff</i>	The staff was involved with the toileting of clients and provided both physical help and verbal prompts (encouragement or reminders).
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Family

<i>Client</i>	The experimental group was composed of twelve men and thirty women who ranged in age from 57 to 91 years old. Clients attended the ADC program on a combination of part-time and full-time basis. The group of clients was composed of a mixture of continent and incontinent individuals. The clients all suffered from either Alzheimer's or other another form of dementia.
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<i>Physical Setting</i>	This study was performed at a hospital based Adult Day Care program that catered to homebound adults with medical problems.
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OUTCOME

Frequency of Toileting: Continent clients voided a mean of 2.6 times during their 6-hour stay, while incontinent clients voided a total of 0.9 times during their stay. Sixty six percent of the continent clients initiated self-toileting, while only eighteen percent of incontinent clients initiated self-toileting. Eighty-six percent of continent clients never required staff assistance, as opposed to 100% of incontinent clients requiring staff assistance. A possible intervention to help prevent incontinence may be a verbal prompting or scheduling of voiding sessions.

Mobility and Toileting skills: Continent clients required a total of 13 to 49 seconds (mean 24.6 seconds) to get in position to void, while incontinent clients required a total of 49 to 203 seconds (mean 115 seconds). The large discrepancy between the toileting times may be attributed to the fact that while the entire group of continent clients were ambulatory, 46% of the incontinent clients were in wheelchairs. Although all of the continent clients were able to self-toilet, only 46.2% of the incontinent clients were able to self-toilet even with verbal and physical cues. Only 5.3% of the continent clients required verbal prompting, while 76.9% of the incontinent clients required verbal prompting. Also, none of the continent clients required physical redirection, but 53.8% of the incontinent clients required physical redirection or assistance.

Mini-Mental Status Evaluation (MMSE): All of the clients completed the examination (24 continent, 18 incontinent). The continent clients had a mean score of 19.5 (range 0 – 30) while the incontinent clients had a mean score of 10.2 (range 0 – 30). A rating below 20 on the MMSE indicates significant cognitive impairment.

The results of this study show that incontinence is associated with mental and/or physical impairment. It should be noted that “mobility and toileting skill” scores provided a higher correlation with continence than did the mental status exam.

Cefalu, C. A., & Ettinger, W. H. & Espeland, M. (1996). A study of the characteristics of the dementia patients and caregivers in dementia – nonspecific adult day care programs. *Journal of American Geriatrics Society*, 44(6), 654-659.

OVERVIEW

In this study, key differences between patients and caregivers of a representative group of “dementia-nonspecific medical” versus “social Adult Day Care centers (ADC’s) with dementia-specific programming” were sought through a telephone interview questionnaire. ADC dementia and caregivers (total = 242) from medical and social (three each) non-dementia specific ADCs participated. Demographic differences were mostly associated with socioeconomic factors. Decreased function and greater number of depressive symptoms of the medical dementia patients reflected poorer health. This was supported by greater numbers of paid help and increased caregiver burden among medical ADCs.

NATURE OF INQUIRY

Two hundred and forty-two caregivers of dementia patients in three medical and three social ADC’s were surveyed by telephone. These centers were all in the Piedmont North Carolina area. Data were analyzed using descriptive statistics of all patient and caregiver variables by subtype of ADC. Caregiver information included demographic information, number of medical conditions, status of relatives, friends or other non-paid help, relationship to patient, status of paid help, employment status, and level of caregiver burden (measured by Relative Stress Scale (RSS)). Combined income levels of patients and caregivers were considered. Dementia patient variables included demographic information, function, continence status, number and type of

abnormal behaviors, transportation status, length of ADC stay, medications, ADL status and status of financial assistance etc.

COMPONENTS OF PLACE

<i>Organization</i>	Two models of ADC – the health and social models are discussed in this study. ADC is considered to meet several needs – maintaining stability, offering structure, orientation to patients, and / or meeting basic human needs.
<i>Staff</i>	Health models deliver skilled nursing services to the patients whereas social models provide only custodial care and social interaction.
<i>Family</i>	
<i>Client</i>	
<i>Physical Setting</i>	The centers included three medical adult day care centers (a free standing private day care, another located in a nursing home, and a third affiliated with a church organization) and three social adult day care centers (one affiliated with a senior citizen agency, another with a hospital and a third with a church organization).

OUTCOME

The two subtypes (social and medical) did not show any significant differences in mean ages of patients and caregivers but showed that there were race differences – more white patients and caregivers were found in medical ADCs. Patients in the medical ADC's had a shorter length of stay than patients in the social subtype – they also had significantly more education than those did in the social subtype. Dementia patients in the medical subtype were found to have a greater number of medical illnesses and also required more assistance with toileting, dressing, and bathing. They also had more abnormal psychological behaviors than those did in the other subtype. Caregivers in the medical subtype had higher education than their social subtype counterparts. Caregivers of dementia patients (medical) had significantly more burdens and gave more “yes” answers when asked whether the patient “frequently appeared depressed.”

The results indicate that dementia patients enrolled in ADCs are of advanced age, have mild to moderate dysfunction, a few illnesses and exhibit a high number of abnormal behaviors. Medical ADCs are better suited for dementia patients with greater functional and cognitive decline but are also more expensive. There is also a discrepancy in utilization – more whites are found to use the ADCs (in general). The low utilization rates by blacks are attributed to socioeconomic factors and other reasons such as failure of physicians to refer blacks for ADC services.

Cohen, U., & Weisman, G. (1990). Experimental design to maximize autonomy for older adults with cognitive impairments. *Generations, 14*, Supplement, 75-80.

OVERVIEW

This article combines research in gerontology and architecture to explain the potential of the physical environment as a resource in maintaining and enhancing the autonomy of older persons residing in institutions. The framework presented in this article defines autonomy within an environmental context and presents a set of broad principles for design.

NATURE OF INQUIRY

COMPONENTS OF PLACE

Organization

The article discusses program approaches that have consequences for autonomy of the cognitively impaired older person; ranging from a “no frills approach... tending to basic physical needs and routinely utilizing physical restraints and psychotropic drugs to control behavior” to “providing a humanizing and existentially supportive context which actively and constantly reaffirms each...patient’s right to dignity, self-esteem and happiness.” Building upon the latter end of the continuum, the article expands the notion of autonomy, placing it within its environmental context by suggesting three dimensions; 1) mobility and independence, 2) environmental control and freedom of choice, and 3) identity and continuity of self.

Staff

Family

Client

The clients in this case are elderly persons with dementia living in long-term care institutions. Dimensions of their autonomy that reflected in the use of their physical environment is the focus of this study.

Physical Setting

Design principles related to autonomy of elderly residents in institutions are summarized in five therapeutic goals:

Eliminating environmental barriers: Environmental interventions such as handrails, ramps, easy-to-operate handles and controls and providing clear and consistent information are suggested as important changes associated with elderly persons’ negotiability in their environments.

Things from the past: Providing valuable associations through familiar artifacts, activities and environments can stimulate social interaction, meaningful activity and reminiscence.

Sensory stimulation without stress: The changing needs and tolerance levels of the elderly residents are acknowledged by providing

opportunities for increasing or decreasing levels of stimulation so that sensory deprivation or overload could be avoided.

Opportunities for meaningful wandering: Wandering is seen as a meaningful activity that could be enhanced by supportive, secure and well-defined paths instead of being treated as a problem to be curtailed by physical and/or chemical restraints.

Public to private realms: A continuum of public to private realms is recommended so that people with dementia could select from a variety of spaces putting them in control of sensory and social interaction.

OUTCOME

Cohen-Mansfield, J., & Besansky, J., & Watson, V., & Bernhard, L. J. (1994). Underutilization of adult day care: An exploratory study. *Journal of Gerontological Social Work*, 22(1/2), 21-39.

OVERVIEW

In this study, caregivers that had inquired about adult day care centers and had not enrolled were interviewed. Respondents' most common reason for not using day care was that the center's composition did not exactly match their needs, especially considering the level of disability of the clients. Other reasons included cost, transportation or, another alternative.

NATURE OF INQUIRY

Four Medicaid-certified ADCs in Montgomery County, Maryland were selected for this study. The staff provided an equivalent level of care of a skilled nursing facility or an intermediate care facility. The centers provided the names of all caregivers that inquired about the ADC (by telephone or in person) during a period of twelve months prior to the study, but chose not to enroll their care-recipient. Phone interviews were conducted with 111 applicants fitting this profile. The telephone interview consisted of open-ended questions about: 1) how they found out about the ADC program; 2) conditions that prompted the inquiry; 3) benefits expected from the ADC; 4) reasons for the subsequent decision not to use ADC; and 5) whether they had utilized any other help service. The interviews were conducted by a trained gerontological anthropologist and were completed within ten minutes.

COMPONENTS OF PLACE

Organization

Staff

Family

Seventy-eight percent of caregivers were female, and twenty-six percent were male. Thirty-four percent were the care-recipient's

spouse and the remaining were others (siblings, daughters-in-law, granddaughters, nephews, niece, and friend).

Client The average age of the care-recipients (potential clients) was 77.1 years, with ages ranging from 35 to 95. Forty-seven percent were male and sixty percent were female.

Physical Setting The four ADCs were situated in Montgomery County, Maryland.

OUTCOME

Source of Referral: Half of those interviewed had found out about the ADC through a professional, 28.4% through a hospital social worker, 15.6% through a physician or nurse and 7.4% through another professional such as a non-hospital social worker. Eighteen percent found out through a public agency/organization, and a small number mentioned that they had known about ADCs for a long time. Around three percent had found out through a newspaper article or advertisement or some other reading.

Conditions that prompted inquiry: A little over seventy-eight percent inquired about ADCs because of a change in the care recipient's condition. Twenty-seven percent of the interviewees mentioned that the care recipient had been released from the hospital just prior to the inquiry. Fifteen percent of the care recipients had just relocated to the area, and 31% had deteriorated, becoming more confused. Thirty-six percent of the caregivers felt that the burden of caregiving prompted their inquiry.

Benefits sought from ADC: Expected benefits for the care recipient mentioned by the caregivers included; socialization; contentment; provision of supervision and safety for client; clinical services such as speech, physical or occupational therapy; medical monitoring; and being an alternative to the nursing home. Respite was the main benefit for the caregivers.

Reasons for not choosing ADC included *external factors* (cost, transportation problems, inconvenient hours), *participant refusal* (did not want to be in group, denied needing help, bad experience in a nursing home), *center composition* (impairment of others did not match – others too impaired, care recipient too weak, care recipient too demented, language barrier, participant social class/cultural level/racial mix, program did not contain particular service desired), *caregivers' perception of need* (caregiver felt s/he did not need help, caregiver felt it was her duty to provide care), *found a suitable alternative* (placement in a nursing home, moved care recipient to home of different family member, hired paid help, received more informal or other help), and *other reasons* (care recipient recovered/improved, care recipient is moving elsewhere, still undecided).

Change in status /other services engaged: Some clients died (11%), some relocated and went into nursing homes, others to assisted living facilities, others into group homes or a hospital, and some moved in with a different family member. Additional help was also sought by some of the respondents including home health care, paid help, and a companion for several hours a week.

Cohen-Mansfield, J., Taylor, L., & Werner, P. (1998). Delusions and hallucinations in an adult day care population: A longitudinal study. *American Association for Geriatric Psychiatry*. 6(2): 104-121.

OVERVIEW

This study examines the frequency of delusions and hallucinations (d/h) among adult day care participants and the relationship between delusions and hallucinations and demographic and medical variables. Changes in d/h were also tracked for a year and compared with changes in agitation, depressed affect and dementia. Relationships were found between d/h and all three of these variables; delusions were more prevalent and were more strongly related to agitation, depressed affect and dementia than hallucinations.

NATURE OF INQUIRY

Self-report measures, staff and relative ratings, and chart assessments of two hundred participants at five senior day care centers in Maryland were collected for this study. Family members responded via a mailed questionnaire. Delusions and hallucinations were measured by using the BEHAVE-AD scale. Hallucination was defined as “a sensory experience that occurs in the absence of actual sensory stimulation, for example, thinking one sees something that isn’t there.” Delusions were rated by a staff member and a relative and were defined as “groundless fixed ideas, a belief in something that is contrary to fact or reality.” Medical information was obtained from the physical examinations of participants (diagnosis of dementia, vision, hearing, etc.). Ratings were based on 1=does not manifest, 2=vague/not clearly defined, 3=clear manifestation, and 4=manifests with verbal/physical actions.

Staff and family were also asked to rate severity of physical pain of participants. Agitation was rated by using the CMAI-C inventory, depressed affect by the Raskin Depression Scale, and cognitive functioning by the Brief Cognitive Rating Scale.

COMPONENTS OF PLACE

<i>Organization</i>	The five Adult Day Care Centers (ADC’s) in the study were all Medicaid-certified and staffed to provide the level of care required of a skilled nursing facility or an intermediate care facility. All centers provided transportation for some of the participants.
<i>Staff</i>	Staff was asked to rate the incidence of delusions and hallucinations based on a rating scale.
<i>Family</i>	Family members were also asked to rate the incidence of delusions and hallucinations based on the same rating scale.
<i>Client</i>	Of the two hundred client participants, sixty-six percent (n=132) were female. The average age of the clients was 80, with ages ranging from 60 –97 years. A little over half of the clients were widowed, 35% were married, 6% were divorced, and 5.5% were single. Clients attended day care on an average 3.7 days for about 5 hours a day.

OUTCOME

Frequency of delusions and hallucinations: Most participants experienced at least one delusion. Data indicated that paranoid delusions and that “people are stealing things” were the most common delusions among ADC clients. The frequency of relatives’ reports regarding hallucinations were consistent with other studies’ reports; however staff ratings were found to be lower. Delusions were more prevalent than hallucinations.

Demographic and medical correlates: Women were more likely than men to experience delusions and hallucinations. Individuals with low vision were identified by staff members as having more hallucinations. Participants with hallucinations were also more likely to exhibit higher levels of agitated behavior. Also participants with dementia experienced more delusions.

Cohen-Mansfield, J., & Werner, P., & Watson, V., & Pasis, S. (1995). Agitation among elderly persons at adult day care centers: The experiences of relatives and staff members. *International Psychogeriatrics*, 7(3), 447-458.

OVERVIEW

This study explored the frequency of agitation and its symptoms in clients of Adult Day Care (ADC) and the correlation between the perceptions of the staff and family caregivers concerning the agitation of the care recipient. The data was collected from 200 ADC clients (31.5% suffering from Alzheimer’s Disease) participating in programs at 5 ADC’s in Montgomery County, Maryland. The results of the study indicate that this population frequently manifested agitated behaviors, with the type of behavior varying between the home and ADC environment.

NATURE OF INQUIRY

The study utilized the 36 item Cohen-Mansfield Agitation Inventory for Community (CMAI-C), which is an expanded version of the Cohen-Mansfield Agitation Inventory (CMAI). The CMAI-C is an assessment tool composed of 36 behavioral descriptions such as: pushing, temper outbursts, grabbing things from others, spitting, and repetitious sentences or questions. Each of the 36 behaviors was rated on a frequency scale of 1 (never manifest behavior) to 7 (several times an hour). The activity directors at each ADC and the family caregiver (mailed questionnaire) rated the behavior of the client using the CMAI-C.

COMPONENTS OF PLACE

Organization

The ADC’s that participated in this study were Medicaid-certified and provided a level of care equal to that of a skilled nursing facility. The centers received funding from Medicaid, federal, state, and local agencies.

Staff

Family

Sixty-two percent of the caregivers were the children of the client, 32.9% were spouses and 3.6% were siblings. In addition, 79.5% of

the caregivers lived with the client and 29.0% had been providing care for more than 5 years.

Client

The study population was composed of 200 ADC clients, of which 60% were female, 53.5% widowed, 35.0% married, 6.0% divorced, and 5.5% single. The participants ranged in age from 60 to 97 years in age, with a median age of 80. The ethnic composition of the study population was 87.5% white, 9.5% black, 1.0% hispanic, 1.0% asian, and 1.0% of another ethnic heritage. Cognitive testing revealed that 62% of the clients suffered some degree of cognitive dysfunction, in addition, 31.5% suffered from Alzheimer's Disease, 34% had heart disease, and 21% had a cardiovascular disorder.

Physical Setting

OUTCOME

The most common agitated behaviors as reported by both family and ADC staff were general restlessness, verbal interruptions, verbal repetitions, pacing or wandering, uncooperative behaviors, repetitious mannerisms, negativism, complaining, constant need for attention, and doesn't like anything. According to the data collected, agitated behavior occurred frequently, 62.9% of the participants displayed at least 1 agitated behavior per week in ADC. The relatives reported that 90.3% of the participants displayed at least 1 agitated behavior per week at home. The staff and family members had a general agreement on the type of behaviors, but varied greatly on the perception of frequency.

The analysis of the ADC staff data indicates that 43.6% of the agitated behaviors at the ADC could be classified as Physically Nonaggressive Behaviors (PNAB), Verbally Agitated Behaviors (VAB), and Verbally Aggressive Behaviors (VAGB). The data obtained from the family indicates that 42.3% of the agitated behaviors at home could be classified as (PNAB's), (VAB's), and (VAGB).

Conrad, K.J., & Guttman, R. (1991). Characteristics of alzheimer's versus non-alzheimer's adult day care centers. *Research on Aging, 13*(1), 96-116.

OVERVIEW

The purpose of this study was to discover the differences between Adult Day Care Programs (ADC's) which serve an Alzheimer's specific clientele and those that do not. The major difference between Alzheimer's specific and nonspecific ADC's appeared to be the increased support for families at the Alzheimer's specific centers. The Alzheimer's specific centers appeared to provide possess a higher level of service with longer hours, more transportation, ADA provisions, and a higher morale. The Alzheimer's ADC's concentrated on programming that would provide therapeutic recreation and entertainment instead of dwelling on issues of maintenance care.

