SUCCESSFUL AGING CONCEPTUALIZATION AND LONG-TERM CARE: A COMPARATIVE CONTENT ANALYSIS OF BROCHURE ADVERTISING PERSPECTIVE

by

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Abstract

This study provided an exploratory qualitative analysis of printed brochures to evaluate the conceptualization of *successful aging*. Data was collected from a sample of 39 printed brochures derived from Kansas Department on Aging Directory (KDAD) of Adult Care Homes 2009. Content analysis methodology was employed to investigate how these brochures reflect the core elements of *successful aging* as constructed in the gerontological literature (Rowe and Kahn's and Baltes and Baltes), as well as compare across the 'traditional' and 'culture-change' models. Other variables of 'licensure classification', 'residency cost' and 'gender' were explored. An overall perspective indicated several brochures met the core elements of *successful aging* delineated by the literature. In most cases, these elements showed no significance difference for brochures representing facilities by model types, licensure classifications, residency cost and by the demographic of gender.

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Dedication

I dedicate my study to my dad Edgar John, dear sisters Nevlyn, Erlyn and Naeisha and my niece Adele who believed and supported me immensely throughout my educational career. To the memory of my mom, I know you are looking down on me and would be very proud of my achievements. To my fiancé Orlandrew Danzell, for your encouragement, sacrifice and continued support throughout this journey. Continuance of my educational career could not have been possible without everyone's encouragement, motivation, support and love.

CHAPTER 1 - Introduction

Demographic transitions throughout the decades indicate considerable changes in the world's population, transitions range from decreases in fertility rates to increase longevity. Improved medical, nutritional and technological advances mean better health and life expectancy of older adults, changing the character and experiences of aging (specifically *successful aging*). These advancements result in an upsurge in the proportion of aging adults alive today, a population stratum that will increase globally (i.e. 'graying of the globe') especially within developed nations such as the United States (i.e. 'graying of America'). As reported by the Administration on Aging (2008), older adults (i.e. 65+) constitute about 13% (35 million persons) of the total population within the U.S. By 2030, this population is expected to almost double in size to approximately 20% (69 million persons) when the baby boom cohort (those born between 1946 and 1964) transitions into retirement age (U.S. Census Bureau 2008; Spillman et al. 2002). Furthermore, the U.S. aging distribution trends indicate variations in the population of older adults across all fifty states (Campbell 1996) with significant increases in the South and Midwestern regions. According to the U.S. Census, Kansas among other states (Missouri, Arkansas, Massachusetts and Connecticut) has a substantial proportion of older adults. Approximately 14 to 16 percent of the state's total population comprises of adults age 65 and older. Given these emergent population trends, both at state and national levels, an expansion for long-term care options for older Americans is imperative (AARP, 1993; Eskildsen and Price 2009), as well as ways of promoting success in aging in later life.

Although long-term care is deemed a necessary transition for many older adults and their families, the movement however from non-institutional into formal care often changes one's lifestyle choices, social environment, and overall quality of life (QoL). Furthermore, care institutions constitute a diverse demographic of older individuals (such as by age and gender), each experiencing aging or success in aging in varying ways. Given the varied understanding of aging, it is crucial that it not be discussed or promoted as a homogeneous process, but instead based on the diversity or heterogeneity that exists across the aging population stratum. Hence, it becomes important that optimal quality of life (QoL) (finding ways to ensure success in aging) is maintained at all levels of the aging process. Baltes & Baltes (1990) contend that *successful aging* is important in understanding the potential of aging, because of the "untapped reserves of

the elderly" and to incite a "probing analysis of the nature of old age as it exist today" (p. 4). Perhaps this perspective is most important within Nursing Homes, Assisted Living and Residential Health long-term care (LTC) facilities than other social structures which purpose is aimed towards providing personal services to a large, diverse group of older adults across all aging demarcations (i.e. from 'young old' to 'old-old').

