SYNOPSIS

KEY POINT SUMMARY

OBJECTIVES

The purpose of this study is to compare the experiences of residents of various supportive housing types using identical measures to assess residents' quality of care, quality of life, emotional well-being, and social interaction.

Community-Based Versus Institutional Supportive Housing: Perceived Quality of Care, Quality of Life, Emotional Well-Being, and Social Interaction

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Key Concepts/Context

Evidence shows that traditional long-term care (LTC) services have been provided in institutional settings such as skilled nursing facilities with the goal of integrating supports and medical care to meet the medical, personal, and social needs of individuals with cognitive or functional disabilities. In recent years, to expand customer choice LTC is providing care and services in diverse settings, ranging from private homes to supportive housing or group residential settings in the community, to various institutional settings. Among community LTC facilities there are a variety of supportive housing alternatives including private homes, age-restricted or retirement communities, elderly and disabled housing, congregate housing, residential care or boarding homes, foster homes, or assisted living (AL) communities. Offering so many options makes for confusion and uncertainty among consumers in their attempts to identify the best setting for their needs and resources. However, little is known about the experiences of residents living in various supportive housing types.

Methods

- The study used both quantitative and qualitative analyses to compare resident experiences in three types of supportive housing: two from community-based settings, assisted living (AL) and residential care homes (RCHs), and one institutional setting, skilled nursing facilities.
- Data was collected from 150 interviews with residents living in 57 AL communities, RCHs, and NHs.
- Interviews were conducted either in person (80%) or by telephone (20%) based on the respondent's preference by trained research staff.

DESIGN IMPLICATIONS

Designing more private room for the residents of AL and RCHs may improve their living experience, whereas designing semiprivate rooms with one or more other residents may improve the experience of NH residents.

Implementing appropriate policy and design intervention may improve feeling of depression and loneliness.

- In both settings structured questionnaires were used to collect study data.
- In-person interviews took place in a private room in the residence or in the resident's room or apartment.
- Interviews took 30 minutes on average, regardless of setting or respondent type.
- A qualitative survey designed with open-ended questions about the respondents' roles in choosing the residence, how they spend a typical day, what improvements they would like to see, and what an ideal residence would look like will vividly illustrate similarities and differences across housing types.
- Quantitative parts were designed with structured questionnaire focusing on quality of care, quality of life, emotional well-being, and social interactions.
- Quality of care was assessed by two indicators of quality of care. First, an overall assessment of the quality of care they receive, rating it as poor, fair, good, or excellent. Second, residence responses were gathered about fear of retaliation if they were to report a complaint or concern, coded as either yes or no.
- Quality of life was assessed by three subscales indicating three dimensions of quality of life: privacy, dignity, and autonomy, designed from Kane's Quality of Life Measures for NH residents.
- The *privacy* scale included five items that assessed how often respondents can find a place to be alone, make a private phone call, spend time with visitors in a private place, be with another residents in private, and how often staff knock and wait for a reply.
- The *dignity* domain included five items assessing how often staff treat respondents politely, treat them with respect, provide care gently, respect their modesty, and take time to listen.
- The four *autonomy* items indicated how often respondents can go to bed when they want, get up in the morning when they want, decide what to wear, and have been successful in making changes in things they do not like.
- Emotional well-being was measured by three indicators of emotional well-being or distress: (1) two questions of *depressive symptoms* screen, (2) how often they feel *lonely, and* (3) how often the *days there seemed too long, rating as* often, sometimes, rarely, or never.
- Social interaction was measured by three questions: (1) "Do you go out into the community as much as you want to?" (2) "Do you get as many visits from friends and family as you want?" and (3) "Do you communicate with friends and family as much as you want?"
- As independent variables the study included several demographic variables and indicators related to participants' experiences in their supportive housing setting: age group, subjective health, length of stay, marital status, private room, and involvement in choosing the residence.
- Data were analyzed question by question, with a series of basic tests computed: frequency, average, and percentage.

- Differences in background characteristics and the dependent variables among residents of NHs, AL, and RCHs were analyzed using chi-square and one-way ANOVA tests for categorical and continuous data, respectively.
- Logistic and linear regression models were constructed to examine the relationship between housing type and each of the dependent variables, controlling for the following covariates: age group, subjective health, length of stay, marital status, private room, and involvement in choosing the residence.
- Content from the open-ended questions was analyzed using standard qualitative analysis techniques.

Findings

- Examining a wide range of both quantitative and qualitative outcomes, overall results show that AL residents have the best experiences and NH residents report the worst outcomes, with RCHs residents varying in the middle.
- Residents of AL and RCHs were significantly more likely to have a private room, while those in NHs typically shared a semiprivate room with one or more other residents.
- Residents' decision to live in their current residence did not differ significantly among the three housing types.
- Perceived quality of care is high and fairly consistent throughout all three types of supportive housing.
- Around 25% participants reported that they worry about retaliation if they were to report a complaint or concern; the fear of retaliation is very similar across all three housing types.
- Quality of life measured in terms of privacy and autonomy did differ among the three housing types, but they did not differ in feelings of dignity.
- AL residents showed higher scores in privacy and autonomy scale compared to RCH and NH residents.
- More than one-third of respondents reported symptoms of depression, with the highest percentage in NHs (43%) and the lowest in AL (20%).
- A large minority of residents of all three housing types reported feeling lonely often or sometimes, with the highest percentage in RCHs (47%) and the lowest in AL (24%).
- The feeling that the days there often or sometimes seem too long was highest in percentage among RCH residents (50%) and the lowest in AL residents (4%).
- AL residents expressed the most satisfaction with each measure of social interaction compared to RCH and NH residents.
- The qualitative findings showed that the most common reason for why residents of all three housing types were living in current homes include (a) health-related (illness), an acute event or they went there for rehabilitation

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and ended up staying, (b) referred there by someone else, or (c) the location of the facility.
- All three supportive housing types gave overall positive accounts of their daily activities, but the quality of the daily experience varied more in the NH and RCH settings.
- AL residents reported a more uniformly positive experience across facilities. NH residents were most likely to desire improvements in food (20%) and the physical environment (19%), followed by better help (17%). Both AL and RCH residents most commonly said nothing needed improving (44%). Those who did want changes focused on entertainment, followed by food in both settings.
- The qualitative findings demonstrated that the majority of AL residents and a large percentage of RCH residents live in their current homes by their own choice for getting independence and to take care of themselves.

Limitations

Limitations identified by author include:

- The study used a targeted convenience sample which may not be generalizable to all residents of the three types of supportive housing included here.
- In this study, there was no sample recruited below age 65 from the AL facilities. The findings suggested that supportive housing residents below age 65 showed a number of negative outcomes, but it is not possible to say whether this finding is also true for residents in this age group in AL.
- AL residents tend to have higher incomes and assets than those in RCHs; income varies among NH residents. These differences may also explain some results across settings.
- The sample included only English speakers and residents without significant cognitive impairments; the results may therefore apply only to these populations.

The reviewer identified additional limitations in the study including:

- The study did not mention any environmental conditions for supportive housing (sound, lighting, thermal condition, visibility, attractiveness of physical environment) to improve the quality of life, quality of care, emotional well-being, and social interaction among residents of supportive living.
- The study did not mention any physical design features as a factor that may improve the quality of life, quality of care, emotional well-being, and social interaction among residents of supportive living.