NATURE OF INQUIRY

This study obtained the data from the 1986 census survey of ADC's in the United States, which used the Adult Day Care Assessment Procedure (ADCAP). The ADCAP is a dense 24 page questionnaire that was given to the onsite administrator and had a response rate of 72.3% or 974 ADC's. This study established a 30% minimum total Alzheimer's clientele to be included in the Alzheimer's Specific test category. According to the 30% minimum the total number of Alzheimer's Specific ADC's were 240 ADC (mean 51.3%) and the number Non-Alzheimer's Specific ADC's was 576 (mean 8.7%). The total number of ADC's analyzed for the study (n=816) was lower than the total completing the ADCAP, due to the absence of 10% or more of the respondent data.

The ADCAP breaks down the ADC center characteristics into structural characteristics (staff, built environment, technology) and process characteristics (services, activities). The structure category was sub-divided into (a) features that make the center more accessible and (b) physical features that promote the quality of care and quality of life. The structure characteristics included categories such as travel time, ADA provisions for safety, and urban or rural location. The process characteristics were composed of the program components that involved items such as staff-client interactions, planning / management of client care, therapies, support / education and recreation, such as counseling, entertainment, and physical therapy.

COMPONENTS OF PLACE

<i>Organization</i>	The ADCAP looked at several areas of organizational program / philosophy, such as average hours and weekend hours, marketing techniques, clinical services, care planning, physical / speech / occupational therapies, self-help, respite care, counseling / support groups, therapeutic recreation, entertainment, client education, cognitive activity, social involvement, administration control, and independence-promoting philosophies.
<i>Staff</i>	The ADCAP assessment addresses areas such as, client : staff ratios, amount of in-service training, and staff cooperation.
<i>Family</i>	
<i>Client</i>	The level of impairment concerning activities of daily living (ADL) and instrumental activities of daily living (IADL) were compared for Alzheimer's and Non-Alzheimer's specific centers.
<i>Physical Setting</i>	The physical environment was examined for aspects of pleasantness / cleanliness, disability features, safety features, provisions of transportation, and urban / rural locations.

OUTCOME

Two analysis methods were utilized, t tests and discriminate function analyses. The results obtained indicated that most significant factor distinguishing Alzheimer's ADC was increased support for families. Alzheimer's ADC's also placed a greater importance on therapeutic recreation, personal care assistance / training, and entertainment. In addition, Alzheimer's ADC's tended to have a higher morale, longer hours, more transportation possibilities, amenities for the disabled, and a more caring and pleasant atmosphere.

Conrad, K. J., & Hanrahan, P., & Hughes, S. L. (1990). Survey of adult day care in the United States – national and regional findings. *Research on Aging*. 12(1) 36-56.

OVERVIEW

This is one of the early articles outlining the structure of ADC centers and the profile of the users in the United States and across the four U.S. census regions. The survey of 1347 ADC centers used the Adult Day Care Assessment Procedure (ADCAP) a 24 page questionnaire to obtain information about the structure, client population and process of ADC. Results show a great variability in ADC characteristics across the country. Although ADCs are well staffed, well equipped, and well linked to other agencies, demand and enrollment were low.

NATURE OF INQUIRY

The ADCAP –a 24 page questionnaire obtained detailed information about the *structure* (physical – quantity and quality of materials and space, staff – client/staff ratios, numbers of staff, volunteers and students, and organizational resources – auspices, procedures, and systems), *client population* and *process* of each ADC center.

Data from 974 responses by on-site directors of centers was broken down by the four U.S. census regions – Northeast, Midwest, South and West.

COMPONENTS OF PLACE

<i>Organization</i>	ADC is described as a community based program designed to meet the needs of functionally impaired adults through an individual plan of care to provide a variety of health, social and related support services to groups of adult clients in a protective setting during any part of a day but for less than 24 hours.
<i>Staff</i>	No significant variations in client/staff ratios were noted. A little over half the respondents had regular formal training programs and seventy-four percent had a handbook for the staff
<i>Family</i>	
<i>Client</i>	Participants in ADC programs across the four U.S. census regions.
<i>Physical Setting</i>	Adult Day Care Centers in both urban and rural settings in the four U.S. census regions.

OUTCOME

The Northeast had the highest supply of ADCs per 100,000 elderly, the second highest percentage in rural settings, the highest proportions of both public and private for-profit centers and the greatest provision of transportation for clients.

The Midwest had the highest percentage of centers in rural settings, the highest percentage of private not-for-profit centers, the lowest proportion of licensed ADCs, the least in-service training, the longest hours, the lowest enrollment and number of staff, the lowest percentage of

centers with waiting lists, the lowest proportion of clients eligible for Medicaid, the least provision of transportation, and the fewest linkages to other agencies.

The South had the highest unmet demand with the highest number of client visits per week and the highest percentage of ADCs with waiting lists. This higher demand when compared to the Midwest is attributed to financial (south has the lowest personal per capita income and the lowest Medicaid rate) and seasonal (Midwest winters might discourage enrollment then, whereas the South has relatively mild winters leading to constant year-round enrollment rates) reasons.

The average age of clients was 72 years – the south had younger clients. Average number of clients per center was 39.7, a majority of whom were female (68%). Twenty percent of the clients lived alone in the community, twenty-nine percent lived with children, twenty percent with a spouse, and about thirteen percent with other relatives and friends. ADL categories with which clients needed the most assistance were bathing, caring for their appearance, and dressing; IADL categories included handling their own money and shopping.

Midwest centers had fewer core regular salaried staff, total staff and total staff hours. A majority of the respondents (79%) had in-service training programs for staff. The Midwest was the lowest with seventy-one percent and the West highest with eighty-seven percent.

Seventy-eight percent of the centers were located in urban settings – the Midwest had the highest percentage of centers in rural settings. Variation among regions was not statistically significant for averages of structural characteristics: square footage of floor space (3800 ft²), rooms for clients (3.6), offices (2.5), bathrooms (2.9), number of toilets (4.4), availability of storage space for clients (77%), furniture appropriate for the disabled (91.4%), presence of rest areas (89.6%) and entry without stairs (97.4%). The Northeast ranked high in the availability of handrails in halls and the South was the lowest

The findings establish the multifaceted nature of ADCs indicating substantial variation in ownership, licensure, number of clients and staff, demand, hours of operation, age of clients and travel arrangements. Regional differences and great intraregional variations in regulation, funding, demography and geography establish a need for explanatory studies at levels of analysis lower than national or regional level.

Conrad, K. J., & Hanrahan, P., & Wang, S. & Hughes, S. L. (1993). A medicare adult day care model: Proposed criteria and available supply. *Journal of Aging and Social Policy*, 5(4) 51-75.

OVERVIEW

This study examines the proportion of existing ADCs in 1986 that would qualify for Medicare funding under the 1989 U.S. Senate Medicare Adult Day Care Amendments. The study also proposed five criteria for Medicare and estimated the impact of these criteria on two policy-relevant subgroups of ADCs – Alzheimer's/non-Alzheimer's and rural/urban. The objectives were: 1) to determine the proportion of centers that would/would not qualify for Medicare funding under the amendments; 2) to clarify what centers would need to in order to qualify; and

3) to determine whether Alzheimer's type and rural ADCs would qualify when compared with non-Alzheimer's and urban ADCs.

NATURE OF INQUIRY

Data collected from a national survey of ADCs conducted in 1986 were used. This included information on physical and organizational resources, staff training, and client characteristics. The Adult Day Care Assessment Procedure (ADCAP), a 24 page questionnaire based on the Multiphasic Environmental Assessment Procedure (MEAP), was used in the 1986 survey to obtain detailed information about the structure of the ADC (types of services and activities provided, staffing patterns and client characteristics including functional status). Data were gathered from 974 centers.

To identify those ADC centers that would qualify for Medicare funding, three steps were followed: 1) Medicare ADC criteria that could be measured with the ADCAP database were determined; 2) Centers that met these criteria closely were identified as Medicare-fundable; and 3) Differences between fundable and non-fundable ADCs were tested for two subgroups, ADCs serving Alzheimer's clients and clients in rural areas. The five criteria selected for testing were 1) services to be provided directly (nursing care, medical social services, personal care); 2) employment of a multi-disciplinary team (registered nurse, social worker, consultants, physicians); 3) services to be provided directly or indirectly (nutrition, physical/speech/occupational therapy, medical supervision, transportation); 4) program activities (social, physical and educational); and 5) other requirements (maintenance of health records, utilization of volunteers, medical emergency procedures). ADCAP measures that would test for these criteria were selected for an analysis.

COMPONENTS OF PLACE

<i>Organization</i>	Alzheimer's vs. Non-Alzheimer's model facilities. Existing conditions at ADC's (services provided, staff consistency, etc...) in comparison to the requirements needed to qualify for Medicare funding.
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<i>Staff</i>	Prevalence of staff training and continued education (in-service). Existence of multi-disciplinary team to meet variety of client needs.
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<i>Family</i>	
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<i>Client</i>	
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<i>Physical Setting</i>	Rural versus Urban physical location
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OUTCOME

Services to be provided directly: A majority of the ADCs provided some type of nursing care. Eighty-four percent of the centers analyzed their clients' level of functional impairment; around seventy percent found it necessary to provide personal care on a weekly basis. Only fourteen percent of the centers met all criteria for services provided directly.

Multi-disciplinary team: In the multi-disciplinary team requirement, nineteen percent of the centers met the three criteria; having a nurse, social worker, and consultant in physical, speech or occupational therapy. Twenty-eight percent had a nurse and social worker while fifty-one

percent had a consultant therapist. Fifty-seven percent of centers had only a nurse and forty percent had only a social worker.

Services to be provided directly or indirectly: All five criteria were met by seventeen percent of the centers. Two-thirds of the centers met the nutrition, psychological services and transportation requirements. Forty-nine percent of the centers met the criteria of "individualized care plan by multidisciplinary team" and fifty-six percent met the provision of physical, speech and occupational therapy criteria.

Program activities: A majority of the centers met the social (85%), physical (96%) and educational (99%) criteria.

Other requirements: Fifty-three percent of the centers met the criterion of having volunteers or students for eight hours per week or more.

Alzheimer's vs. non-Alzheimer's: The hypothesis that centers serving thirty percent or more of Alzheimer's clients would meet less of the criteria was not supported. The hypothesis was based on earlier findings that Alzheimer's-type ADCs use a lower level of medical services. However, there were no significant differences between Alzheimer's and non-Alzheimer's centers. In fact, Alzheimer's ADCs scored higher on eight indicators; medication administered by staff, monitoring the care plan, assisting in personal care, provision of special and regular diets, individual, group and family counseling, therapeutic activities, physical fitness, exercise, and utilization of volunteers. The only low scoring indicator was transportation.

Rural vs. Urban centers: The hypothesis that rural centers would fare poorly on the criteria when compared to urban centers was supported on fourteen of twenty-one indicators. A lower percentage of rural centers met the criteria: medication administered by staff, drug history and review, monitoring the care plan, information and referral, analysis of ADL needs, employment of an RN or an LPN, employment of a social worker, employment of both a nurse and a social worker, provision of special and regular diets, psychiatric or psychological services, developing, monitoring and revising care plans, discharge planning, therapeutic activities, physical fitness and exercise, and utilization of volunteers and students.

The study concludes that the Medicare ADC proposals are based on an incomplete specification of the role of ADC in long-term care and that it would be more cost-effective for Medicare to build on the strength of ADCs as a community-based provider.

Conrad, K. J., & Hughes, S. L., & Hanrahan, P., & Wang, S. (1993). Classification of adult day care: A cluster analysis of services and activities. *Journal of Gerontology: Social Sciences*. 48 (3): S112-122.

OVERVIEW

This study used 1986 national survey census data of 774 adult day care (ADC) centers to determine a classification system based on measures of program services and activities, and to delineate the found characteristics on other measures of structure, process and client population.

The aim was to develop more accurate expectations about how the different ADC classes might function so that service delivery, client matching, generalizability of research findings and funding foci could be determined more effectively. Six classes of ADC centers were revealed in a cluster analysis of ten “process” measures of services and activities: Alzheimer’s Family Care, Rehabilitation, High Intensity Clinical/ Social, Moderate Intensity Clinical/ Social, General Purpose, and Low Scoring. Profiles of these six classes were described further using thirty other characteristics.

NATURE OF INQUIRY

The Adult Day Care Assessment Procedure (ADCAP) was used to obtain detailed information about the structure, client population and the process of each ADC by administering questionnaires to on-site directors in 1347 centers. Of 974 responses, 774 had usable data. Each questionnaire had four sub-scales:

- 1) Services and Activities (clinical services, care planning, rehabilitation, personal care, personal services, counseling, support for family, therapeutic recreation, entertainment, pastimes),
- 2) Social Environment (morale, staff cooperation, director control, degree of promotion of client independence, family and community involvement),
- 3) Structure (resources such as staff, architectural environment, and technology), and
- 4) Client Population (ADL and IADL levels, continence).

COMPONENTS OF PLACE

<i>Organization</i>	For the purposes of this study, measures of services and activities of ADC programs are chosen as clustering variables (unlike other variables in previous studies -- case mix, auspice and staffing characteristics) as more direct and proximal indicators of the process/ programming in the facilities.
<i>Staff</i>	The classes revealed that caseload per staff was not uniform across all ADCs—the staff in the RC had a lower caseload than the other groups.
<i>Family</i>	Services and activities involving family members such as family support groups and educational programs are considered in the assessment.
<i>Client</i>	Clients in the AFC class were the most cognitively impaired and needed more ‘maintenance’ activities than rehabilitation. In contrast, RC clients showed a higher need for rehabilitative services. Clients in HIC had more physical disabilities and mild cognitive impairment. MIC clients were cognitively intact but moderately impaired physically and required a great deal of personal care and training. The GP was more suited to clients who had mild impairments but did not require much of clinical or social services. The LC centers offered very minimal services and activities catering to clients who were fundamentally independent.
<i>Physical Setting</i>	Physical features that helped make each center more accessible, especially those promoting ‘improved quality of care and quality of life’ (page S115) are mentioned as desirable

OUTCOME

The cluster analysis of the responses revealed six distinct classes:

Alzheimer's Family Care Class (AFC): This class showed low scores in morale problems and independence-promoting approach, second lowest in communication and highest in director control. It also scored the highest in percentage of clients with Alzheimer's, lowest in total IADL score, highest in average age, second highest on percentage depressed and second lowest in total ADL score.

Rehabilitation Class (RC): This class scored lowest in client/staff ratio (indicating a lower caseload for staff), scored highest in safety, and showed no highest or lowest score on social environment scales.

High Intensity Clinical/ Social Class (HIC): This category had the highest scores on the Services and Activities Scales. It was also notable for relatively high social involvement, independence-promoting approach, and its communication. In Structure, it scored high in amenities, safety, weekday hours, enrollment, and facility space.

Moderate Intensity Clinical/Social(MIC) and General Purpose (GP): These two categories scored in the mid-range on all the characteristics, MIC scored significantly higher in caring, social involvement, and director control. MIC was also higher in inservice, pleasantness, amenities, vehicles, weekday hours, location in an urban area, advertising, and linkages.

Low Scoring Class (LSC): This class scored lowest on all scales leading to the inference that this type of ADC is of lower quality and qualifies more as a senior center program than an ADC program.

The above results suggest that it is hardly appropriate to consider ADC in generic terms – as a common set of services, activities, facilities or client populations. The AFC treated families with clients having Alzheimer's disease in smaller facilities with high morale where the director had strong control and where an independence-promoting approach was not used. The RC treated physically impaired clients in an environment with more safety features where the caseload was relatively low per staff person. The HIC was higher in structural and social features than, but very similar to the MIC and GP classes in its client population. A majority of the ADCs fell in the GP class and the MIC class.

Conrad, K. J., & Hultman, C. I., & Hughes, S. L. & Hanrahan, P. (1993). Rural / urban differences in adult day care. *Research on Aging, 15(3), 346-363.*

OVERVIEW

This study was conducted to confirm/disprove expectations that rural adult day care (ADC's) centers would be disadvantaged relative to urban centers in terms of structure and services, and that this disadvantage would be reflected in the client population. Using data from a national survey of 822 ADC centers, the study found significant differences between urban and rural

ADC centers on 23 of 42 structure, process and client measures from the ADCAP. Rural ADC centers tended to have lower enrollments and a significantly less impaired client population (supported by the fact that there were less clinical services being offered at these centers). Rural ADCs also showed less family and community involvement in activities.

NATURE OF INQUIRY

The Adult Day Care Assessment Procedure (ADCAP) which assessed forty-two measures of *structure*, *process* (services, activities and social environment), and *client characteristics*; there were significant differences on twenty-three measures. Discriminate analysis was used to determine which variables were the most important discriminators between rural and urban centers.

COMPONENTS OF PLACE

<i>Organization</i>	The provision of services in rural areas is considered to be fundamentally different from service delivery in urban areas because of the ecological, organizational, economic features of the places and the attitudes of the rural elderly. It is also assumed that these centers function under conditions of low population densities, lack of public transportation, limited economic and organizational resources and disproportionately low percentage of federal and state funding.
<i>Staff</i>	Rural centers had a low client/staff ratio and also had lesser on-the-job training programs for staff.
<i>Family</i>	Family involvement was minimal in the rural centers – the numbers indicate that most clients lived alone and the centers substituted as surrogates providing services that families would normally do.
<i>Client</i>	
<i>Physical Setting</i>	Rural and urban ADCs were assessed by features such as pleasantness of the interior environment, amenities for the disabled, and size in square feet of floor space.