It is evident by the literature that numerous studies (past and present) explore the concept of *successfully aging*. However, research examining this concept via long-term care advertising remains non-existent. The proposed study has been undertaken to explore and describe this positive construction of aging (i.e. *successful aging*) as exemplified in a variety of advertised brochures from LTC facilities. Exploring the conceptualization of *successful aging* from this perspective is significant because an increase proportion of older adults at varying ages and needs reside or request long-term care residency. Besides, formal long-term care providers are more closely involved in the lives of this diverse group and are in positions to directly implement or reinforce behaviors, philosophies, and images to promote aging successfully which can ultimately increase the number of older individuals who achieve successes in aging. According to several scholars, it is salient to advance programs, social policies and services that improve optimal quality of life (QoL) and promote *successful aging* in later life (Rowe & Kahn, 1998, 1987; Ryff 1982; Baltes, 1990, 1987), endeavors that can be readily provided by formal LTC organizations. Further, other scholars emphasized that a philosophy for growth and creative development needs to be encourage in later life (Cohen, 2005; Hill 2005).

Although the common intent of the selected LTC facilities in this research is one of advertising care to an aging audience, it is notable that they may vary in their philosophy of aging. This difference may further influence the conceptualization of *successful aging* and how it is featured in brochures classified into 'traditional' and 'culture-change' facilities. Applying two major schools derived from the gerontology literature, the conceptualization of *successful aging* is explored across all facilities. Combined, both schools encompass five core elements of 'social health', 'physical and mental health', 'emotional-spiritual health', 'autonomy/personal choice and independence', and 'privacy and safety'. The first application (established mostly by the works of Rowe & Kahn, 1987 and discussed more traditionally), defines *successful aging* exclusively from a 'Physiological-Psychosocial' perspective. Since their conceptualization of *successful aging* forms a major part of the discourse throughout this thesis, a brief description is identified here. Rowe and Kahn emphasized three characteristics to measure an individual who

has aged successfully or ways in which *successful aging* can be attained: (1) low disease and disability, (2) maintaining high cognitive and mental functioning, (3) active engagement. Although their approach has merit and is germane to this study, it is embedded exclusively within the elements of physical as well as psycho-social health in conceptualizing *successful aging*. Rowe and Kahn's three-part criteria proves a less objective measure of *successful aging* because of the limited features it encompasses (criteria reflective only in some older adults and by LTC facilities that accommodate mostly 'young-old, ignoring other potentials of aging adults).

To address the built-in bias established from the first application, Baltes and Baltes (1990) present a non-traditional discourse of *successful aging* (departing from the narrow criteria posited by Rowe & Kane). Advancing on with the 'Emotional-Spiritual' characteristics to 'Subjective' states of *successful aging*, Baltes and Baltes (1990) produce a more thorough yardstick for comparing brochures representing 'traditional' and 'culture-change' facilities. Their application indicates that *successful aging* can be achieved regardless of one's physical or mental limitations. In other words, foregoing ageist labels often attributed to older adults'. While the conceptualization of *successful aging* seems multidimensional (*successful aging* conjure various features and meanings), the two major schools capture important aspects in conceptualizing *successful aging* and form the basic discourse throughout the research. In essence, both approaches provide positive perspectives of aging.

This introductory chapter outlines the organizing framework for my current research. It is organized in the following manner: Chapter I presents the introductory overview of the underlying conceptualization of *successful aging*, purpose and objective of study, and the central research questions; Chapter II reviews the literature that is pertinent to the current study and definition of key terms; Chapter III is the methodology section including the research design, data collection, categorization and coding procedures; Chapter IV details data analysis, interrator reliability; Chapter V reports results from the analyses and discussion of findings; Chapter VI concludes the research and highlights limitations and implications.

Purpose and Objective of Study

I believe dichotomies in the discourse of aging are evident and clearly noticeable in long-term care advertising: ageist stereotypes versus a positive perspective of aging (i.e. a traditional versus a non-traditional construction of aging). My study is motivated in part by the notion that

despite ageist stereotypes and labels commonly misconstruing the meaning of growing old, we must not allow these negative social and cultural constructions to dissuade us from conducting research that focuses on aging in successful ways. Therefore, my study investigates how a selection of long-term care facilities promotes aging (i.e. the conceptualization of *successful aging*) themselves to an aging population. For the purpose of this research I explored the elements of *successful aging* from the perspective of printed brochures specified within two major schools from the gerontology literature. Utilizing a content analysis methodology, I am investigating the tenets of *successful aging* as advocated by the two schools (discussed above) for any similarities and/or/ differences that may emerge between advertised brochures representing facilities in the 'traditional' and 'culture-change' models. The schools are applied to determine if their conceptualization of *successful aging* is observable in the content units. If so, how do they compare across model types. Both the visual images and written narrative were examined since messages communicated in the content units may vary, but provide important details about the advertiser's intent.

