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Feature Article

The process of adult day service use

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ABSTRACT

The objective of this study was to examine why and how families and older adults utilize adult day services. The current study included three months of participant observation in one rural and one suburban adult day service program in an upper-Midwestern region of the United States as well as semi-structured interviews with 14 family members of clients and 12 staff members from these programs. Several key constructs emerged that organized the multiple sources of qualitative data including *programmatic philosophy, positioning, and environment of ADS*; *clients' and family members' reasons for use*; *the process of ADS use by families and clients*; and *pathways to family/client psychosocial and client functional outcomes.* A number of inter-related themes emerged within each construct. The constructs identified and their potential associations among each other were used to expand upon and refine prior conceptualizations of ADS to frame future clinical and research efforts.

Introduction

Adult day service (ADS) programs offer out-of-home supervised activities and socialization for older persons or other adults. Among the goals of ADS programs are to offer families who provide care to elderly relatives with relief from day-to-day care responsibilities of disabled relatives, to enhance the functional independence and quality of life of older clients who attend ADS, and to allow clients to remain in a home/community setting for as long as possible.[1] A recent national survey of ADS programs found that there are 4600 operational programs that serve more than 260,000 people in the United States.[2] Seventy-one percent of all ADS programs operate on a non-profit basis and 61% are affiliated with some other health care organization such as skilled nursing facilities or home care programs.[2] Average client capacity for ADS is 51 with a 6:1 client to staff ratio.[2] Nearly half of ADS clients suffer from some form of dementia, 58% of clients are women, and 69% are 65 years of age and older.[2] The cost of ADS varies based on services provided and utilized and the average is $61.71 per day.[2]

Although research in the 1970s and early 1980s pointed to the potential benefits of ADS in improving life satisfaction and functional dependence of elderly clients, subsequent multi-site, randomized evaluations of ADS offered more ambiguous results.[3] While the mixed findings suggested the limited effects of ADS use on clients' functional outcomes, other quasi-experimental or descriptive studies indicated potential psychosocial benefits for clients such as satisfaction with services and increased life satisfaction, improved emotional well-being for family caregivers, and enhanced adaptation to nursing home admission for clients.[4] A common gap among prior evaluations was that participants were often classified as to whether they used ADS or not; moreover, programmatic or policy characteristics of ADS were not considered. It generally remains unknown how size, staffing, service content, and other program-level dimensions influence key outcomes over time among users.[5,6] Similarly, current research has not adequately specified how family caregivers and clients utilize ADS programs,

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and how this process can lead to potential benefits for family caregivers and their relatives in ADS.

Such gaps can in part be addressed with the use of more appropriate methodologies. For example, ethnographic or grounded theory approaches[7–10] could yield valuable insight into those processes and components of care that appear linked to the key outcomes of ADS utilization.[11–15] These methodologies can also explain those processes and components of care that appear linked to the key outcomes of ADS utilization. In doing so, constructivist/interpretive approaches may suggest: a) pathways to benefit for clients and family caregivers; and b) constructs to operationalize and measure (via quantitative data collection techniques) how clients and families use ADS and what programmatic components are more likely to result in positive outcome for these individuals.

Prior research has relied on constructivist epistemological stances and associated methodological frameworks to develop conceptual models of ADS benefit. Dabelko and Zimmerman[16] postulated that ADS operates through two domains of influence: psychosocial well-being and physical function of clients. Bull and McShane (2008) examined the transition to ADS use for family caregivers of ADS clients and utilized grounded theory techniques to develop a conceptual model that described how families and older adults make the decision to utilize ADS, the adjustment process to ADS, and how families and clients integrated ADS into their everyday lives.[17]

The focus of the present study was to utilize semi-structured interviews and observational information to determine how ADS provides respite to family caregivers and therapeutic benefits to clients. Specifically, this study attempted to identify constructs and their relationships with each other in order to determine how and why families and clients utilize ADS, and whether such use does or does not lead to positive outcomes for clients and family members. Multiple qualitative methods were utilized to understand how potentially therapeutic activities, environmental aspects, programmatic philosophy, and social interaction facilitates client engagement and family well-being. This investigation of the process of ADS use aimed to advance current research by effectively framing clinical practice and future evaluations of ADS to examine how this important type of community-based long-term care can lead to positive outcomes for clients and their family caregivers.