OUTCOME

Rural centers had a significantly lower ratio of clients to regular staff while the urban centers employed more volunteers and students. Rural Centers also had fewer on-the-job training programs for the staff, provided less transportation (indicating either fewer vehicles or lower enrollment on weekdays), and had shorter waiting lists. Clients were younger, less impaired and poorer in the rural centers and a greater percentage of these clients lived alone in the community. Urban centers had a higher percentage of clients who lived with children; the clients were older and a greater percentage had Alzheimer's disease.

Scores on some of the physical features such as pleasantness of the interior environment, amenities for the disabled, safety, and size in square feet of floor space did not reflect any significant differences between rural and urban centers. Rural ADC administrators reported less care planning, less physical, speech and occupational therapy, less personal care and training, less counseling, less therapeutic recreation and less entertainment. Rural centers scored significantly lower on activities that including toileting, grooming, training in ADLs and reality orientation. However they scored high on the family-type services scale indicating that they

tended to more of the things that a family would normally do for the clients -- such as bathing, laundry, help with banking, and twenty-four hour and weekend care. However they showed low scores on the ADC center's interaction with family members, that is, support for families. This indicates that the clients are functional enough to live independently but have difficulty with certain types of tasks and do not have home caregivers readily available.

Thus there were fewer clients, fewer staff, fewer linkages to other agencies, fewer services and activities and a less physically dependent client population in rural ADC programs. However contrary to expectations and results in previous studies, the number of clients/full time equivalent employment and family-type services scored higher in rural ADCs.

Cox, N.J., & Reifler, B.V., & Yates, K. (1998). Building adult day center census by preventing premature terminations. *American Journal of Alzheimer's Disease*, 5-6, 124-130.

OVERVIEW

The purpose of this study was to uncover the reasons behind the terminations (dismissal from the program) of Adult Day Care (ADC) clients. In addition to discovering the reasons, the article provides possible solutions to help prevent or postpone termination of clients from an ADC program.

NATURE OF INQUIRY

This investigation followed the termination patterns of 53 Adult Day Care Centers (ADC's) for a period of 39 months. Each ADC submitted a quarterly report containing the number of terminations and the reasoning for each based on a subscribed list of 13 reasons: institutionalization, functional decline, death, client absenteeism, medical illness, moved away, caregiver noncompliance, program doesn't meet needs, unmanageable behavior, financial reasons, improvement in functional status, seasonal attendance, transportation problems, or unknown. Once the data concerning cause of termination was gathered, it was categorized according to the possibility of prevention. The three categories of prevention are good potential for improvement, moderate potential for improvement, and little or no potential for improvement.

COMPONENTS OF PLACE

Organization

Staff

Family

Client

The clients involved in the study included individuals with Alzheimer's or related disorders (average 70.5%), mental retardation/developmental disorders, chronic mental illness, and/or physical problems.

OUTCOME

According to the data collected, six reasons for termination accounted for fully 80% of the total terminations: institutionalization (27.4%), functional decline (13.7%), death (11.6%), client noncompliance (10.7%), medical illness (9.2%), and moved away (7.4%).

The termination categories considered having the greatest potential for improvements were as follows: institutionalization (27.4%), client absenteeism (10.7%), and financial reasons (1.9%). Institutionalization may be avoided by providing greater caregiver support opportunities and marketing to attract earlier enrollment in ADC programs, thus increasing the duration of enrollment. Client absenteeism may be helped by providing activities directed toward client interests and establishing a mentor system to help acquaint new clients with the program. Caregiver education may also help promote attendance by instructing the family how to better communicate with a loved one suffering from Alzheimer's Disease. Financial incentives for attendance such as prepayment billing or discounts for multiple day attendance might also be employed. Termination due to financial reasons may be helped with the establishment of scholarships or endowment funds.

The termination categories that had moderate potential for improvement are as follows: functional decline (13.7%), family noncompliance (4.7%), unmanageable behavior (3.1%), and transportation problems (1.1%). Termination due to functional decline may constitute a reason to increase the scope of the ADC's program. If a large number of clientele are discharged due to functional decline, the ADC may consider expanding to meet the growing need. Family noncompliance usually results from a desire to keep the loved one at home. ADC caregiver education may help alleviate this situation by promoting socialization and therapeutic benefits to the client, in addition to respite for the caregiver. Unmanageable behaviors such as wandering, verbal or physical abuse, socially inappropriate behavior, and incontinence may be lessened or eliminated through staff training in handling these issues. Transportation problems may be handled through the use of local services such as county transports or establishing a car pool.

The final six reasons for termination, which fall under the little or no potential for improvement category, include; death (11.6%), medical illness (9.2%), moved away (7.4%), program doesn't meet needs (3.2%), improvement in functional status (1.8%), seasonal attendance (1.3%). Only one of these six reasons is under the possible control of the ADC. The "program doesn't meet needs" reason occurred as a result of discharge to a mental health or retardation facility, this small percentage 3.2% may be reclaimed if the ADC expanded its range of services.

It should be noted that this study ignored the impact of the physical environment on client terminations.

Curran, J. S. M. (1996). The impact of day care on people with dementia. *International Journal of Geriatric Psychiatry*, 11, 813-817.

OVERVIEW

Adult Day Care (ADC) has potential benefits for both caregivers and care recipients. This study examines the impact of ADC on clients suffering from Alzheimer's disease or another form of dementia. Results indicate that 42% of the ADC clients showed significant improvement in mood and/or behavior as a result of attending ADC.

NATURE OF INQUIRY

This study focused on the responses of 19 caregivers concerning the behavior of care recipients enrolled in ADC. After enrollment in the ADC program the clients were assessed with the Mini Mental State Examination (MMSE) which indicated the presence of dementia. The caregivers were interviewed (within three months of initial attendance) to obtain self-demographic data, along with the demographic data of the client. The caregivers were asked to complete three evaluation surveys of the client; the Crichton Royal Behavior Rating Scale (CRBRS), the General Health Questionnaire (GHS), and the Beck Depression Inventory (BDI). Comparison data were obtained by interview of the caregiver following 6 months of care recipient participation in the ADC program.

COMPONENTS OF PLACE

<i>Organization</i>	The ADC program is designed to serve a maximum of 15 clients and is open 5 days a week, with 5 hours on Saturday.
<i>Staff</i>	The center is staffed by a day care coordinator, three care assistants, and three volunteers.
<i>Family</i>	The family caregivers (n=19) provided information about the clients behavior and any changes as a result of participation in the Adult Day Care program.
<i>Client</i>	All clients (n=19) involved in this study suffered from dementia and other physical impairments.

Physical Setting

OUTCOME

The results indicated that 42% of the caregivers noted an improvement in client behavior and / or mood at home. The caregivers attributed this improvement to attendance at the Adult Day Care Center. It was discovered during the second interview that most clients continued to show improved behavior and / or mood (9 months after enrollment). All of the clients who showed significant improvement were female and had less of a cognitive impairment than female non-responders.

Gutkowski, S., & Guttman, F. (1992). Program and process: Designing the physical space of a day hospital. *Israel Journal of Psychiatry Related Sciences*, 29(3), 167-173.

OVERVIEW

Changes in the method and purpose of mental health care have resulted in alterations of the care environment. This article discusses the trend toward outpatient mental health care, which promotes interaction with family and the community. This trend has resulted in the alteration of mental health facilities, which is demonstrated in this article. The day hospital staff wanted to redesign the space to establish an environment to promote human interactions, self-esteem, security and development of interpersonal skills.

NATURE OF INQUIRY

The redesign of the day hospital is discussed in a general format, with specific detail given to colors and light, reception area / defining boundaries, assigning therapeutic goals to various spaces, and interaction between staff and patients.

COMPONENTS OF PLACE

Organization The activities at the day hospital may include group therapy, psychotherapy, family intervention, occupational therapy, psychodrama, and so forth.

Staff A mixture of professionals (nurses, doctors, psychologists, occupational therapists, and general assistants) constitute the multidisciplinary team at the day hospital.

Family

Client The clientele of this outpatient mental health facility consisted of 30 clients (male and female) who were undergoing treatment for acute crisis's and general rehabilitation.

Physical Setting *Colors and light:* The facility was painted in light, bright colors, and new lighting was installed to create a positive hopeful environment.

Reception area / defining boundaries: The entrance hall allowed access to two separate facilities, the day hospital and the rehabilitation ward on the second floor. A small wall (short in length) was added to the entrance hall, which provided the patients and staff of the rehabilitation ward with a separate entrance. Due to this change, the reception area for the day hospital became a useful multi-purpose room.

Assigning therapeutic goals to various spaces: The main room provides space, privacy, and a visual connection to the garden and is used for group therapy sessions. The living room was established with the addition of comfortable chairs, large rug, and a piano for live musical performances.

Interaction between staff and patients: The therapy rooms are located on two floors, which promotes the difference between “private” and “public” therapy. The psychologists offices are located below grade, which helps reinforce the private confidential nature of the therapy. The main floor however is composed of rooms meant for group therapy or open informal discussion between patients and staff.

OUTCOME

This article expresses the importance of a synthesis between therapeutic policy and the physical environment to achieve a task, in this case mental recovery or rehabilitation. Minimal architectural changes such as painting, boundary definition, and personalization of the environment can have important benefits (Minimum effort – Maximum result).

Guttman, R.A. (1991) *Adult day care for alzheimer's patients: Impact on family caregivers.* New York: Garland Publishing, Inc.

OVERVIEW

Doctoral dissertation which focuses on Adult Day Care (ADC) program, family caregivers' burden of care, and factors leading to institutionalization. The results substantiate the benefits of day care, which include more relaxation, less caregiver burden, greater social contact, and pursuit of personal interest.

NATURE OF INQUIRY

The information was generated from a doctoral dissertation. The data was gathered from questionnaires administered to 118 female caregivers in two experimental groups (day care vs. no day care).

COMPONENTS OF PLACE

<i>Organization</i>	ADC programs provide respite for family caregivers and can be seen as cost effective by improving caregivers' physical, financial and emotional well being.
<i>Staff</i>	
<i>Family</i>	The social support network has both informal and formal components. Topics examined include nature of caregiver stress (caregivers burden) and the desire to institutionalize.
<i>Client</i>	Thirty to eighty percent of the clients involved in the study suffered from one form of dementia or another. The length of involvement in Adult Day Care programs ranged from five months to thirteen years.
<i>Physical Setting</i>	

OUTCOME

The results indicate that caregivers who utilize the services of Adult Day Care experience more relaxation and less levels of caregiver burden. The clients of Adult Day Care have greater social contact and the ability to pursue personal interests. Caregivers with high levels of stress (caregiver burden) showed a greater desire to institutionalize the care recipient.

Hasselkus, B.R. (1992). The meaning of activity: Day care for persons with alzheimer's disease. *American Journal of Occupational Therapy*, 46(3), 199-206.

OVERVIEW

This study attempted to understand the meaning of daily activities at an Adult Day Care Center (ADC) for clients with Alzheimer's disease and the experience of being a staff member. The article illustrates the realities of activity planning and staff roles at ADC's. The reality is that activities and the role of staff mostly concentrate on activities concerning ADL's and prevention of harm, which take precedence over activities involving either rehabilitative or therapeutic goals.

NATURE OF INQUIRY

This four-week study involved participant observation, interviews with staff, and document review. During the first and second week of the experiment the researcher served as a staff person during the mornings and afternoons respectively. The researcher served as a full time ADC staff member during the third and fourth week. Ethnographic interviews were also conducted during the fourth week with the certified occupational therapist assistant, the nurse's aide, and the site coordinator. The open-ended interviews concentrated on the perceptions of the staff concerning the daily routine, feelings about the activities, and their idea of a "good" versus "bad" day. The documents collected for review included intake forms, informational flyers, assessment forms, weekly planning charts, and card files on clients.

The study focused on four areas: structure of the daily activities; meaning of that structure to staff; staff-client interactions; and obvious and subtle guidelines for behaviors and routines during the day.

COMPONENTS OF PLACE

Organization

This article infers ADC's organizational philosophies based on program activity types. The activities are discussed in reference to maintenance versus therapeutic philosophies. The maintenance ADCs deal only with ADL's while the therapeutic ADCs hope to restore or partially rehabilitate the client to his/her highest possible level of functioning.

Staff The staff consisted of six professionals; a nurse, nurse's aide, social worker, certified occupational therapist assistant, and a program specialist / site coordinator.

Family

Client The number of clients varied from 7 to 14 on any given day of the week. A full attendance at the center would consist of 17 clients (3 men, 14 women) who all suffered from Alzheimer's Disease or another form of dementia.

Physical Setting This ADC was located in a midwestern city, in a church on the edge of a residential area and was designed to handle clients in the mid to late stages of Alzheimer's Disease or related dementia.

OUTCOME

According to the data collected the activities at an ADC can be summarized into the following categories: preventing harm, keeping it calm, catching trouble early, keeping people together, using separate tables, toileting, booking, and providing some meaningful purpose.

Preventing Harm: The goal of preventing clients from harming themselves or others was the most prevalent issue in the ADC setting. This guiding principle can be seen in the structured and organized activities. Possible scenarios to prevent include clients becoming extremely agitated, exhibiting socially inappropriate behaviors, physical aggression, and wandering out of the building.

Keeping It Calm: The ADC environment was kept calm, avoiding activities that resulted in mental or physical over exertion. The ideal activity would provide mental stimulation, but not coerce the client into agitation and frustration.

Catching Trouble Early: The ADC staff displayed an ability to predict when a situation may result in an inappropriate social behavior or disruption. The staff needed to keep constantly alert for situations, which may involve intervention and redirection.

Keeping People Together: This is in reference to the behavior control practice of keeping as many people as possible engaged in group activities. If a group activity was working well, the staff may extend the allotted time for the activity. A group activity was advantageous because it allowed easier surveillance over the client behavior and activities.

Using Separate Tables: Sometimes it was necessary to separate an individual from the group activities due to agitation or unpredictable behavior. This separation may involve movement to another part of the room or another room in general. The staff usually tried to engage the client in another activity separated from the group.

Toileting: This term was used to describe the bathroom practices of the clients. Toileting had the largest potential for problems associated to it. The staff spent a lot of time in this area, due to its unpredictable nature and the need for individualized attention.

Booking: The activity which the ADC staff wanted to avoid at all costs was "booking", which is the elopement of a client from the center. All the activities were designed to help prevent elopement from the center.

Providing Some Meaningful Purpose: The underlying goal of the activities at the ADC were not only to facilitate the general program, but to also provide some meaning and purpose to the daily routines of the ADC.

This article informally discusses the behavior of clients during the observation period. The behaviors range from agitation to lack of social interaction. Possible causes of problematic behavior such as lack of control over the environment are also discussed. The article discusses staff roles in activities in association with the desire to maintain a safe environment. The discussion of staff roles (interviews) involves a control versus over-control philosophy, which lead to the issue of client autonomy.

Hasselkus, B. R. & Labelle, A. (1998). Dementia Day Care Endings: The Uncertain Limits of Care. *Journal of Applied Gerontology*. 17(1) 3-24.

OVERVIEW

The purpose of this study was to understand the satisfaction / dissatisfaction of staff experience of endings (period of time surrounding and including the final day of participation for a day care client) of dementia day care. Interviews with a random statewide sample of dementia day care staff yielded narratives of especially satisfying / dissatisfying experiences of care. The study found that experience of endings of dementia day care are shaped by Western ideologies of the 'good' of community care versus the 'bad' of institutional care. Also, endings proved to be a salient aspect of staff's experience that had not received due attention.

NATURE OF INQUIRY

Fifty day care centers were selected as a random sample from members of the Wisconsin Adult Daycare Association. Forty-two staff members were interviewed from forty facilities (whose directors agreed to participate in the study). The question in the phenomenological interview that usually lasted 20 to 45 minutes was, "Think back over your practice and describe an especially satisfying [dissatisfying] experience in your adult day care for people with dementia." The tape recorded and transcribed interviews were analyzed through preliminary coding and second call-back interviews initiated in an attempt to clarify details and allow for further articulation of emergent themes.

COMPONENTS OF PLACE

Organization

Staff

The staff members who were interviewed ranged in age from 28 to 66 years and held different positions; 25 were program coordinators or directors, 6 were activity directors. Except one, all respondents were female and had various professional backgrounds; nursing, social work, music therapy, occupational therapy, physical education, and recreational therapy.

Family

Client

Physical Setting

OUTCOME

The results indicate that uncertainty about the limits of care shrouds the process of dementia day care. The endings of dementia day care occurred either by the death of the day care client or by the termination of the client's participation (by family, staff and / or client). The death of a client was on occasion a deeply satisfying end to dementia day care, or a hoped-for ending or a goal of care. However, termination of participation was considered equivalent to losing a client and was more likely to be a dissatisfying experience.

Three main dimensions of endings were discovered in both satisfying and dissatisfying experiences during the analysis;

Capacity: The capabilities of the staff and the family to cope with problems and obstacles, to continue with care and the functional capacity of the client appeared to be challenged in statements by the staff and hinted at the uncertain limits of care.

Ethical dilemmas: Statements regarding uncertainty of doing more harm than good also emerged in several interviews. The fact that day care may be detrimental to the client was a prospect that was difficult to accept by the staff especially because it led to a decision to terminate care.

Working together: There were also statements conveying a sense of partnership between family members and staff in maintaining care and functional status of the client.

The study concludes by urging caregivers to examine their ideologies of care and be open to redefining their roles in community and institutional care. It also calls for special training measures to increase the caregivers' capacity to meet the demands of their profession.

Hedrick, S., & Johnson, R. J., & Inui, T. S., & Diehr, P. (1991). Factors associated with participation in a randomized trial of adult day health care. *The Gerontologist*. 31(5) 607-610.