Part of the rationale of this study also explored the prevailing concept across these facilities based on the prevalence of core elements to show that these elements, or any combination, may or may not be the message and image that LTC facilities (i.e. 'traditional' and 'culture-change') desire to communicate. How then are long-term care facilities advertising opportunities for residents to age successfully (i.e. based on the five core elements)? Ultimately, this study forms a basis for theory building because of its exploratory nature. Other values include providing LTC facilities within the United States with helpful information that allows for advancement of positive philosophies and images of the aging process. Also, to promote messages as well as services, conducive for enjoying an optimal quality of life (QoL) for older adults at all levels in the aging process.

To address the central questions in the current study, 39 printed brochures were analyzed employing the qualitative assessment method of content analysis and quantifying results for further statistical analysis. In particular, the data collected were aimed at (a) measuring *successful aging* for a selected group of facilities utilizing two major schools generated from the literature; (b) examining potential disparities in the conceptualization of *successful aging* across model types, licensure classifications, residency cost and gender; (c) comparing any significant differences/similarities across these facilities to provide a more descriptive analysis from the

observations; and (d) make inferences to contribute to the overall discourse of *successful aging* observed in this research.

To systematically test the central questions, the core elements were operationalized using specific indicators to explore brochures representing facilities in the 'culture-change' and 'traditional' models, by licensure classifications and residency cost. For a more comparative analysis, I explore the conceptualization of *successful aging* across an additional variable of gender. Because long-term care facilities vary, the following central questions were explored:

RQ1: How do advertised brochures from long-term care facilities in the state of Kansas reflect core elements of the successful aging concept used in the gerontology literature? In particular, the characteristics presented within two major schools by 'Rowe and Kahn' and 'Baltes and Baltes'.

RQ2: How do advertised brochures representing facilities in the 'traditional' model compare with facilities in the 'culture-change' models across the core elements of successful aging?

CHAPTER 2 - Literature Review

Gerontological investigations throughout the decades provide a more comprehensive discourse in aging and age-related issues affecting older adults. Several studies indicate that the elderly are beset by physical, mental and cognitive limitations as they age, yet, numerous studies focus primarily on positive constructions and meanings of aging (Rowe & Kahn, 1998, 1987; Baltes & Baltes 1990; Palmore, 1979; Havighurst, 1961; Vaillant, 2002; Lawton, 1983). Establishing discourses in aging from the positive-success context (i.e. non-traditional perspectives) are important in changing the negative connotations often associated with the aging process. *Successfully aging* has been one such perspective under much discussion. The question however arises, what constitute s*uccessful aging*? *Successful aging* is a concept that is broadly defined. In general terms, features that encourage improvements and satisfaction in the overall quality of life (QoL) in later years are salient in defining *successful aging*. The primary purpose of this chapter is to review the scholarships germane to the current study as it pertains to *successful aging* within the U.S by consolidating various scholarly criteria for an inclusive definition.

To date, the literature provides numerous explanations of the *successful aging*, still, no clear consensus on a single definition or measurement of the concept exists. The diverse characteristics in explaining *successful aging* lends itself to varying perspectives. In this study however, two major schools derived from the gerontology literature guide the discussion on *successful aging*. Although these perspectives represent opposing views, they provide valuable contributions in conceptualizing the concept via printed long-term care advertising. The first application discusses the "Psychosocial and Physiological" perspective (primarily by Rowe & Kahn); whereas the second focuses on the "Emotional-Spiritual" and "Subjective" states (primarily by Baltes & Baltes). Discussions on both perspectives are presented next.