Methods

The methodological framework chosen for this study incorporated elements from qualitative gerontology and grounded theory[8–10,18,19] in order to develop a conceptual model (categories/constructs, themes, and theorized relationships among them) to more fully describe the process of ADS use for clients and family members. University of Minnesota Institutional Review Board approval was granted for the research activities reported here (IRB#0807S39521).

Adult day program settings

Two adult day programs were selected to conduct participant observation and semi-structured interviews (their names are changed to protect confidentiality). The first, referred to as Blue Lake Adult Day Center (BLADC), is located in a rural community approximately 55 miles from a large, upper-Midwestern metropolitan area in a town of 4674 people (as of 2012). The estimated median household income in the town BLADS is located was $37,733 in 2011; estimated per capita income was $19,522. Based on 2010 U.S. Census data, the percentage of White alone residents was 96.47%. The second adult day program, Century Adult Day Services (CADS), is located in a suburb adjoining the same large, upper-Midwestern metropolitan area (population = 20,404 in 2012). The 2011 median household of the town CADS is located in was $52,442; in 2010 85.3% of the population was White alone. BLADC is a private, not-for-profit ADS and has been in operation since 2000. BLADC cost clients approximately $56 per day of attendance. Eighteen clients attended BLADC. BLADC is affiliated with a local nursing home operator but is physically located in a nearby church. CADS is also not-for-profit, has been in operation since 1990, and served 53 clients. CADS cost clients approximately $83 per day of attendance and is not affiliated with a long-term care operator. CADS occupies space in a former community hospital which has been transformed to include CADS (which is located in the former nurses' station area), a nursing home, and several other community organizations. The staffing mix at BLADS included 3 program aides/direct care staff, 1 nurse's aide, and 1 director. The staffing mix at CADS included 1 activity coordinator, 2 program aides/direct care staff, 1 floor director, 1 administrative/executive director of the business office (the business office at CADS also included one billing staff person), 1 owner, 1 manager of in-home services, and 1 physical therapist assistant.

Variations were apparent in client composition. The age range of clients in BLADS was 24–90 years of age, while in CADS the age range was from 56 to 94. Sixty-six percent and 53% of CADS and BLADS clients were women, respectively. All BLADS clients were Caucasian, while only 72% of CADS clients were Caucasian. A high proportion of clients (70% vs. 61%) in CADS and BLADS were Medicaid eligible, respectively. Both programs were open soon after 6:00 AM and closed at 6:00 PM in the evening, Monday through Friday.

Participant observation

Participant observation was utilized to better understand the types of therapeutic activities or rehabilitative services offered in each ADS during various times of the day. A principal goal of the observational activity was to identify how and why certain activities, environmental details, and social interactions facilitated client engagement. An additional goal was to better understand the programmatic context of ADS in terms of its care philosophies and day-to-day operation.

Observations of adult day programs took place from June 2009 to August/September 2009 (with a final observational visit in May, 2010). The first author, who has extensive research experience on ADS programs and their efficacy,[1,3] conducted all observations. Each program was generally observed for an hour every other week during different times and days. While a formal randomized process to identify the days and times participant observations were to occur was not used, the days and times the author attended varied and took place during the following blocks of time: at opening, during the morning activity hours, during lunch, afternoon activity hours, and client departure times. The author assumed a participant observer role;[10,20] he observed activities, staff-to-staff, client-to-staff, and client-to-client interactions and also had several impromptu, unsolicited conversations with ADS directors and staff to discuss the stories of residents or the care philosophy of each ADS. The observational protocol included detailed handwritten notes of activities, the program environment, number of clients, gender of clients and staff present, room location, and client and staff location in each room as well as verbatim transcriptions of oral communication where possible.[9] Usually within 24 hours following an observation notes were recorded in a handheld digital recorder. In addition to these field notes, approximately once per week theoretical and methodological notes were recorded to summarize more general impressions of each ADS and to begin to formulate concepts to explore further. These digital recordings were then