OVERVIEW

This study was a part of another congressionally mandated study in which the medical efficacy and cost effectiveness of adult day health care (ADHC) was evaluated as an alternative to nursing home care for chronically ill elderly veterans. It gathered data through standardized interviews with potential ADHC participants during 18 months of recruitment in order to obtain a 'profile' of ADHC participants and compare their characteristics with non-participants. The findings revealed that participants were more likely to be in nursing homes and home care at referral and have more behavior problems - contrary to the study's assumption that those in most need of ADHC, (that is, frail and isolated elderly who extensively use the health care system) are

also the most unable or unwilling to enter the ADHC program. The results inform policy and practice decisions and helps optimize utilization of ADHC services.

NATURE OF INQUIRY

Data was collected at four Department of Veterans Affairs Medical Centers at Little Rock, Arkansas; Miami, Florida; Minneapolis, Minnesota; and Portland, Oregon. Patients were screened by specially trained nurses to determine whether they met the department's regulations for eligibility for the program and at least one of the program criteria (described in Clients below). Participation was sought from eligible participants and their caregivers and those thus enrolled were randomly assigned to receive either 1) ADHC services or 2) care they would have received otherwise.

Four variables formed the basis of data collection:

- 1) The referral process -- the discipline of referring staff, whether the patient was a hospital inpatient, in a nursing home or in a home care at the time of referral.
- 2) Demographic and health status -- age, gender, race, type of current residence (private home vs. other), mobility (independence in walking or wheeling at least 50 feet), car transfer (independence in getting in and out of vehicles) and dependence in activities of daily living (bathing, feeding, dressing, toileting, transfer or continence)
- 3) Patient's living situation -- marital status, number of children, number residing in the household, and number of months at residence.
- 4) Caregiver information -- availability, identity (spouse or other), caregiver's self-rated health and level of independence in instrumental activities of daily living (described above in Family) and assessment of patient behavior by caregiver.

COMPONENTS OF PLACE

Organization

Staff

Family

When caregivers were available, they were asked to self-rate health, their level of independence in the instrumental activities of daily living (IADLs such as preparing meals, housework, shopping, taking medicine, managing money etc.), and also assess patient behavior problems (such as confusion, wandering, interrupted sleep etc.)

Client

The referred clients were screened to determine whether they met at least one of the program appropriateness criteria: 1) currently reside in or admitted to a hospital from a nursing home, 2) use personal assistance or supervision for ambulation, toileting or dressing, 3) bowel incontinence, and 4) significant cognitive impairment.

Physical Setting

OUTCOME

Data from participants (those who signed the informed consent) and non-participants were analyzed using regression analyses and chi-square tests. The results of the study indicate:

- 1) Participants were significantly less likely to be hospital inpatients at referral than non-participants, but significantly more likely to have been enrolled in a nursing home at admission than were non-participants.

- 2) Participants were more dependent on caregivers for IADLs than non-participants although both groups did not show major impairments.
- 3) Participants had more behavioral problems as rated by their caregivers than did non-participants.

The best predictors of participation were not being in a hospital, and having more behavior problems.

The study concludes that recruitment of patients in nursing homes and home care programs might yield better results than recruitment from patient wards. Higher impairments in participants' caregivers (IADLs) indicate that ADHC meets caregiver needs as well. Thus patients whose caregivers require assistance may have a role in convincing patients to participate.

Henry, M. E., & Capitman, J. A. (1991). Finding satisfaction in adult day care: Analysis of a national demonstration of dementia care and respite services. *Journal of Applied Gerontology*. 14(3): 302-320.

OVERVIEW

This study examined the effects of adult day care (ADC) operational choices on the satisfaction of informal caregivers. Cognitive, behavioral and affective components of satisfaction of caregivers were examined at ten study sites (selected for participation in the Robert Wood Johnson Foundation's national demonstration of Dementia Care and Respite Services (DCRS)). Perceived affordability, length of stay, intensity of use, and caregiver wellbeing were used as measures of satisfaction. The results indicate that program operational choices about nursing approaches, respite services, and activities programming had direct and indirect effects on satisfaction. Although operational choices made by ADC were found to influence consumer outcomes, no single choice could account for consumer satisfaction. Moreover, dementia status was not considered as a strong predictor of satisfaction.

NATURE OF INQUIRY

At ten sites that were part of the DCRS demonstration selections, 312 pairs of caregivers and care receivers were examined for *cognitive* (does the caregiver think ADC is a good deal?), *behavioral* (do the caregiver and care receiver stay with the program and use a high level of ADC service) and *affective* (does the caregiver feel better about being a caregiver) components of satisfaction. The ten sites provided weekday ADC and a combination of expanded services (evening/weekend hours, overnight care, service coordination, case management and/or caregiver skills training) to both dementia and non-dementia elderly.

ADC operational choice measures (activities programming, nursing and respite goals) were self-assessed by ADC directors, researchers assessments based on site visits and data collection, and a rating based on observable criteria. The study expected that caregivers would be more satisfied by programs that emphasised three main objectives. The first was programs that chose to emphasize the growth and development of participants rather than those that simply

encouraged social participation and conflict avoidance (activities programming). The second desirable quality was, programs that proactively attempt to maximize the health status of participants rather than those limited to avoiding risks to health and safety (nursing approach). Lastly that caregivers would look for programs that maintain strong supportive relationships with caregivers (routinely reaching out to them in times of need).

COMPONENTS OF PLACE

<i>Organization</i>	The purpose of the DCRS program was to expand ADC and other community services for people with dementia to demonstrate that ADC centers could provide or coordinate required services. It also assessed the financial viability of this activity for the Robert Wood Johnson Foundation. The study views consumer satisfaction as a consumer attitude that affects service utilization levels and not just the choice of ADC as a service.
<i>Staff</i>	Staff are an integral part of the ADC experience -- the extent to which staff have and use their knowledge of individual participants in activities sessions, and their degree of contact with caregivers for ongoing supportive experiences are considered during the assessment of ADC program measures and consumer satisfaction.
<i>Family</i>	Caregivers' (sometimes spouses) needs, preferences and satisfaction are considered an important aspect of the viability and longevity of ADC services.
<i>Client</i>	The clients are both dementia and non-dementia participants in ADC services with a range of chronic care needs. Their age, gender, and health status (measured by ADL (Activity of Daily Living) levels, dementia status, hospital or nursing home placement, etc) constituted care receiver characteristics in this study.

Physical Setting

OUTCOME

The study found that ADC operational choices influenced affordability, utilization and discharge but not caregiver well-being. Regardless of dementia status, consumers (especially when the caregiver was a spouse) in programs with activities to promote growth and lifelong learning showed higher use of ADC and lower discharge rates than other programs without such activities. Also, participants in programs that saw respite as ongoing, proactive support and interaction with caregivers were less likely to be discharged. Caregivers in programs that pursued nursing goals to maximize good health were more likely to be satisfied with the price of ADC but used less care. Dementia status was positively associated with increased levels of both cost and care provision both but not with the perceived affordability or utilization.

The study outlines several policy and practice implications and emphasizes details of ADC programming with a sharper look at program operation, fiscal, and management practices. Assumptions are questioned concerning what is best for the consumers - e.g. study findings of higher discharge and lower utilization rates in medically oriented ADC programs suggest concern about over reliance on health care to satisfy consumers. The research acknowledges the task of assessing customer satisfaction which is complex and dynamic in nature.

Hensley, A. D., & Travis, S. S. (1997). The provision of staff development programs in adult day care centers. *The Journal of Continuing Education in Nursing*, 28(4), 173-180.

OVERVIEW

This study used a multi-step survey design to compare existing center programs with research and practice-derived model staff development program for orientation, in-service education and continuing education opportunities. It was found that thirty-seven percent of the responses described staff development activities that satisfied the criteria for a model program. Centralized or regionalized programming is recommended in order to address unmet staff training issues.

NATURE OF INQUIRY

The survey was sent to administrators of all licensed adult day care centers in the State of Virginia. Of the forty-two centers, thirty-eight were eligible to participate. The survey consisted of three parts focusing on 1) center and staff characteristics (e.g. size, average number of daily participants, hours and days of operation, total operating budget, for-profit/not-for-profit, center ownership, length of time in operation), 2) budget and other components of the staff development program, and 3) the meaning of staff development from the administrator's perspectives.

COMPONENTS OF PLACE

<i>Organization</i>	In-service programs, other aspects from center characteristics.
<i>Staff</i>	Staff characteristics of the different centers are described below in Outcome.
<i>Family</i>	
<i>Client</i>	Average number of total daily participants was less than 20.
<i>Physical Setting</i>	

OUTCOME

Center and Staff characteristics: Half of the centers surveyed had fewer than twenty participants per day. Ten centers reported that staff to participants ratio was higher than required by the state licensure laws. The remaining centers reported the minimum ratio and determined this according to the level of need of the population being served. Eighty percent of the ADCs had a full-time director, only thirty-seven percent had a full-time assistant director.

Programs offered: One-third of the ADCs provided six in-service programs in six months based on adult day care center information (inclement weather procedures, documentation, personnel policies, and team building), general safety (lifting techniques, assistance with activities of daily living, fire safety, infection control and federal occupational safety standards), and aging issues (programs on death and dying, care of the visually handicapped, nutrition and the elderly, dementia and abuse, neglect/exploitation).

Budget issues: Forty percent of the ADCs did not have a specific budget allocated for staff development. Half of the ADCs allocated one percent of the total operating budget for educational activities.

Overall the staff of ADCs were found to wear many hats based on need. Therefore no one person is able to give more than split time and attention to the process of staff development. Also the designated coordinator may not have any knowledge of or background of staff training issues. The study concludes with recommendations for centralized or regionalized programming as two viable solutions for addressing staff training issues.

Kirwin, P. M. (1991). *Adult Day Care: The Relationship of Formal and Informal Systems of Care*. New York: Garland Publishing.

OVERVIEW

This study describes and explains the complementary roles of Adult Day Care programs and primary groups (family and friends) in meeting the community needs of dependent elderly. The purpose of the study was to examine 1) client factors associated with being at-risk of institutionalization, 2) caregiving tasks performed by ADCs and the informal system of caregiving, 3) total cost of publicly funded social services received by the population through area agencies on aging, 4) the extent to which the formal system of care (ADC) succeeds over time in working with the informal caregiving network to maintain the frail elder in the community, and 5) to test Litwak's theory of complementary roles at the community level.

The results indicate that assistance with instrumental activities of daily living were more indicative of at-risk factors associated with ADC use than physical activities of daily living. Both the ADC and the informal system of care provided the clients with a wide variety of tasks. All program officers interviewed felt that ADCs delayed institutionalization and reduced caregiver stress. The data also revealed that ADC and family caregiver roles were more parallel than complementary unlike Litwak's theory.

NATURE OF INQUIRY

Adult Day Care programs in three southeastern Pennsylvania counties were studied in four phases; these agencies provided funds to 639 adult day care participants through fourteen programs. Characteristics and other assessment data of 159 randomly selected service recipients were collected from the ADC program records for fiscal year 1986-1987. A structured data collection instrument was used in this phase. The second phase involved a structured mail survey designed to gather administrative program details from each agency. A third phase comprised of semi-structured field interviews with randomly chosen family caregivers (who were willing to participate) to determine reasons for using ADCs, their service needs, technical and routine qualities of their caregiving, employment and health status of caregivers etc. The final phase was a structured survey mailed to ADC directors in the three counties. It was designed to gather information on patterns of participant utilization, aspects of program technicality and routinization, levels of staff education, services offered, program model indices, and location of participants who had left the program since the study year.

COMPONENTS OF PLACE

<i>Organization</i>	The study regards ADCs as formal components of the caregiving process for elderly who are considered at-risk for institutionalization. Both medical and social models of ADCs are a part of the study sample taken from four counties.
<hr/>	
<i>Staff</i>	
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<i>Family</i>	It was usually through the family member's contact that ADC clients were led to participate in ADC programs, that is, family caregivers sought the assistance of ADCs. Most often, client participation in ADCs was a result of a social work case assessment initiated by caregivers contacting the area agency on aging. Half of the caregivers were employed and ranged in age from 32 to 83 years.
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<i>Client</i>	The typical ADC participant in this study was a widowed/single 78 year old female client, with a median income of \$600 per month and living with a family member, usually a daughter.
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<i>Physical Setting</i>	The ADCs in this study are located in the southeastern counties of Chester, Delaware and Philadelphia in Pennsylvania.

OUTCOME

Client factors associated with being at-risk of institutionalization: Seventy percent of the study's population was at moderate-to-high risk of institutionalization. It was found that the number of instrumental activities of daily living (IADLs) appeared to be a more powerful measurement of at-risk factors than decline in physical activities of daily living (ADLs). That is, those who could not shop or cook for themselves were considered unlikely to maintain good physical health and therefore at higher risk for institutionalization. Thirty-three percent of the clients required assistance in three or four ADLs and in at least one IADL, putting them in the high risk category. Thirty percent of the clients did not require any assistance and were considered a low risk of institutionalization, while another thirty percent required help with one or two ADLs and at least one IADL making them moderately at-risk of institutionalization.

Caregiving tasks performed by the formal (ADC) and informal caregiving systems: Caregivers performed a wider variety of tasks than the ADC program staff. The informal caregiving network comprised of family and friends primarily provided assistance with shopping, cleaning, laundry, and financial activities. Although both systems provided personal care and emotional support, neither assisted with home repairs.

Total cost of publicly funded social services received by ADC participants through the area agencies on aging: The cost for one ADC program day ranged from \$10.25 to \$42.88. The clients received very few additional social services; participants in Philadelphia County received more services than the other counties. Clients at a higher risk of institutionalization received care from a medical model of ADC that was found to be lower cost than the social model ADCs.

Extent to which ADCs and informal caregiving systems are able to maintain elder within community: Ninety-one percent of clients lived with a caregiver. The study found that this made the difference between remaining within the community and institutionalization, because nearly

seventy percent of the clients were actually at a high risk of institutionalization. The ADCs provided respite for the caregivers, especially those who worked.

Litwak's theory of complementary roles at the community level: This theory suggests that formal organizations (such as ADC) and primary groups (family/friends) manage complementary aspects of the same goal; that ADCs would handle the routine predictable events which require technical knowledge and the informal caregivers would handle the non-uniform unpredictable events which require everyday knowledge. However the study found that the two systems worked in parallel rather than complementary ways; ADCs primarily served as respite for the caregivers who actually provided care in almost the same areas as the ADC and in fact for longer periods of time.

Kirwin, P.M., & Kaye, L.W. (1991). Service consumption patterns over time among adult day care program participants. *Home Health Care Services Quarterly*, 12(4), 45-58.

OVERVIEW

This study had two goals (a) discover what the extended pattern of service consumption is for Adult Day Care (ADC) clients and (b) which of the services are performed by ADC staff or contracted to an outside agency. Results of the study indicated that the pattern of service use changes with length of enrollment in the ADC program. Surprisingly, the services experienced both an increase and decrease in frequency of use over time. The most contracted services tended to be specialized or professional in nature.

NATURE OF INQUIRY

The data was gathered by three methods, file review (N=290), survey questionnaires (N=59), and face to face interviews with clients (N=67, N=54), respectively. The file review consisted of current and former ADC clients and this information was used to assess the change in service needs over time. The survey questionnaires were given to the directors of the 59 ADC's and the data was used to establish the Activity Index and part of the Service Provision Index. The interview data was used along with the program director responses to complete the Service Provision Index.

The functional abilities of the clients were determined based on analysis of physical activities of daily living (PADLs), instrumental activities of daily living (IADLs), emotional and intellectual status, and social participation.

A modified version of the Service Provision Index (Kaye, 1982) was used to assess the type and frequency of services provided and any change over the assessment period by the formal (ADC staff) and informal (family) network of caregivers.

An Activity Index (Von Behren, 1986) was also used to determine the number and type of services provided by in-house services and those contracted to outside agencies.

COMPONENTS OF PLACE

<i>Organization</i>	The Service Provision Index compared the frequency of provision of 19 services either from Formal (ADC's) or Informal (family) caregivers. The 19 services included activities, such as laundry, serving a meal, companionship, simple nursing tasks, and so forth.
<i>Staff</i>	ADC's services may be provided by the staff or contracted to outside parties. It was assumed that the Adult Day Care staff would perform less technical or professional activities, while the contracted services would be more technical and professional in nature.
<i>Family</i>	The family was discussed in terms of the type and frequency of services provided to the client by a family caregiver. Families provide a broader range of services than do ADC's, with the family more likely to perform such tasks as shopping, cleaning, laundry, and financial assistance.
<i>Client</i>	The majority of the clients (61.5%) were female and the mean age was 76.6 years old with a range of 54 - 98. If the client did not live with the caregiver, 55% lived within 5 miles, 27.3% within 6-10 miles, and 3% over 11 miles from the caregiver. The consumption of services over time was based on up to 5 reassessment periods (out of 18 months) of the ADC client.

Physical Setting

OUTCOME

According to the Service Provision Index data, ADC's are more likely than caregivers to performs services such as, serving a meal, identifying client needs, speaking on behalf of clients at community offices, providing emotional support, hands-on care, recreational activities, helping with family problems, teaching proper nutrition, and simple nursing tasks. According to the Activity Index data this assumption was correct. The most commonly contracted activities included medical, psychiatry, podiatry, dentistry, physical therapy, speech therapy, and occupational therapy. The Adult Day Care staff was most likely to perform less technical activities such as toileting, recreational activities, and exercises. It was discovered that frequency of use does not necessarily increase for all services over time. A decrease in frequency of use by clients was noted for in-home personal care, laundry/light housekeeping. Increased demand for services included homemaker service, transportation, and counseling.