While their explanations are far from complete, the works by Rowe and Kahn (1998) from the MacArthur Successful Aging Project provide a requisite contribution in conceptualizing *successful aging* throughout this study, mainly incorporated into formulating the first approach (see also Cohen 2003; Verbrugg & Jette, 1994; Phelan et al. 2004; Adams & Bliezner, 1995; Lang & Carstensen, 1994). From Rowe and Kahn's (1998) perspective, three core features define someone who has aged successfully or what constitute *successful aging*: the ability to maintain (1) low risk of disease and disease-related disability; (2) high cognitive and physical functional

capacity; and (3) active engagement with life" (p. 38). They suggest that 'low risk of disease and disease-related disability' is an important element that can influence the aging process, specifically experiences of *successful aging*. This criterion entails avoiding illness or preventing the ill from becoming disabled, and assisting older individuals with physical limitations to avoid further risks. In agreement, some older adults' themselves associate success in later life with the absence or reduction of chronic ailments and the ability to care for one's self (Phelan et al., (2004). Equally important, are the criteria of 'high cognitive and physical functionality' and 'active engagement with life.' Based on these two later criteria, s*uccessful aging* is explained as engagement in activities/exercises, classified into 'interpersonal relations' (i.e. contacts and transactions with others), and 'productive activity' (i.e. activities that "[produce] societal value that help to retain and stimulate the cognitive and physiological abilities of older adults") (Rowe & Kahn 1997:433-434). Cohen (2003) for example, supports this reasoning and suggests that maintaining levels of activeness are "important for obtaining and sustaining satisfaction, self-esteem, and overall health" (p. 114). Other scholars also agree that the maintenance of activities (active lifestyles i.e. social health) and contact with others can affect how an individual ages (*i.e. successful aging*), and improve the well-being and coping abilities for adults in later life (Adams & Bliezner, 1995; Lang & Carstensen, 1994; Centers for Disease Control 2003).

Together, the first premise in conceptualizing *successful aging* is well established by social and physiological explanations. Furthermore, Rowe and Kahn (1998) emphasized that the element of physical health is the "crux of successful aging" (cited in Novak p. 112) and is contingent on behavior or ones health, lifestyle choices and efforts. To age successfully, one must be in "[sound] body, mind, and social environments if you are to live and age ideally" (Bortz 1996: 51). Specifically, Rowe and Kahn (1991) themselves define *successful aging* as "people who demonstrate little or no loss in a constellation of physiologic functions [and] would be regarded as more broadly successful in physiologic terms" (p. 21). It is by this explanation, the first approach seemed limited in its scope and too rigid, providing dichotomies of successful vs. unsuccessful aging in later life. Faber et al., (2001) posit that Rowe and Kahn's view of *successful aging* is described as "the positive extreme of normal aging [however] others see successful aging as a successful adaptation of the individual changes during the aging process" (p. 2694). Goldfield (2003) strengthens the claims reiterating that *successful aging* include social support, active involvement in physical and cognitive activities, cultivation of attitudes of self-efficacy, mastery, and curiosity; avoidance of unhealthy behaviors (p. 194).

As an important tenet of *successful aging*, Rowe and Kahn (1987) believed that to better understand the aging process researchers need to focus on the heterogeneity that exists among older adults, a perspective that departs from the essentialist belief that all older adults experience aging the same way (based primarily on the declines in aging). This perspective sparks discussion that older adults vary not only across demographic patterns but also in their quality of life (QoL), experiences and levels of success in aging. Albeit Rowe and Kahn emphasized the importance of heterogeneity among older adults, their perspective on *successful aging* seemed biased, and in several cases unachievable among older adults experiencing cognitive and physical limitations. According to Friedrich (2001), "one can show no signs of disease or disability, but deal with later life in unsatisfying ways." (p. 150). Rowe and Kahn's construction however, served as an important explanation of what constitute a healthy, vital, positive image of aging. It is a useful approach employed in the conceptualization of *successful aging* throughout this study, and helpful in assisting care institutions in fostering behaviors and features for an enhanced quality of life (QoL) in later life.

Often emphasized in the traditional context, the discourse thus far, (primarily by Rowe and Kahn) suggests that many older adults may be excluded or only a few will meet the criteria to age successfully. Going beyond the traditional application, advocates of the second school posit that individuals with physical limitations or disability can still age in successful ways. These advocates present a new conceptual framework of *successful aging* rooted in the emotional-spiritual and subjective states (Baltes and Baltes 1990, 1996; see also Ryff 1982; Hilton et al., 2009; Post 2003; Crowther et al., 2002; Himes et al., 2004; Nadelson 1990; Vaillant 2002; Flood 2002; Wink and Dillon 2003). Baltes and Baltes (1990) proposed a six-dimensional model which qualifies important elements of *successful aging* linked to the second school: self-acceptance, positive relations with others, autonomy, environmental control, spirituality or attaining a sense of purpose, maximizing independence (freedom from dependence) and personal growth. Hilton et al., 2009 for example indicate that "making the most of a difficult situation, maximizing independence and autonomy, and finding satisfaction and meaning in life, whatever the circumstances," the "inner experience" of aging (pp.40-41) constitute *successful aging.* Other constructs of *successful aging* from the works of Baltes and Baltes (1996) and others include: subjective states (i.e. happiness, control emotional wellness), personal control, and emotional wellness. Furthermore the strengthening of one's reserve capacities through educational, motivational and health-related activities reinforces growing old successfully or realizing "age

not as a defeat, but as a victory" (Loetterle 1994:9). In other words, growing old in itself is a successful achievement.

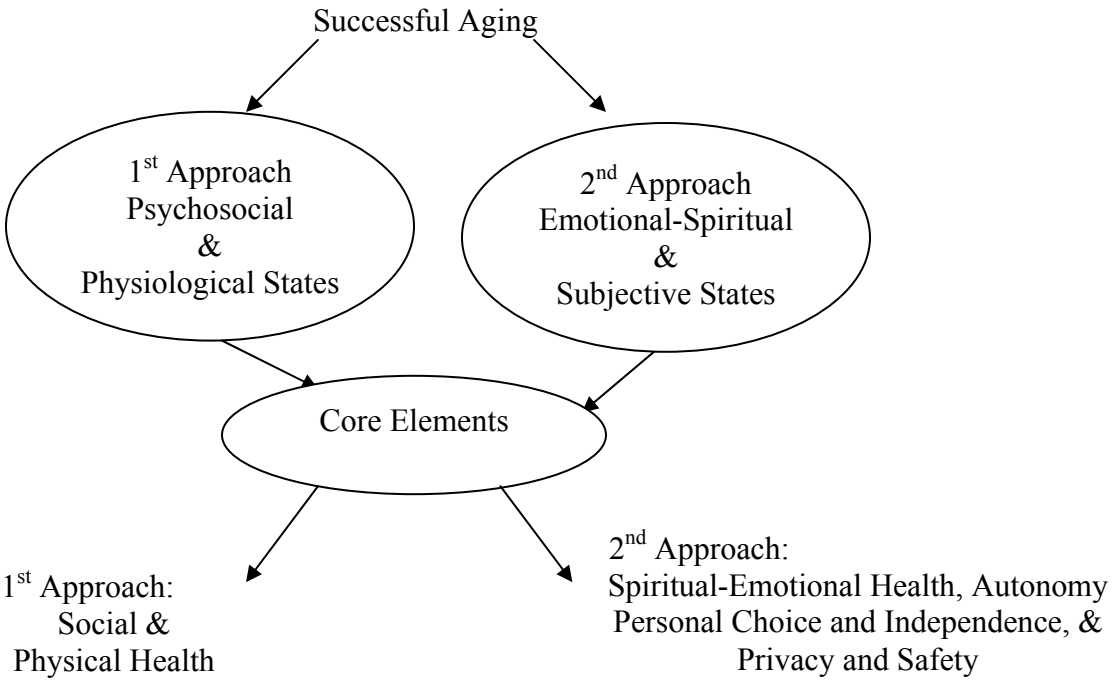
According to Baltes and Baltes, "*successful aging* [encourages] people at [any] age or physical condition, to make the most of their ability" (cited in Novak 2009, p. 116) and believe that 'length of life' is the "prototypical indicator of successful aging" (Baltes & Baltes 1990:5). Ryff (1982) suggested that *successful aging* can be achieved at any stage in the life span. In other studies, it is defined not only in terms of prolonged life (i.e. longevity) but the satisfaction derived from it (Havighurst, 1961; Palmore 1979, 1995). Furthermore, older adults experiencing functional limitations such as chronic illnesses or disease-related disabilities can age successfully employing the 'selective optimization with compensation' (SOC) method (Baltes & Carstensen, 2003; George, 2006, cited in Novak, 2009, p. 116). Several other general principles are outlined that encourage *successful aging* as: length of life, engagement in healthy lifestyles, society flexibility (i.e. social competence) personal control and life satisfaction.