Kirwin, P.M., & Kaye, L.W. (1993). Parallel service delivery in community long-term care. *Journal of Social Service Research*, 17(1/2), 19-40.

OVERVIEW

This study examined the relationship between formal and informal caregiving networks. The goal of this study was to determine if formal caregiving services (Adult Day Care Centers) served a complementary or parallel role with the informal caregiving services (family). The results of this study indicated that formal (Adult Day Care Centers) and informal (family) care networks provided parallel services, but the informal (family) caregivers performed a wider range of services.

NATURE OF INQUIRY

Data were obtained from interviews of 59 Adult Day Care Center (ADC) program directors and 67 family caregivers.

The attributes of the services provided to the clients by formal and informal networks of care were categorized into three components: technicality, routinization, and task division, each with its own assessment tool.

The technical knowledge (specialization of function and expertise) of the formal and informal caregivers was measured using a seven question survey with a possible ranking of each on a 3-point scale. The questions on the survey inquired into the methods used by the caregivers to obtain information about their functions as caregivers. The methods were divided into technical (classes at school, on-the-job experience, community training organization, and other) or non-technical knowledge (discussions with supervisors and/or caregivers, personal experience, and other).

The Index of Routinization of Technology, which is a 6-item, 4-point scale, was used to measure routinization (the degree of routineness of work activities). The Index of Routinization of Technology was composed of statements such as: I do the same job in the same way every day, one thing I like about the caregiving is the variety of the work, in providing care there is something new happening every day, etc.

Task division (who does what service and how often) was assessed by the Service Provision Index (SPI), which was a 19-item listing of possible services. A scale of 1 – 5 concerning frequency of service provision was used on the SPI.

The clients were measured according to Physical Activities of Daily Living (PADL), Instruments of Daily Living (IADL), health status, social participation, emotional status, and intellectual functions.

COMPONENTS OF PLACE

Organization

Staff

The staff was surveyed to determine how the caregiving techniques were learned and to what degree they considered work "routine."

<i>Family</i>	This study examined the services provided by family caregivers and how they learned the caregiving role..
<i>Client</i>	The majority of the clients (61.5%) was female and the mean age was 76.6 years old with a range of 54 to 98. If the client did not live with the caregiver, 55% lived within 5 miles, 27.3% within 6-10 miles, and 3% over 11miles from the caregiver.

Physical Setting

OUTCOME

The technical knowledge data showed that most family caregivers (88.7%) and ADC staff (79.7%) reported that they learned their caregiving roles through non-technical means. A higher percentage of ADC staff (20.2%) did receive technical training as opposed to the family caregivers (11.3%), however neither group received a significant level of technical training.

The data for Index of Routinization of Technology suggest that family caregivers (2.7) find the caregiving role more routine than the ADC staff (1.9). This finding was assumed to be the opposite of what the data showed. Possible explanations include the larger number of care recipients handled by the ADC staff and the endless variations that occur in a larger physical setting.

The Task Division data indicates that the formal network performed such tasks as serving a meal, identifying client needs, and providing emotional support. On the other hand informal services performed included personal help with bathing, eating, dressing, toileting, simple nursing tasks, teaching proper nutrition, helping with family problems, recreational activities, minor home repairs, and speaking for clients at community offices more often than formal services. The formal network of care rarely performed such tasks as minor home repairs, household cleaning, budgeting assistance, or laundry.

Lindeman, D.A., & Corby, N.H., & Downing, R., & Sanborn, B. (1991). *Alzheimer's day care: A basis guide*. New York: Hemisphere Publishing.

OVERVIEW

This book provides information on various aspects of Adult Day Care (ADC). The topics discussed include ADC development, program activities, evaluation of programs, and family issues.

NATURE OF INQUIRY

A synthesis of current information forming a general reference book on ADC topics, such as planning / administering a adult day care program, financial management, issues of problem behaviors, medical ethics, and participate pathways are discussed.

COMPONENTS OF PLACE

<i>Organization</i>	Discusses the purpose and meaning of ADC activities in respect to therapeutic or maintenance goals. Therapeutic activities are subdivided into physical, social, and cognitive / intellectual performance categories.
<i>Staff</i>	Staff training concerning orientation and continued education (in-service training) is discussed. The topics cover all aspects of (staff issues), including recruitment, training, and retention / burnout.
<i>Family</i>	The needs of the family are covered along with the needs of the client. Caregiver burden and the importance of family support groups are discussed.
<i>Client</i>	The clients are the foundation of the ADC program. Client intake and assessment, participant orientation, reassessment procedures, and behavioral problems are reviewed.
<i>Physical Setting</i>	The physical setting is discussed in terms of rooms, noise, lighting, chairs, space, outdoors, circulation, and mnemonics: <i>Rooms:</i> size and number, flexibility, multipurpose <i>Noise:</i> minimizing extraneous stimuli <i>Lighting:</i> brightness without glare <i>Chairs:</i> accommodate physical impairments and materials <i>Space:</i> safety & security and wandering <i>Outdoors:</i> activity settings <i>Circulation:</i> between activity spaces <i>Mnemonics:</i> memory aids

OUTCOME

Lovering, M. J. (1990). Alzheimer's Disease and Outdoor space: Issues in Environmental Design. *The American Journal of Alzheimer's Care and Related Disorders & Research*, 5/6, 33-40.

OVERVIEW

In this article a landscape architect presents design principles for outdoor spaces within special care units for individuals with Alzheimer's. The focus is on compensating for limited physical and mental abilities of Alzheimer's patients by providing prosthetic supports and orientation aids to increase their sense of independence and well being.

NATURE OF INQUIRY

COMPONENTS OF PLACE

<i>Organization</i>	The principles emphasize a social model of care within an environment that fosters independence, autonomy and self-sufficiency among the residents.
<i>Staff</i>	
<i>Family</i>	
<i>Client</i>	Residents are considered to be people with special needs, especially because of the decreasing visual and auditory acuity, physical mobility, and impaired memory among other things. Lawton's adaptation theory and Kahana's person- environment congruence model are used to conceptualize the resident – environment relationship. Accordingly the provision of prosthetic aids such as proper site furnishings and orientation aids are targeted to resident individuals with lower competence levels in order to increase their sense of well-being.
<i>Physical Setting</i>	<p><i>Enclosure without confinement:</i> Provision of a safe walled space that allows wandering and minimizes escape by camouflaging gates and locks and locating trees far from walls to discourage their use as climbing aids.</p> <p><i>Sensory Stimulation without Stress:</i> Use of baffles to mitigate conflicting background sounds from the street, traffic, air conditioners etc. to avoid confusing and overwhelming the residents with a variety of noises. Provision of adequate lighting, appropriate degree of contrast and use of non-reflective materials to reduce glare and accommodate decreased visual acuity.</p> <p><i>Safety:</i> Provision of automatic doors, adequate space to maneuver, frequent rest stops, appropriate seating with backs and arm rests, minimal changes in grade and avoidance of cross slopes etc. promote safe use of the outdoors and minimize the risk of falling among the residents.</p> <p><i>Wayfinding:</i> The use of distinctive landmarks visible at short distances and a wide continuous route with no hidden spaces along the way to minimize the fear of getting lost enable residents to find their way independently.</p> <p><i>Social interaction and Privacy:</i> Sufficient flexible seating to provide for different arrangements that allow for privacy, small intimate groups or large gatherings as the situation may demand.</p>

OUTCOME

Lyman, K. (1990). Staff stress and treatment of clients in Alzheimer's care: A comparison of medical and non-medical day care programs. *Journal of Aging Studies*, 4(1) 61-79.

OVERVIEW

This research study identifies and compares work-related stress factors among staff at two day care centers - one medical program (day health care), and one non-medical (social day care). Three dimensions were compared; high demands, low control, and perceived lack of social support among staff. Medical typifications of clients, props (physical environment features that enable interaction) and conversational scripts (daily conversations among staff and residents) are observed and analyzed to show that the medical model reflected lower staff stress but showed lower expectations and greater infantilization (treating clients as if they were children) of clients.

NATURE OF INQUIRY

The study involved extensive participant observation and guided conversation with staff (recorded in field notes) at two ADCs. Information was gathered for four variables, work-related stress (guided conversations with staff), medical vs. non-medical programs, institutional policies (archival data, participant observation, semi-structured interviews), and physical environments (Physical and Architectural Features checklist).

COMPONENTS OF PLACE

Organization

This study examines adult day care programs modeled after child day care centers in which "dementia is typified as a deterioration to a child-like state of dependency and normative violations." Within this structure, the study looks at differences among medical and non-medical (social) models. Medical ADC provides nursing services and various therapies and prescribes a division of labor among specialized staff members. The Social ADC on the other hand, frames its services as 'activities' rather than therapies, does not prescribe a division of labor, and has few specialized staff.

Staff

The study targets work-related stress among staff and staff-client interactions in two day care centers. Staff treatment of clients is also the focus. The social ADC employed a director, five full time workers and a part-time nurse (staff-client ratio was 1:10). The medical ADC staff comprised of the director, four full-time and eight half-time workers (staff-client ratio was 1:5). Volunteers worked regularly at both ADCs.

Family

Client

The social ADC had a daily census of about 30-35 clients, 80-90% of them with some sort of dementia. The medical ADC had a daily census of 20-25 clients, 35-40% of whom had dementia.

Physical Setting

The medical day care was in a working class town in Northern California located in a cramped basement of an old three story building. The social day care was housed in a wing of a converted elementary school in an affluent suburb in Southern California. In the

study, physical features pertaining to work-related stress were observed and documented, especially whether the facility is secure, allowing easy supervision of wanderers, and whether staff had their own space to retreat to periodically.

Physical differences in 'props' that set that stage for staff-client interactions are carefully noted in the study. The medical ADC had suitable props for therapies such as parallel rails, full length mirrors (for stroke rehabilitation) and other objects and devices used to monitor and develop muscle strength and coordination. The character of the setting therefore enforced an institutional look. The social day care program on the other hand contained props/equipment for chair exercises, games, music, piecework assembly, and meals.

OUTCOME

The study found differences in funding (medical ADC funded by state/federal insurance programs whereas social ADC relied on private and community grants), and licensing (medical ADC required specialized staff for nursing, social work, physical therapy and occupational therapy). It was found that although regular therapies in the medical ADC were very similar to activities at the social ADC, they differed in labels, e.g., cooking was labeled as 'occupational therapy' at the medical ADC. Although both ADCs had common therapeutic goals, the medical ADC 'therapies' helped legitimize state/federal reimbursement while 'activities' did not.

The medical ADC also tended to perform diagnostic/assessment procedures, referring to the clients as 'patients' in their records and to family. As a result, staff conversations showed 'typification' of their 'patients' such as "delusional", "late senile paranoia", "classic Alzheimer's" etc. In contrast, the social ADC staff did not have easy access to case file information -- the accent was on getting to know the clients as individual persons. Therefore clients in this setting were discussed more in personal terms. The conversations at the medical ADC also revealed staff as more authoritarian whereas an egalitarian relationship prevailed at the social ADC.

The physical setting at the medical ADC was restrictive with many barriers unsafe for frail persons causing staff stress who felt they had to keep an eye on 'wanderers' and 'traffic control'. Despite cramped inadequate therapy rooms, the staff office space had been allocated, allowing frequent breaks and mediate the demands of the environment. The social ADC in contrast had spacious and separate rooms for different program activities but did not have any special place for staff to retreat.

The study concludes that work-related stress at the medical ADC is one-dimensional, that is, stress is expressed as high 'demands' because the institutional policies allow staff to exert 'control' over their working conditions and encourage strong 'social support' among staff. On the other hand, at the social ADC, stress was multi-dimensional, there were multiple 'demands', staff 'control' over their working conditions was limited, and 'social support' was inhibited by institutional policies (although clients became a source of social support).

Lyman, K. A., & Pynoos, J. & Cohen, E. (1993). Occupational stress and workplace design: Evaluating the physical environment of Alzheimer's day care. *Journal of Architectural and Planning Research*, 10(2), 130-145.

OVERVIEW

This study explores the relationship between the design of ADCs and stress among service providers. It involves an evaluation and training intervention designed to increase staff control over their working conditions, by participating in the design or modification of ADCs. Evaluation included observer ratings, interviews with fifty staff, and slides (35 mm.) of twelve Alzheimer's day care facilities to identify stressful design features. Results identified four stressful aspects of facility design; 1) inadequate space and spatial arrangements, 2) security and surveillance features, 3) bathrooms and personal care facilities, and 4) staff space and privacy. The study concludes with design modifications to help minimize stress for the staff.

NATURE OF INQUIRY

The study consisted of two phases; an on-site evaluation of twelve adult day care facilities and a training intervention. The evaluation was conducted with the help of the Dementia Environmental Checklist (DEC) which contained 1) evaluative aspects such as safe supervision and surveillance, wayfinding, accessibility, autonomy and privacy, 2) other facility design aspects that minimize intellectual, sensory and physical losses of patients, and 3) features that affect fatigue and frustration for the staff. Other sources of data included photographic records, interviews and focus group discussions with program managers and staff.

Upon finding in an initial survey that the physical environment is taken for granted by administrators, a training intervention (using slide shows with a hundred images, a script and experiential exercises) was introduced to increase awareness about the physical environment, to provide day care staff with information leading to environmental assessments and plan modifications in their own facilities.

COMPONENTS OF PLACE

Organization

Of the twelve day care centers in California chosen for this study, eight were social day care centers (social model) and four were day health care (medical model). Nine programs served primarily people with dementia while the other three served fewer people with some degree of cognitive impairment.

Staff

Family

Client

Physical Setting

OUTCOME

Results indicate that stress in Alzheimer's day care is managed when staff have some degree of control over their working conditions and if the demands of working with a cognitively impaired

population can be minimized. Four main aspects of the workplace environment were found to contribute to occupational stress;

Inadequate space and spatial arrangements were found to be problematic in seven of the twelve facilities. Specifically, moving clients through the facility, acoustical privacy, congestion in hallways and passageways and traffic control were major concerns.

Security and surveillance features in seven of the twelve facilities were inadequate (the number and location of exits, perimeter fencing and gates, and alarm systems) especially regarding the supervision of potential wanderers.

Bathrooms and personal care facilities were inconveniently located in five of the facilities making it hard for wayfinding and accessibility. This also conflicted with security issues in some cases. Staff were required to accompany clients even if they were capable of finding and using the bathroom independently.

Staff space and privacy was inadequate in five of the facilities. Facilities that had an office, lounge, or bathroom space for staff to retreat to, provided some degree of control over working conditions.

After the intervention, staff in most facilities made innovative modifications in their work environment including, the creation of secure outdoor spaces where clients could pace freely and staff could get out for a while, creating access to an art gallery, developing areas that offered a change of scenery and visual stimulation, providing 'quiet rooms' for clients who need privacy, and promoting wayfinding cues such as colored lines on the floor leading to the bathroom etc.

Maynard, M. (1990). Exploring adult day care participants' responses to psychosocial stressors. *Occupational Therapy in Mental Health, 10(2)* 65-84.

OVERVIEW

This quasi-experimental study explores the degree of psychosocial stress among the frail elderly and the effectiveness of stress management procedures. The results showed that both experimental and control group participants scored in the low to moderate stress level range both before and after intervention and the four week intervention (experimental group) was found to have limited effect on stress reduction.

NATURE OF INQUIRY

Self-report scales of day care participants in Richmond, Virginia were used as pretest and post-test measures for an experimental and control group. The scales were 1) Frustration, overload, boredom and loneliness self-assessment reports, and 2) Internal health locus-of-control scales. Participants assigned to the two groups were chosen by initial selection criteria (mentally alert and interaction skills).

The stress reduction intervention consisted of thirty-minute sessions conducted three times per week over a four-week period. The session included identifying stressful situations, personal

management of stress, use of relaxation, autogenics, visual imagery, problem solving and cognitive strategies. Intervention group members were also requested to keep a weekly stress log to monitor time, events, symptoms of stress and degree of success in using relaxation and biofeedback methods to reduce stress.

COMPONENTS OF PLACE

Organization

Staff

Family

Client The mean age of the clients in the intervention group was 70 years old (n=10) and the control group (n=5) was 76 years.

Physical Setting

OUTCOME

The stress logs showed more insight into participants' daily stressors and coping methods. Waiting room anxiety, stress related to various ailments, and pains were mentioned as sources of stress. Coping methods included taking medication, other remedies, to take one's mind off the problem by reading or listening to music, going to church, praying and / or resting. ADC helped them cope with stressors by providing social and other support.

Most participants in both groups scored in the moderate to low stress levels on the pretest and post-test Overload, Boredom and Loneliness and Frustration scales. Since the stress levels were low to begin with, the intervention session showed a limited effect on reducing stress levels, also indicating that the session may have been too short to create a significant effect.

McGadney, B. F. & Madison, A. (1997). Use of formal services by family caregivers of African American elders. *Michigan Academician*, 29(2), 199-220.

OVERVIEW

Forty-four family caregivers of African-American ADC participants in a Midwestern city were interviewed to determine a) caregivers' attitudes toward community service use, b) clients' functional limitations and sources of support, c) type of formal services client receives, d) frequency of ADC and transportation use, and e) barriers to ADC use. Results indicate that caregivers held positive attitudes toward using community services and are seldom faced by barriers that could negatively influence enrollment of elders in the ADC. The mildly cognitively impaired elders were found to need the most help with instrumental ADLs, with this help being provided mostly by primary family caregivers.

NATURE OF INQUIRY

Forty-four family caregivers of African-American elders at the ADC were interviewed in regard to the following: 1) their attitude toward utilizing a community service, 2) clients' functional status and sources of support, 3) formal support, 4) ADC and transportation use, and 5) barriers to using ADC.