Thus far the explanations provided by the second school depart from labeling older adults as aging successfully vs. unsuccessful aging. These scholars focus primarily on the quality of life (QoL) component of aging successfully rather than the physical construct commonly employed by the first school. Other scholarly contributions to the body of knowledge on *successful aging* included the works of Bryant et al., (2001), Crowther et al., (2002), Post (2003) and Tornstam (1989), Vaillant (2002), Himes et al., (2004). Some of these scholars believed that spirituality is a pivotal element in the discourse on *successful aging* that is too often omitted. As an addendum to the first approach, Post (2003) posits that 'spirituality' or attaining a sense of purpose should be a significant component in defining *successful aging* which offers meaning and purpose in life. Furthermore, positive spirituality is a vital mechanism of aging successfully rather than the element of physicality (Crowther et al., 2002; Himes et al., 2004; Vaillant 2002). Advancing a similar argument, spirituality or positive meanings of life allow individuals to age successfully despite their physical or mental health conditions (Flood 2002; Wink and Dillon (2003). In essence, the dimension of spirituality encompasses the philosophy of personal well-being and satisfaction in life and adds to a more advanced conceptualization of *successful aging* and quality of life (QoL) in later years.

It is apparent that in examining the literature on *successful aging*, conceptual differences emerged. In light of these established perspectives, *successful aging* is multidimensional. The scholars in the first school focused primarily on the physical and psychosocial aspects of

successful aging. The advocates in the second school provided a broader view of *successful aging* rooted in the emotional, spiritual, and subjective aspects of the individual (Figure 1). These varying approaches allowed for a greater understanding of the aging process and what it means to grow older successfully (i.e. optimal aging). This study adopted the view that apart from these variations, common elements of the *successful aging* were consolidated into the definition applicable to this research. For this study, *successful aging* is a multifaceted phenomenon that embraces a philosophy for growth, creative development and wellness, states of physical functional capacity/health, cognitive efficacy, social competence, emotional, psychological and cultural well-being, spiritual connectedness or a sense of purpose, as well as establishing autonomous lifestyles and choices in an effort to promote a healthier, vital, satisfied and enhanced quality of life (QoL) for older adults.

Figure 1. Major Gerontological Approaches and Core Elements Conceptualizing Successful Aging



Thus far, the literature elaborates on key elements pertinent to the conceptualization of *successful aging*. While several scholarships have been established, no research has yet explored the conceptualization of *successful aging* from the perspective of long-term care advertising. This is unfortunate since these institutions are directly allied to a diverse group of aging adults (i.e. 'young old' and 'old-old'), and placed in important positions to be more cognizant of the aging process. According to Kane (2001), a good quality of life (QoL) (and in this case, elements for successful aging) should be "elevated to a priority goal for LTC rather than a pious afterthought to quality of care" (p. 297). It requires a sense of safety, security, and order, dignity, functional competence, relationships, meaningful activity, enjoyment, physical comfort, privacy, individuality, autonomy/choice, spiritual well-being (Kane 2001:287-298), important elements to ensure *successful aging* in later life.

As one of the first investigations, this study conceptualized *successful aging* from the perspective of printed long-term care advertising. Davis and Davis (1985) state that, "advertising is an attempt to influence judgment of a considerable number of people about a particular product or activity" (p. 59). Advertisements are seen as vehicles for promoting an organization's objective or belief with structured content of what the advertiser deemed as important to promote to a target audience. Hence, advertising via printed brochures may serve older adults in their post retirement years with important information prior to acquiring formal residential accommodations. Friedrich (2001) emphasized that "the primary audiences for successful aging are practitioners dealing with older adults and prospective practitioners enrolled in higher education" (p. 77). For instance, in the proposed study the selected printed brochures may present images or narratives that distinguish between facilities and describe their intent and services of continued quality of life (QoL) for the elderly. Information communicated via advertised brochures to older adults can reflect an ideology of the traditional constructions of aging, or drastically departs from this image allowing for an ideology of enhanced quality of life (QoL) for older individuals. Hilt and Lipschultz (2005) stated, "in the case of shared beliefs about aging, it is possible that media provide a cultural explanation for our understanding for growing old-one that may offer easy negative stereotypes rather than complex description" (p. 20) (i.e. labels often generalized to the aging populations that conceals the diversity of a broad age group).