COMPONENTS OF PLACE

<i>Organization</i>	The ADC in this study had specific program goals: to "provide to the frail elderly that improves or maintains participants' functional independence, enabling them to avoid institutional care and remain at home, and to do so at the same or less cost as other traditional long-term care programs there is a strong emphasis on the use of day health care and a reliance on a multidisciplinary team to manage and deliver (on-site and in-home) services." Thus the emphasis of this ADC is to facilitate participants to receive services in their community.
<i>Staff</i>	The staff comprised a multidisciplinary team of primarily African American social workers, nurses, physical therapists, physicians etc.
<i>Family</i>	Family caregivers are an important part of the ADC program -- a monthly dinner support group meeting is held for all caregivers, with sitters provided for clients in attendance. The caregivers interviewed in this study ranged in age from twenty to eighty-one years, and half were daughters of clients.
<i>Client</i>	The clients ranged in age from sixty-four to ninety-eight years.
<i>Physical Setting</i>	The research site was an ADC in the urban center of a Midwestern city, located in an economically deprived community. The center is described as filled with pictures and paintings by African American artists, and quilts and artwork by participants. The ambiance during exercises is enhanced by gospel music or jazz or blues.

OUTCOME

It was found that more than eighty percent of the caregivers believed that community services were responsive to their needs, less than half were worried about their elder's safety when taken care of by community services, and most believed that it was not difficult to get community service help and rely on it for their elder's care. In fact most preferred asking for community service help before asking for help from family members.

An analysis of clients' activities of daily living and degree of formal assistance (as reported by the family caregivers) revealed that the clients needed less assistance with ADLs (personal care) and more supervision and assistance with instrumental tasks of daily living (IADL) such as cooking, housework, managing money, transportation, taking medication and grocery shopping. The ADC helped the clients with both types of activities. Clients however received most of this help from family caregivers rather than a formal organization. The clients also used home-based services such as nursing care and home health aides that may prohibit premature institutionalization.

Murphy, M.B. (1997). *A manual for training the program assistant in adult day care.* Washington, DC. The National Adult Day Services Association

OVERVIEW

This packet of information was assembled to assist in the training of Adult Day Care (ADC) program assistants. The packet provides a step by step method to both explain the concept / philosophy of ADC and provide specific job training. A video, which illustrates physical services (ADL's, biohazard procedures, lifting techniques), techniques for interaction (patience, communication, and respect), and the needs of Alzheimer's clients supplements the manual.

NATURE OF INQUIRY

COMPONENTS OF PLACE

<i>Organization</i>	The general concepts and philosophies of ADC are discussed along with center-specific rules and functions. An ordered presentation of services and individual methods for personal care (ADL's) are discussed in-depth. Specific detail is given to "modifying" the care program for clients suffering from Alzheimer's or related dementia. The video supplements the training information by providing demonstrations of ADL activities such as toileting, feeding, bathing, and the required safety techniques associated with them.
<i>Staff</i>	The staff is familiarized with the chain of command and all positions or responsibilities in the ADC program.
<i>Family</i>	
<i>Client</i>	The target population is described along with the mental and physical effects of aging. A section of the manual is dedicated to presenting the special needs of an Alzheimer's or dementia afflicted population. The video illustrates the needs of dementia patients and the methods or techniques used to assist them.
<i>Physical Setting</i>	A walk-through discussion of the facility is encouraged to familiarize the program assistant with all areas of the center, along with all safety and sanitation equipment.

OUTCOME

NOTE: Since this manual is used as an educational tool, a section is included on effective use of the information provided, which includes a 12 step training schedule.

Newman, S., & Ward, C. (1992-93). An observational study of intergenerational activities and behavior change in dementing elders at adult day care centers. *International Journal of Aging and Human Development*, 36(4), 321-333.

OVERVIEW

This study investigated the effects of intergenerational activities on the behavioral responses of adults suffering from Alzheimer's Disease or other forms of dementia. It was hypothesized that the Adult Day Care (ADC) clients would consistently show positive social behaviors (dependent variables) during the activities with children (independent variable), behaviors which would not occur without the children. The data collected indicated that ADC clients had a significant increase in touching and extending hands when the children were present.

NATURE OF INQUIRY

This study involved the observation of ADC clients (n=21) who interacted with 4 and 5 year old children (n=20) during a structured music activity that occurred once a week for a total of five weeks. The music activities were conducted for thirty minutes without the presence of the children and then repeated with the children after a fifteen-minute break. The music activities performed with and without the presence of the children were identical.

The clients were separated into groups of three or four (triads) for ease of videotaping during the sessions with and without the children. Every week each triad was filmed at 3-minute intervals for a total of 12 minutes. Two graduate students who were not told about the true nature of the experiment scored the taped musical activities for positive behaviors. The positive behaviors were categorized into 9 possible scenarios; smiling, extending hands, clapping hands, tapping feet, singing, verbal interaction, touching, hugging, and holding hands. The graduate students scored 5 randomly selected 10 second intervals for each 3-minute recording of a triad. The students scored the positive behaviors for a total of approximately 16 minutes per client.

A comparison of individual behavior with the presence of children during music activities was performed using non-parametric tests (Pearson's χ^2 Test and Fisher's Exact Probability Test).

COMPONENTS OF PLACE

Organization

The ADC's in this study were non-profit, non-sectarian centers, that served the frail elderly who suffered functional and cognitive impairments. The ADC located in Pittsburgh, PA served moderately to severely impaired clients, while the site in the suburbs served mildly to moderately impaired clients.

Staff

Family

Client

The 21 ADC clients who participated in the study all showed signs of Alzheimer's Disease or similar dementia disorders. The subject pool consisted of both male (33%) and female (67%) clients, who ranged in age from the 50's to 90's.

Physical Setting

The clients attended two ADC's, one located in Pittsburgh, PA and one in the neighboring suburbs of Pittsburgh, PA.

OUTCOME

According to the data collected, touching (p=.051) and extending hands (p=.04) showed a significant increase with the presence of the children. On the other hand, smiling, clapping hands, tapping feet, verbal interaction, and hugging showed no significant difference with or without the children present. Contrary to assumed beliefs, holding hands showed a significant increase when the children were not present.

Possible reasons for the increase in extending hands and touching (spontaneous behavior) include the presence of the children within eye contact and physical reach of the clients. These factors may have encouraged the clients to initiate interaction with the children.

Holding hands (directed behavior) requires the participation of both the children and the clients, the children may have been too shy or young to cooperate in the holding of hands.

In general the findings do suggest that the presence of children may elicit positive behaviors that result in responsiveness and participation from low functioning individuals who are normally unresponsive and not in touch with reality.

O'Brien, N., & Sainer, J., & Lindeman, D., & Soos, J., & Huffman, E. (1995). *Technical Assistance Guide for the Brookdale National Group Respite Program*. New York: The Brookdale Foundation.

OVERVIEW

This technical assistance guide describes the components, policy areas and procedures essential to operate a small non-medical group respite service. It includes the best practices of the Brookdale respite model and specific program examples and sample forms (e.g., staff evaluation, volunteer application).

NATURE OF INQUIRY

COMPONENTS OF PLACE

Organization

The Brookdale approach emphasizes definitive administrative policies and procedures and a strong governance structure to ensure a viable and permanent respite program. The Brookdale vision to "serve the special needs of older persons" encompasses a "commitment to support human dignity, and to respect all participants, regardless of ages, sex, race, cultural heritage, or cognitive limitations; and an intent to enhance the quality and meaning of life for persons with dementia and their caregivers."

<i>Staff</i>	The Brookdale Group strongly emphasizes using professional staff and qualified volunteers to ensure safety, security and optimum functioning of participants. The Program Director can be recruited from various professions such as social work, nursing, public health education, occupational therapy, and recreation therapy. A ratio of five participants to one staff member (actively working with them) is recommended. Position summaries for each job are provided in this guide.
<i>Family</i>	Family caregiver issues are outlined and discussed including length of respite per day, transportation, exhaustion of caregivers, family resistance to use respite, cost of respite care.
<i>Client</i>	The guide contains a chapter on the profile of the client. The process of recruiting and tips for contacting specific groups (governmental agencies, private service providers, churches, lodges, service clubs) to increase enrollment is discussed. Problem behaviors and problem solving techniques are discussed.
<i>Physical Setting</i>	Numerous issues including site selection options, safety and security issues, accessibility, physical suitability and appearance, availability and location, colors, lighting, furnishings and décor are discussed with examples and samples in a separate chapter. In particular, points for evaluating facilities authored by national and international experts are compiled and checklists provided. Particular aspects of facilities that house ADCs are discussed; <i>design and use of space</i> -- access, reception/entry and transition, large group activity room, special activity/breakout rooms, clusters of small activity spaces and activity alcoves, offices, rest rooms, food service and kitchen, intimate dining area, storage, entrance and exits, secure space, positive outdoor spaces and provision of windows, <i>environmental issues</i> --sensory stimulation without stress, atmosphere, floor, orientation cues, temperature, noise, light, eliminating environmental barriers and, <i>licensing and certification</i> .

OUTCOME

Short-DeGraff, M.A., & Diamond, K. (1996). Intergenerational program effects on social responses of elderly adult day care members. *Educational Gerontology*, 22, 467-482.

OVERVIEW

The goal of this study was to examine the behavioral responses of 10 elderly Adult Day Care (ADC) clients when exposed to intergenerational activities with 12 children ages 3 and 4. This

experiment was designed to measure two separate baseline (A) and intervention (B) conditions. The data obtained from this A-B-A-B design indicated that the ADC clients showed higher levels of social interaction and lower levels of typical isolation behavior around the presence of the children, in comparison to the absence of the children.

NATURE OF INQUIRY

This study examined the positive influences of intergenerational exchanges by observation of non-structured “free-time” activities. This study did not record the behavioral patterns of the ADC clients during “group time” because the structured sessions eliminated the possibility of spontaneous and self-initiated activities. Instead, the ADC clients (n=10) were observed interacting or not interacting with the children (n=12) for 15 minute intervals during the first 2 hours of the program. Several possible activities were set-up around the ADC, inviting participation from the children and clients. The subjects were randomly selected for observation (3 seconds observed, 7 seconds recorded) until at least two separate observations were obtained for each subject under each experimental condition. The 3-year-old children participated on T-R and the 4 year olds on M-W-F, the children were only present when school was in session.

The behavioral observations were categorized into three possible scenario; positive social interaction, solitary productive activity, nonsocial / nonproductive activity. Positive social interaction was characterized as the client actively engaged with another person in conversation or mutual activity. The observers also recorded with whom the clients conducted the conversation or activity (other clients, staff, children, and children’s teacher). Solitary productive activity was defined as the subject being independently directed and involved with objects or working with materials towards accomplishing some task (knitting, reading paper, etc...). The last behavioral scenario was nonsocial / nonproductive behavior, which is defined as a behavior that does not accomplish a task or support positive social interactions (starring vacantly, sleeping, etc...).

COMPONENTS OF PLACE

<i>Organization</i>	This ADC is based on the social model, with an emphasis on intergenerational activities.
<i>Staff</i>	The staff at this ADC consists of a nurse and social worker along with volunteers.
<i>Family</i>	
<i>Client</i>	The 10 ADC clients in this study ranged in age from 66 to 94 and many suffered from Alzheimer’s Disease and/or other physical and mental impairments.
<i>Physical Setting</i>	This ADC was in a small house located in a residential neighborhood.

OUTCOME

The results of this study indicated that Intergenerational Activities have an effect on the social behaviors of elderly participants, even those suffering from one form of dementia or another. The positive social interaction ratings with the 3 and 4-year-old children increased from baseline to intervention for 95% of the clients, in addition to the decline of solitary productive behavior. The non-social interactions showed an increase with the presence of the children; this could be explained as lapses in the activity with the children. During these lapses in activity the clients

may watch, smile and sometimes laugh at the children. Technically, since the clients were not actively engaged in an interaction they would receive a non-social rating. This reflects a significant shortcoming in the operationalization of this study.

**Stevens, A. B., & King, C. A., & Camp, C. J. (1993).
Improving prose memory and social interaction using
question asking reading with adult day care clients.
*Educational Gerontology, 19, 651-662.***

OVERVIEW

This study examined differences between social interaction produced by two reading group activities at an Adult Day Care Center (ADC) in New Orleans. An existing reading group activity was contrasted with a Question Asking Reading procedure (QAR) for amount of social interaction during the activity and retention of information presented. The QAR procedure was found to produce more social interaction and participants showed better comprehension and retention of information.

NATURE OF INQUIRY

The study was conducted with ten clients at a day care center in New Orleans who were participating in a reality orientation (RO) class or a health class; each used a reading exercise to present clients with information. The reading passages were written at a third to fifth grade reading level. A memory-prose test for each passage was created to test free recall, recognition, and comprehension. Index cards and a written script were used as external memory aids to focus the client's attention on a different aspect of communication during the test.

Phase One: Clients were matched according to performance on pretest measures (the Mini-Mental State exam and the memory-prose test) into two groups A and B. Each group was randomly assigned to either 1) Group A, initial QAR, or 2) Group B, delayed QAR. Group A members participated in the QAR procedure (led by the experimenter) three days a week for six weeks. The QAR procedure began the discussion with the day's events and current topics in the news following which each participant received a card with a question and the first paragraph of a two-paragraph passage. Participants were encouraged to initiate discussions based on the questions on their cards. Group B members followed the regular reading procedures led by a staff person at the center for the same passages. Regular procedures involved reading the passages aloud as a group and looking for key words in the text. Social interaction during the activity was recorded on microcassettes and transcribed for analysis. After the intervention period of six weeks, both groups took a comprehensive content test and the Mini-Mental Test.

Phase Two: In this phase (also six weeks) group A continued to participate in the QAR procedure but was led by the staff person. Group B continued the regular procedure but was led by the experimenter.

Data analysis: Two days from each week of the intervention period were randomly selected for data analysis. Transcripts of reading group activity were coded for amount of social interaction (measured by a frequency count of utterances by each group member).

COMPONENTS OF PLACE

Organization This article discusses reading activities, specifically the question and answer reading format.

Staff

Family

Client All clients in this study were attending either a reality orientation class or a health class and had an average age of 66.3 (ranging from 41 to 79). According to medical records the clients could be grouped into three categories, organic brain disorders (n=5), schizophrenia (n=3), and severe hypertension (n=2).

Physical Setting

OUTCOME

The results were examined for the effects of the QAR procedure in relation to three research questions; Did implementation of QAR influence retention of information contained in prose passages? Did the implementation of QAR influence social interaction within groups? Did QAR influence measures of general cognitive abilities?

The Phase One Group A using the QAR procedure produced higher scores on the content test than Group B. Phase Two content scores for the two groups (when both used the QAR procedure) were similar. An overall increase in both group's retention of passage information was found when the QAR procedure was used. Social interaction among participants, and participants and staff was also found to be higher when QAR was used regardless of the group leader.

Stremmel, A.J., & Travis, S.S., & Kelly-Harrison, P., & Hensley, A.D. (1994). The perceived benefits and problems associated with intergenerational exchanges in day care settings. *The Gerontologist*, 34(4), 513-519.

OVERVIEW

Thirty-six adult day care center (ADC) administrators and three hundred child care center (CCC) administrators in Virginia contributed to a survey on perceptions of the benefits and problems associated with providing regular opportunities for intergenerational interaction in day care settings. The results of a qualitative analysis showed that generational differences and organizational/ service delivery issues were offset by socio-cultural and organizational benefits.

NATURE OF INQUIRY

All ADC and CCC administrators were located at centers throughout Virginia, both urban and rural in context. The data was gathered through the use of a multi-step mail survey procedure.

The survey was composed of three basic parts. The first part of the survey asked questions concerning the background characteristics of the respondent, including but not limited to gender, ethnic origin, age, time in current position, etc. The second part of the survey asked the administrator questions concerning his or her attitudes toward children, older adults, and intergenerational exchanges. The third and final section of the survey was composed of two open ended questions to help the experimenters form an accurate perception of how Adult Day Care and Child Day Care administrators feel about intergenerational exchanges.

COMPONENTS OF PLACE

Organization Ninety-one percent of the ADCs were operating as non-intergenerational activities, but were already utilizing intergenerational activities at the ADCs and CCCs; music (72%), conversation time (69%), telling/reading stories (55%), playing games (49%), arts and crafts (44%), field trips (37%), and cooking / baking activities (20%).

Staff The two respondent categories differed in their median ages ADC 41 (range 28-65) and CCCs 39 (range 20-74). However, both groups were composed of a majority of white (83%) women (90%) administrators. The CCC administrators had a broader range of employment than the ADC administrators, (CDC = 2 months – 42 years, median 4.5 years), (ADC's = 3 months – 18 years, median 2.8 years). The formal educational backgrounds of the administrators varied between the two groups. While the ADC administrators had a majority of degrees in the health and human services, the CDC administrators had a wider range of degrees, such as education, psychology, physical sciences, etc.

Family

Client

Physical Setting All of the ADCs (n=34) and CCCs (n=193) were located throughout the state of Virginia, with 68% in mid-size cities. All administrators mentioned inadequacy of separate spaces for the children and adults. This implies that more space is needed for those “breather” moments for both groups to get away from each other when required.

OUTCOME

The data on perceptions showed three prominent themes – socio-cultural, generational and organizational / service delivery issues.

Sociocultural benefits: Both ADC and CDC administrators felt that these programs:

- 1) offered opportunities for both groups to respect and learn from each other and provided access to unconditional love, attention and companionship and,

- 2) offered opportunities to experience grandparent figures in the absence of an available extended family.

Generational differences: Both ADC and CDC administrators viewed these as problems, especially:

- 1) differences in energy and activity levels between the two groups
- 2) divergent interests that made planning suitable activities difficult,
- 3) fear expressed by children of elders – of not being used to having them around or because of their physical impairments and the fear of illness or death, and
- 4) fear expressed by elders for their personal safety when children were around.

Organizational and Service Delivery Issues: ADC and CDC administrators observed

- 1) cost savings and reduced duplication of services/ resources, program enrichment and access to additional helpers (an extra set of hands, eyes or a “spare lap to comfort a child”),
- 2) greater and more specific demands placed on staffing and program planning – additional staff training and supervision was required – were seen as problematic,
- 3) the need for each group to have space of their own to “be able to get away from each other” was considered essential and was not met in their locations and hence caused problems,
- 4) infection control was also an important aspect mentioned in higher numbers – especially when both children and elders were vulnerable to communicable diseases.

The report charts directions for the future in suggesting training and supervision of staff who might plan and implement intergenerational activities and develop curriculum guides for age and developmentally appropriate activity programming. In general, the response indicated favorable reactions to having such programs and the problems were mostly logistic and could be managed with some thought and preparation. Also, it recommends that additional cost savings studies, effectiveness of segregated versus integrated activities, and the opinions of family members should be examined for future decisions.

Teresi, J. A., & Holmes, D., & Koren, M. J., & Dichter, E., Ramirez, M. & Fairchild, S. (1998). Prevalence estimates of cognitive impairment in medical model adult day health care programs. *Social Psychiatry Psychiatric Epidemiology*, 33 283-290.

OVERVIEW

This study uses commonly used screening measures to estimate the prevalence of cognitive impairment among adult day health care (ADHC) clients. Using a probability sample of 336 clients, age-adjusted and non-age-adjusted prevalence estimates were developed. Traditional cutting scores on standard cognitive screening measures such as the Mini-Mental State Examination were used. The analyses yielded a prevalence estimate of 58% across age cohorts and 63% for those aged 65 and above. Latent class estimates of moderate to severe impairment indicated that around 30% of the clients had cognitive impairment suggestive of probable or definite dementia. The study concludes that age-adjusted prevalence ratios for this client sample approaches the bounds of the institutional estimates indicating that the institutional setting will

continue to play an important role in severely impaired individuals, and that ADCs are serving a high proportion of the mildly and moderately cognitively impaired individuals.

NATURE OF INQUIRY

ADCs were selected randomly from the 1991 census of New York state. A simple random sample of nine facilities was drawn from an initial sample of sixty-four facilities. Trained research nurses and social workers visited each ADC for two weeks in the summer of 1992. Clients present at that time were administered a screening interview (using the Mini-Mental State Examination, the Blessed Information-Memory-Concentration Test, Kahn-Goldfarb mental Status Questionnaire, the CARE Mental Status Questionnaire, and the Short portable Mental Status Questionnaire) to assess level of cognitive functioning range of motion and ambulation capabilities. Staff helped to identify a primary caregiver for each client from whom researchers obtained further information in a telephone interview. Other sources of data included a structured chart review and information from the ADC program's nurse and social worker. Interviews were conducted in Spanish (n=16) and Korean (n=8) in addition to English.

Prevalence estimates were developed 1) through use of standard cutting scores applied to the cognitive screening tests, and 2) using the method of latent class analysis – a method to estimate prevalence in the absence of a criterion diagnosis. The latent class analysis assumes that there is an underlying latent attribute and measurable by fallible indicators.

COMPONENTS OF PLACE

Organization

Staff

Family

Client

Physical Setting

Forty-nine percent of the ADCs were located within the New York metropolitan area, that is, the five boroughs of New York City, Long Island, and Westchester.

OUTCOME

The uncorrected prevalence for cognitive impairment at comparable cutting scores ranged from 40% to 61%, the corrected ratios ranged from 45% to 66%. The MMSE provided a corrected prevalence ratio of 58.4%. These findings and their average indicate that at least 55% of the ADHC population suffered from cognitive impairment. The prevalence ratio for the clients above age 65 was 22% whereas it was 42-47% for the same group in the nursing home sample in an earlier 1985 National Nursing Home Survey which used staff reports and diagnoses entered in medical records. Also, the ADHC estimate of 22% was found to be lower than the ADHC estimate observed using a moderate to severe cut point on the screening measures. The findings indicate that using direct assessment methodologies yield higher prevalence estimates than staff reports with medical records. Thus the study concludes that in order to assess cognition levels of elderly for making placement and reimbursement decisions, the more expensive and time consuming direct assessment methods are preferred over total reliance on staff informants or administrative archival data.

Travis, S.S., & Das, P. (1994). University based adult day care center for research and training: Design, funding, and programmatic issues. *Educational Gerontology*, 20, 557-565.

OVERVIEW

This article discusses the inception and implementation of an Adult Day Care Center (ADC) at the College of Human Resources at Virginia Polytechnic Institute and State University. This ADC is a result of an educational agenda established by the university during the early 1980's. The aspects of ADC concerning building design, funding, state certification, and marketing are discussed. The Virginia Adult Day Care Project revolves around three stated mission goals: extension, research, and teaching. The university will fulfill the extension goal by providing technical assistance to groups wishing to explore the ADC option. The research goal will involve exploration of ADC options such as intergenerational activities and community based long term care. The third goal of the ADC is to provide teaching through an interdisciplinary curriculum to develop a Community-Based Long-Term Care Administration Degree.

NATURE OF INQUIRY

This article is an overview of the ADC program at Virginia Tech.

COMPONENTS OF PLACE

Organization

This article discusses the concerns around the decision to establish the ADC as a health care, research, and training center. The ADC program also had a desire to establish intergenerational activities in conjunction with the Department of Family and Child Development. The ADC program at Virginia Tech experienced problems dealing with the cost of construction and operating expenses. Optional funding strategies were discussed and finally the university secured additional funding through a philanthropic agency. Marketing strategies to build a clientele and establish an ADC were also discussed.

Staff

Virginia Tech. needed to employ staff who could fill dual roles in the university and the ADC. To meet state certification the ADC was required to hire full time staff and then supplement with students during the academic year.

Family

Client

This Adult Day Care Center (ADC) will serve a clientele with physical and mental impairments.

Physical Setting

The ADC will be located in a new addition to the existing Child Development School, a facility located on the campus of Virginia Tech. The new addition will have a view of the children's classroom and play yard, in addition to a shared intergenerational activity room. The final ADC will be composed of an activity room, offices, kitchen, examination room, intergenerational activity room, and bathrooms.

OUTCOME

Twigg, J. (1997). Deconstructing the 'social bath': Help with bathing at home for older and disabled people. *Journal of Social Policy*, 26(2), 211-232.

OVERVIEW

The 'social bath' can be viewed as relating to three concepts: medical versus social models of care, the social meaning of bathing, and private versus public social phenomena. The act of bathing concerns issues not normally part of policy debate such as washing, touching, and nakedness. Bathing is presented as involving health issues, social involvement, ritual application, and the sensory experience of bathing. The trend of moving services away from more expensive medical model facilities toward less expensive social model settings has resulted in the unclear definition of bathing service provision.

NATURE OF INQUIRY

Information is gathered from sources on historical, sociological, psychological, and economic relationships to the provision of bathing services. The synthesis of information is presented in a discussion format in relation to current trends in the provision of care.

COMPONENTS OF PLACE

<i>Organization</i>	Discusses differences in medical and social care institutions. Long-term care facilities incorporate aspects of both systems, thus crossing the border of medical and social care. The growing aged population has forced the political redefinition of care from the medical model into the social model, due to concern over extensive payments and lack of funding.
<i>Staff</i>	The changing role of the care provider concerning bathing and touching is discussed. Traditional professional hierarchies considered individuals who directly touched patients as occupying a lower professional class (doctors versus nurses).
<i>Family</i>	
<i>Client</i>	Client gender differences are discussed regarding the significance of touch during the bathing experience. Male clients are more likely to rate touch by a service provider during bathing as a negative factor.
<i>Physical Setting</i>	The physical setting of the bathing procedure has a significant influence on its meaning and experience. Bathing performed in a home environment differs greatly from the public domain of the hospital or other care provider. The home provides a territorial space (personal space) under the control of the client; the public domain does not.

OUTCOME

Home help traditionally has been viewed as merely assistance with ADL's, stopping short of providing bathing assistance. The redirection of medical services into the social model resulted in the decline of nursing services with no corresponding increase in the scope of social services,

thus leaving bathing in a gray area not covered by either approach. The transition of bathing services to a social model reflects a more extensive care need being provided for by less trained and experienced personnel.

Touching has several social meanings attached to it and often the social context controls the refusal for basic service provision. Gender differences occur in the perception of touching during the bathing experience, with males tending to rate the experience as negative.

Nakedness is traditionally seen as a state of vulnerability and intimacy. The experience of nakedness for the elderly is compounded when combined with another individual who is fully clothed and often much younger (as in the social bathing experience).

Wallace, S. P., & Snyder, J. L., & Walker G. K., & Ingman, S. R. (1992). Racial differences among users of long-term care: The case of adult day care. *Research on Aging*, 14(4) 471-495.

OVERVIEW

A representative sample of ADC participants in Missouri is analyzed in this study to examine any differences in patterns of use by African-Americans and Caucasians. The results indicate that African-American elderly use ADC at twice the rate of older Caucasians. Also they were more likely than Caucasians to rely on children as primary caregivers and to rely on Medicaid. There were no differences found in the functional and cognitive need levels of participants.

NATURE OF INQUIRY

Twenty-five ADC directors in Missouri responded in a one hour telephone survey covering facility level information. Twenty-one of the centers also completed client assessments mailed to them. The sample of participants was compared with a complete census from 1989 and was found to be statistically equivalent.

COMPONENTS OF PLACE

Organization Social goals reported included providing respite to caregivers of ADC clients; socialization; and rehabilitation. However all ADCs in this study provided medical services, most provided nursing services and physical therapy.

Staff

Family Family members, mostly daughters were found to be primary caregivers.

Client

Physical Setting

OUTCOME

The structure (location, financing and goals) of ADC in Missouri indicate that ADCs are accessible to African-American elderly. The results indicate that African-Americans use ADCs more frequently (5 days a week) than Caucasians (1 or 2 days a week).

Assistance and Impairment: There were no statistical differences between the two races in terms of mean level of assistance needed (for activities of daily living or IADLs). The most common impairments in both races were in judgement and memory – the only significant difference was that Whites were more likely to be diagnosed with Alzheimer's disease than the African-Americans.

Caregiver Status: More African-American ADC participants were less likely to be married than the Whites and were more likely to live with nonspousal relatives than alone. When spouses were available, they were the primary caregivers. Daughters were the most common caregivers for those without spouses.

Webb, L.C. (1989) *Planning & managing adult day care – pathways to success.* Baltimore: National health Publishing.

OVERVIEW

This book presents and discusses numerous issues concerning Adult Day Care (ADC) such as history of ADC, facilities development, transportation, staffing, financial management, marketing, intake assessment, plan of care, family services, record keeping, and program evaluation.

NATURE OF INQUIRY

Edited reference book

COMPONENTS OF PLACE

<i>Organization</i>	Examined the goals of ADC which are maximize functional levels, encourage independence, promote sense of control, and provide opportunities for social contact.
<i>Staff</i>	Staff orientation, staffing patterns, and support staff are discussed
<i>Family</i>	Family participation is encouraged and the families have access to support services such as group counseling and newsletters.
<i>Client</i>	Client topics included intake assessment, importance of trial periods, activity levels, and orientation to the facility.
<i>Physical Setting</i>	Issues discussed include site placement, orientation, and exterior finishes. The placement of the facility covers topics such as location

in town, transport, image, accessibility to handicapped, signage, comfort, and service delivery. Specific design features such as vestibule, reception area, and mnemonic cues are also examined. The design goals of the physical setting are to provide safety / security, awareness / orientation, and flexibility of programming spaces.

OUTCOME

Weissert, W. G., & Elston, J. M., & Bolda, E. J., & Zelman, W. N., & Mutran, E. & Mangum, A. B. (1990). *Adult Day Care: Findings from a National Survey*. Baltimore: The Johns Hopkins University Press.

OVERVIEW

The purpose of this study is to describe the state of Adult Day Care centers after a decade of their inception and growth. Of particular interest was a profile of the users, staffing and services offered by ADCs, costs, revenues, and client satisfaction. The study also probed whether ADCs served different populations, and if so whether the services, staffing, costs, revenues and client satisfaction differed accordingly. The findings indicate that Adult Day Care is not one single entity; instead three models were found to emerge in the analysis. They are categorized into 1) Auspice Model I (typically providing service to a physically dependent, older, white population most without any mental disorder), 2) Auspice Model II (serving a predominantly unmarried and female population, frequently a racial minority, most under 85 years of age and most suffering from a mental disorder), and 3) Special Purpose (serving a single type of clientele such as blind, mentally ill or veterans) centers.

NATURE OF INQUIRY

A two-stage sample of ADCs and ADC clients were chosen through a random sample of ADCs that were in operation for at least a year. The first stage included a systematic sample of 200 centers drawn from a National Directory of ADCs from which a simple random sample of 28 centers was selected. Thirty-five new centers unlisted in the directory were also included to yield a total of 63 centers; sixty agreed to participate. The second stage included a systematic random sample of eight participants from each of the sixty centers; a subsample present on the day of the researchers' visit was interviewed. Caregivers (n=168) were also interviewed over the phone.

Researchers visited each center for one or two days and 1) administered questionnaires to center directors, 2) inventoried an evaluated facilities and equipment using a survey based on the Multiphasic Environmental Assessment Procedure (MEAP), 3) collected data from archival sources such as attendance logs and financial reports, and 4) conducted interviews with clients. In addition, telephone interviews with caregivers identified by staff (for each participant interviews when applicable) were conducted.

COMPONENTS OF PLACE

<i>Organization</i>	Three models of ADCs emerged in the analysis as explained in the Outcome section below. Directors of Special Purpose centers were more likely to think of their centers as providing respite to the informal caregiver than Model II directors who cited health maintenance and monitoring as their primary purpose. All emphasized social interaction and recreation and that the intent was to delay or avoid institutionalization.
<i>Staff</i>	Typical staffing included a director (trained as a nurse or social worker) and an assistant, with some or all of – recreation activity and nursing aides, nurses and therapists, custodial workers and van drivers, case managers and social workers, and administrative personnel and office staff.
<i>Family</i>	
<i>Client</i>	The average age of participants was 78 years, with a few (under twenty percent) being older than 84 years. Most were white, unmarried female participants who did not live alone. Forty percent of the participants suffered from a mental disorder and more than half were functionally dependent. One-third of all participants had been hospitalized during the past year and less than one-fifth had spent time in a nursing home in the past year.
<i>Physical Setting</i>	Most were housed in multipurpose facilities, especially within churches, nursing homes and senior centers. Most Model I centers were housed in a nursing home. Interior median space was on an average, 136 square feet per participant, and ranged from one large room to multiple rooms and office space. Outside areas were also available for participants' use. Special Purpose centers had significantly more space per participant but were less likely to meet handicapped access standards or be inspected annually by a health department. There was a wide variety of equipment (arts and craft supplies, refrigerators, audiovisual equipment, pianos, library books, wheelchairs etc.) in all centers. Model I centers had physical therapy, bathing and hair care facilities etc.

OUTCOME

Models of Adult Day Care: The study had hypothesized that centers operating under different auspices would serve different populations distinguished by case-mix measures (e.g. dependency in ADLs -- activities of daily living). This was proved to be true; the percentage of clients who were severely dependent and those who were independent in ADLs correlated with the auspices under which the centers operated. Analysis of variance showed that there were differences between eight types of auspices (freestanding, nursing home, hospital, rehabilitation hospital, senior program, municipal, housing authority and other social service). Also there were statistically significant differences between programs affiliated with nursing home/rehabilitation hospital and the other six auspices. Other analyses of goodness of fit indicated three models of ADCs; Auspice Model I (nursing home, rehabilitation hospital), Auspice Model II (hospital,

freestanding, housing authority, senior program, municipal, other) and Special Purpose (veterans, mental health, cerebral palsy, blind).

Participant and caregiver satisfaction: Satisfaction with ADC programs was high; participants were satisfied with transportation to and from the center, the attention they received from staff, and program hours. There was some disagreement about quality of food, noise level, center temperature, and crowdedness. Caregivers were more satisfied if they themselves worked especially those who worked full-time.

Expenses and Revenues: Expenses exceeded revenues that usually averaged \$140,000. Revenues were drawn from federal sources, especially Medicaid. The most expensive costs were attributed to labor followed by transportation, facility and food. Daily participant expenses ranged from \$9.88 to \$105.62.

Weissert, W. G., & Elston, J. M., & Musliner, M. C. & Mutran, E. (1991). Adult day care regulation: "Déjà vu all over again"? *Journal of Health Politics, Policy and Law*, 16(1) 51-66.

OVERVIEW

This national survey studies differences between centers pertaining to their regulatory status, and relationship between regulatory status and satisfaction. ADC regulations were found to be mainly structural in nature and differences did exist among centers based on regulatory status. Regulated centers also had more satisfied clients overall, compared to unregulated centers.

NATURE OF INQUIRY

A two stage sample of day care centers and participants was chosen through a national random sample of ADCs located in metropolitan statistical areas with 1980 populations of 80,000 or more. Sixty of the sixty-three centers agreed to participate. In the second stage, a systematic random sample of at least eight participants in each center was drawn for a total of 529 participants. From this larger sample, a subsample of participants who were present on the day(s) of the visit was interviewed. Researchers administered questionnaires to center directors, inventoried facilities and equipment and reviewed attendance and financial records.

COMPONENTS OF PLACE

Organization Fifty-three percent of the ADCs were licensed. Certification provides conditions pertaining to funding, usually federal, mostly Medicaid and Medicare, Social Services Block Grant and Older American Act funding. Fifty-four percent of the ADCs were certified, forty percent were both licensed and certified, and thirty-three percent were neither licensed nor certified.

Staff See staffing differences in Outcome under Differences in centers by regulatory status.

OUTCOME

Differences between certification and licensure: Certification requirements stress personnel requirements, minimum hours of service per day, program content, and transportation. However licensure requirements emphasize safety and well-being of the persons being served, for example, elements such as food preparation, building capacity, compliance with health and safety codes, number of toilets, lighting, furnishings, and grounds conditions. Both requirements however do have an overlap.

Differences in centers by regulatory status: Four domains were compared; staffing, services, facility and attendance. Certified centers were more likely to employ a medical director than uncertified centers. They also had a higher overall staff-to-participant and nursing staff-to-participant ratios. Certified centers were significantly more likely to offer nursing services, medical supervision and drug consultation than uncertified centers. Licensed centers were more likely to offer case management, nutrition education, transportation, shopping and physician services than unlicensed centers. Licensed and certified centers were also more likely to be housed in a building used exclusively for day care unlike unlicensed and uncertified centers. They were also more likely to meet handicapped accessibility standards than unlicensed and uncertified centers.

Regulation related to satisfaction: Satisfaction was tested with nine items which yielded three major dimensions in a factor analysis; amenities (center's hours, transportation to and from the center, quality of food, temperature of the facility), overall intrinsic features (satisfaction with center and staff), and milieu (a measure of how crowded and noisy the center seemed). Participants of centers that were neither licensed nor certified were more satisfied with the degree of noisiness and crowdedness of their centers. Satisfaction with the amenities of the center was not significantly correlated with either licensure or certification.

The study concludes that regulatory status does affect the provision of care as showed by the significant differences in staffing, services, facilities and attendance. Also the presence of regulation was associated with increased satisfaction with the overall center and staff.

Werner, B.J. (1994). Adult day care programming and supportive therapies for the frail elderly: How to do it and how to pay for it. *Journal of Long-Term Home Health Care*, 13(2), 251-263.

OVERVIEW

The focus of this article is the Samuels Adult Day Services Center (SADSC), which is an urban medical model Adult Day Care (ADC) program in New York. The themes discussed include activity programming, staffing concerns, expenses / revenues, and marketing options.

NATURE OF INQUIRY

This case study of SADSC was performed by the associate director of the center.

COMPONENTS OF PLACE

Organization

Programming: The goal of activity programming is to encourage engagement of clients in tasks that provide therapeutic benefits in terms of social interaction and cognitive stimulus. Group activities will help alleviate individual problems due to cognitive and/or physical impairments. The ultimate goal is to provide a physically and emotionally stimulating milieu that is appropriate to each impairment level.

Scheduling: Consistent client attendance establishes group cohesion and routine of activity. The clients motivation, attention span, energy level, and financial reserves determine the number of visits per week. One-day-per-week participation is not considered an adequate contribution to the day care experience, 2 or 3 day schedules at minimum are preferred.

Revenues / Expenses: Numerous sources of revenue need to be accessed for a strong ADC program. Various sources such as Medicaid, private pay (client fee), grants, donations, and in-kind subsidies should be utilized. Staffing is the largest expense in the ADC program. Volunteers and adequate retention may help to reduce staffing fees. Specialized employees may reduce the number of billable labor hours to the organization.

Staff

The staff needs to be well-trained (in-service, continued education) and participate in staff development programming (team building skills). Training is especially important in dealing with the possible unpredictable nature of dementia clients, patience and understanding should be emphasized. Utilize volunteer sources such as religious and service organizations and local high schools or colleges.

Family

Client

The clientele at SADSC are frail elderly with physical and cognitive impairments.

Physical Setting

OUTCOME

Wilber, K.H., & Specht, C.V. (1994). Prevalence and predictors of burnout among adult day care providers. *The Journal of Applied Gerontology*, 13(3), 282-298.

OVERVIEW

This study has two major components: (a) to determine the frequency of burnout among the staff of Adult Day Care Centers (ADC's) and (b) to explore the relationship of burnout to demographic characteristics, daily hassles, and perceptions of the work environment. This study proposed two hypotheses, (a) ADC employees have a rate of burnout equal to the norm for health care workers and (b) work environment characteristics will be associated with burnout. The data collected indicated that the ADC staff experienced lower levels of depersonalization and higher feelings of accomplishment; in general the staff experienced a lower than average level of burnout.

NATURE OF INQUIRY

The data was gathered from 102 employees working at 31 ADC's in California. Data was collected through the use of mailed questionnaires, which were sent to the directors and then distributed to the paid employees. The questionnaire packets contained questions concerning six categories, three independent variables (demographics, daily hassles, work environment), and three dependent variables (emotional exhaustion, depersonalization, and personal accomplishment). Daily hassles were evaluated through the use of the Hassles Scale (HS) which lists 117 possible daily hassles, and subjects are asked to identify each hassle and their perceived severity of it. The relationship between the ADC work environment and burnout was examined using the Work Environment Scale (WES). The WES is composed of 90 true or false question's which evaluate the employees' perception of the work environment. The WES is constructed of 10 categories: involvement, peer cohesion, supervisor support, autonomy, task orientation, work pressure, clarity, control, innovation, and physical comfort. Emotional exhaustion, depersonalization, and personal accomplishment were measured using the Maslach Burnout Inventory (MBI-- a 22-question assessment tool.

COMPONENTS OF PLACE

Organization

Staff

The 102 employees in this study were mostly female (89%), ages 22 to 76 (mean age 41.6), and 26% had advanced degrees. Most employees were married (52%), 21% single, 20% divorced, and 6% widowed. Respondents worked an average of 34.4 hours per week and were employed on average for the last 3.4 years.

Family

Client

Physical Setting

OUTCOME

According to the data collected, the first hypothesis (rate of burnout = health care norm) was not fully supported. The results of the MBI indicated that ADC employees did not differ

significantly from the normative data concerning emotional exhaustion (ADC-20.97, Norm-21.35), but did on the depersonalization (ADC-4.23, Norm-7.46) and personal accomplishment scales (ADC-36.96, Norm-32.75). In other words the ADC staff experienced lower levels of depersonalization and higher feelings of accomplishment. As a result the ADC staff experienced a lower than average level of burnout.

The analysis of the data started with the introduction of demographic confounds and professional status into the model for analysis. Next, the two measures of hassles (frequency and intensity) were accounted for in the theoretical model which resulted in demographic and stress variables accounting for 28% of the variance in emotional exhaustion, 21% for depersonalization, and 21% for personal accomplishment. Finally, the work environment variables (.15 significance) were entered into the model. The resulting analysis indicated that work pressure/supervisor support accounted for 10% of the variance in emotional exhaustion, work pressure/supervisor support/control accounted for 12% of the variance in depersonalization, and finally peer cohesion/clarity accounted for 15% of the variance in personal accomplishment. Thus when the WES and MBI variables were combined for analysis it was discovered that they did influence the frequency of burnout, thus supporting the second hypothesis.

The ADC's employees experienced a higher average of daily hassles than the normative data, but reported a more positive work environment on nine of the ten WES sub-scales.

Williams, B. & Roberts, P. (1995). Friends in passing: Social Interaction at an Adult Day Care Center. *International Journal of Aging and Human Development*. 41(1): 79-88.

OVERVIEW

This study explores the existence and type of social interactions and friendships among cognitively impaired adult day care participants. During a five-month participant observation of an adult day care center, fifty-three clients ranging in age from sixty-two to ninety-three were observed. Findings indicated a variety of social interactions and friendships enabling clients to maintain a sense of self and to adjust to group norms. Four types of interaction emerged: general socializing, enduring friendships, helping relationships, and client integration.

NATURE OF INQUIRY

The study explored social interactions and friendship patterns among cognitively impaired day care participants focusing on 1) the types of interactions which take place, 2) the intensity of the bonds, and 3) variables which might contribute to the interactions. Participant observation was conducted by one of the authors who participated as a volunteer on two half-days in a week at an adult day care center in southern California. Staff was found to reinforce certain relationships and discourage others, and played an important role in assigning seating for activities based on functioning levels and gender. Therefore mainly the staff determined access to other clients during regulated activity periods. Thus the study focused on social interaction during 'free time' when clients could choose their friends. Friendship was determined by observing voluntary seating arrangements, conversations and voluntary interaction between clients, and occasional

comments of clients expressing affection or positive sentiments towards other clients during recreational/leisure periods. Data were organized based on frequency or consistency of social interaction and client's functioning level.

COMPONENTS OF PLACE

Organization

ADCs are considered to be structured and safe settings in which clients can engage in meaningful activities. In addition to health maintenance activities and social interaction, Alzheimer's day care centers emphasize reality orientation and the maintenance of communication and motor skills to prevent/delay institutionalization of clients and to provide respite to caregivers. The adult day care center in this study followed a social model -- that is, emphasis was on social rather than medical aspect of client care.

Staff

Family

Client

Clients were categorized into low (28%) and high functioning (72%) people; low functioning clients typically required assistance with activities of daily living (ADLs) and had difficulty in communicating and participating in planned activities whereas high functioning clients could conduct meaningful interactions, required little assistance with ADLs and readily took part in activities. All participants (median age = 77, number of male = 26, number of female = 27) lived at home and a majority exhibited varying degrees of cognitive impairment.

Physical Setting

The adult day care center conducted activities in two large rooms and several small adjoining rooms. The main activity room had a player piano, television, and comfortable padded chairs arranged in two different configurations based on the time of the day. This room was adjacent to a fenced patio with a flower garden, table and chairs. A separate dining room had three tables to seat eight persons each and doubled as an arts and crafts activity room. During activity sessions, seating was regulated in two concentric half-circles – the inner circle contained verbal, high functioning women and the outer consisted of men and low-functioning clients.

Interactions took place in different settings when clients were allowed to roam the center during their free time after lunch;

At the pre-arranged chairs – clients this time chose who they talked to, however they seldom returned to the same chair after a short break to move around or to visit the restroom.

At the patio – people watching was a popular activity at this location; low functioning clients also used this place to meet, sit and hold hands and watch other people outside the center, occasionally reminiscing about their lives.

In the main room – some clients walked around the main room avoiding other locations like the patio, stopping at different points to exchange a few words (e.g., stopped at chalkboard to point out different words to one another).

In the back of the room – a group of friends (the largest social group in the facility) was found to converse here or out on the patio.

OUTCOME

The study found that a majority of the interactions were friendly, cordial and provided a means for passing the time although there were a few enduring social relationships. The enduring relationships were mostly among clients who are long-time members or share a common characteristic. Clients generally tended to associate with members of the same functioning level. Mostly the low-functioning clients (with the higher-functioning client responding out of courtesy) initiated cross-level interactions.

Zarit, S.H., & Stephens, M.A.P., & Townsend, A., & Greene, R. (1998) Stress reduction for family caregivers: Effects of adult day care use. *Journal of Gerontology*, 53B(5), S267-S277.

OVERVIEW

This study was designed to evaluate the psychological benefits of Adult Day Care (ADC) for family caregivers of individuals who suffer from dementia. The data collection procedure utilized both a treatment (users of ADC) and control group (nonusers of ADC). The data collection was performed for initial (baseline), short term (3 months), and long term (12 months) assessment periods. The results of this study indicated that caregivers who had care-recipients enrolled in ADC experienced lower levels of caregiver-related stress and higher levels of well being in comparison to a control group not using the service.

NATURE OF INQUIRY

This study is composed of two experimental groups; treatment (users of ADC) and control (nonusers of ADC). The treatment group consisted of family caregivers that enrolled their care recipient into an ADC, while the control group was composed of family caregivers that did not enroll a care recipient in ADC. The data was collected via a 75-minute interview either in the caregivers home or other location. Both groups were assessed three times: initial (baseline), 3 month (short time), and 12 month (long term). The caregivers in the treatment group were assessed within the first five days of enrollment in ADC.

The interview consisted of six categories (role captivity, overload, worry and strain, depression, anger, and positive feeling) each with its individual assessment tool. Role captivity consisted of a 3 item scale (range 3-12) designed to show the extent to which caregivers feel trapped or constrained by their caregiving role. A 7-item scale (range 7-28) which assessed the extent to which the demands of caregiving are exhausting the caregiver determined overload. An eight item scale (range 8-32) was used to determine worry and strain, which was classified as the extent to which caregiving was a source of chronic physical and psychological strain. A 20 item scale (range 0-60), the Center for Epidemiological Studies Depression Scale (CES-D) was used to measure the extent of depression in caregivers. Anger was measured by a 4 item scale (range 4-16) partially adapted from the Brief Symptom Inventory (BSI). Lastly, positive feeling was

measured by a 10 item subscale (range 10-50) of the Positive and Negative Affect Schedule (PANAS).

The caregivers also evaluated the care recipients for the number of Personal Activities of Daily Living (PADL; eating, dressing, hygiene, etc.) and Instrumental Activities of Daily Living (IADL; cooking, laundry, shopping, etc.) for which he/she required assistance. The relatives also described the number of memory problems and behavior problems that the care recipient exhibited. The caregiver was then asked to rate the amount of time spent on assisting or dealing with PADL, IADL, memory problems, behavior problems, or general supervision of the relative.

COMPONENTS OF PLACE

Organization

Staff

Family

The two experimental groups (treatment and control) consisted of family caregivers from different regions with similar population demographics such as per capita income, median education, % of population over 65, population density, etc... The treatment group was selected from a group of ADC's in New Jersey (n=45), while the control group was selected from Ohio and Pennsylvania.

Clients

The care recipients of the treatment group were required to attend a maximum of eight hours of ADC per week, in contrast to the control group who were required to have less than 8 hours of formal help per week. The average age of the client in the short-term panel and long-term panel was 77.6 and 76.7 years old. Both the short term and long term experimental groups were composed of approximately 60% female clients.

The study also surveyed the clients impairments and activity levels, which were rated on individual scales; PADL (range 0-5), IADL (range 0-5), memory problems (range 1-6), behavior problems (range 1-14). The average number of PADL that clients needed assistance with for both the short-term (2.5) and the long-term (2.3) were lower in frequency than the number of IADL, which were (4.7) for both categories. Both groups had an average number of memory problems of 5.3. Lastly the caregivers reported the average number of behavior problems to be 6.4 and 6.6 for the short-term and long-term groups respectively.

Physical Setting

The Adult Day Care centers in this study are dementia specific facilities located in New Jersey.

OUTCOME

This study utilized both an experimental group (treatment group) and a control group (non-treatment) to analyze the effects of ADC enrollment on caregiver stress and well being. Results indicate that benefits from the ADC program may occur after 3 months of care recipient participation in the program. The data obtained in this study indicates that caregivers of relatives that use ADC programs will experience lower levels of caregiver stress and a better psychological well being.

Zelman, W. M., & Elston, J. M. (1991). Financial aspects of adult day care: National survey results. *Health Care Financing Review, 12(3), 27-37.*

OVERVIEW

This investigation sought to answer two main questions concerning the Adult Day Care Centers (ADC's) in the continental United States: how are the ADC's funded and what are the major operating expenses? The answers to those questions were obtained by surveying the financial performance of several ADC's over an extended period of time.

NATURE OF INQUIRE

The information was collected from 60 ADC's for a 36 month period between January 1983 and December 1986. The data was obtained using mailed surveys, personal interviews, and telephone communication. The financial data was compared according to fiscal years and the formation of two ADC models. The first model of ADC was a nursing home or rehabilitation hospital and the second model of ADC was a general hospital or social service. The data collected was separated into three categories of analysis; (a) Median revenues, expenses, and profits for ADC's, (b) Median revenues and costs per ADC client, and (c) Capacity-adjusted costs per ADC participant day.

COMPONENTS OF PLACE

Organization This study divides Adult Day Care Centers (ADC's) into two model types, rehabilitative hospital / nursing home (Model 1), and general hospital / social services (Model 2).

Staff

Family

Client The nursing home or rehabilitation ADC's (Model 1) generally served a physically dependent, older white population, who did not suffer a mental impairment. The general hospital and social service ADC's (Model 2) served an unmarried, racial minority, with minimal dependence for Activities of Daily Living (ADL's), but suffered from mental impairment.

Physical Setting

OUTCOME

The data collected for the first category of median revenues, expenses, and profits for ADC's was as follows: Median annual revenue was \$143,660, which was generated from a variety of potential sources including, Medicaid, Older American Act, social services, Medicare, private, fund raising, and donations. In terms of expenses, 75% went to direct costs (25% to indirect).

The second category of analysis was revenues and costs per ADC client. The median revenue per client per day was \$28.82 while the total median cost per client per day was \$29.50, indicating a median loss of \$0.68 per client per day. Labor costs are responsible for the bulk of all fees at ADC, accounting for more than 50% of the costs. The median direct labor costs

varied greatly between model 1 (\$22.80 per client day) and model 2 (\$14.20 per client day). Model 1 had a clientele that was more impaired than model 2 and had a higher paid staff.

The final category for analysis was capacity-adjusted costs per client day. This category attempts to account for the inefficiencies associated with volume. Model 1 facilities were operating at a median capacity of 67% and Model 2 facilities were operating at a median capacity of 80%. Increasing the Adult Day Care Centers operating capacity to 100% may reduce the cost per client day. The increased number of clientele will spread the cost of fixed expenditures to a larger number of individuals. A lower client population (due to absenteeism) may result in the waste of assigned employee hours. Flexible employee scheduling and part-time employment may help alleviate the unexpected nature of client attendance.



List of Citations

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