Since the community formed within LTCF's represents a diverse group of older adults, several facilities have embarked on a movement toward transforming their goals and

philosophies of the aging process, departing from the traditional perspective (often associated with the traditional medical model). Categorized as the 'culture-change' model, these facilities embrace new constructions of aging. Calkins (2002) stated "culture change, or re-structuring, or re-engineering, or resident-directed care, or resident-centered care, this movement is all about changing the way nursing homes operate" (pp. 45-46). Nevertheless, facilities within this model often vary because they are at different stages in the culture-change process. Based on changes in their initiative aimed at reestablishing elements such as independence, autonomy and resident-center care, the rationale is simple: Since the 'culture-change' perspective of aging reflects nuances of change in the quality of life (QoL) and ideology of aging for older adult requiring long term care, it is important for these facilities to promote information that emphasize these sentiments. The content unit (words/concepts/images) can clearly highlight the elements of *successful aging* as part of the advertising message or deviate from promoting that ideology.

It is important to study the demographic of race in the conceptualization of *successful aging* because of variations that exist across the racial categories of older individuals. For this study however, only the demographic of gender was explored because the images represented in the brochures were not racially diverse. As part of the rationale on gender, it is reported that with increases in the number of older adults alive today, females outnumber their male counterparts (Kausler and Kausler 2001). Nevertheless, few males are physically disabled and they maintain community roles that permit leadership (Baltes & Baltes 1990:333). Moreover, women report higher rates of ADL[1] and IADL[2] limitations compared to their male counterparts and constitute the majority of nursing home and assisted living residents (Novak 2009; Stein et al., 1986;). The Institute of Medicine reports that "elderly woman are more likely to reside in long term care facility, more cognitively impaired and have greater limitations with activities of daily living" (p.1). Therefore, the rationale in exploring gender rests on the premise that since older females tend to reside in LTCFs, the images displayed in the advertised brochure should portray more females than males. Nevertheless, the core elements in conceptualizing *successful aging* may be less observable in the images representing older female vis-à-vis males.

An important question to be measured in this research pertains to socio-economic status and quality of life (QoL). Using daily and monthly residency costs as a proxy of residential SES

[1] Activity of daily living

[2] Instrumental activities of daily living

(socio-economic status), the rationale indicates that facilities categorized as 'more-expensive vis-à-vis 'less expensive may vary in the core elements conceptualizing *successful aging*.

In conducting a comparative exploratory research, the information obtained can assist professionals and long-term care agencies and providers to reevaluate their behaviors, ideologies and image of the aging process to better provide services to the elderly to enhance quality of life (QoL) and promote success in aging.

Definition of Terms

Before delving further, explaining key terminologies are essential to provide clarity to the reader. The following discussion provides the meaning of several important concepts used throughout this study. Aging is defined as, "a fundamentally a biological process" (Masoro 1999, p. xi). In agreement, Albert (2004) defines aging as "the maturation and senescence of biological systems" (p. 25). As De Beauvior (1972) succinctly states, "old age, is not a time for wisdom or summing up, it is a time for continual engagement" (p. 21). The World Health Organization (WHO) defines aging as a "process of progressive change in the biological, psychological and social structure of individuals" (cited in Franklin & Tate 2008, p. 6). Specifically, *successful aging* is defined as "adding life to years" and "getting satisfaction from life" (Havighurst 1961). Gibson (1995) defines *successful aging* as enjoying states of physical, social, and psychological wellbeing in later life that is self-gratifying. To other scholars, *successful aging*, is usually used "as a construct for those individuals who are healthy in their latter decades of life, the "healthy elderly" (Franklin and Tate 2008, p. 6). It is adaptation to aging "to maintain or achieve life satisfaction, high morale, and psychological well-being" (Thesaurus of Aging Terminology p. 140). In general terms, spirituality is defined as an individual's "ultimate concern, the basic value around which all other values are focused, the central philosophy of life" (Moberg 2001 cited in Novak 2009 p. 137).

Long-term care "is a system of activities undertaken by informal caregivers (family, friends, and/or neighbors) and/or professional (health, social and other) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment, and human dignity" (p. 36) (2000,http://www.milbank.org/ooo712oms.pdf cited in Weiner & Ronch 2003). For this study, long term care refers to all services provided by nursing homes (NH), assisted living facilities

(ALF) and residential health care facilities (RHCFs), for older individuals. As used in this research, nursing homes (NHFs) are facilities that offer 24-hour care to the 'old old'. The services offered entail assisting residents with daily activities such as bathing, dressing, meals and, general mobility. Assisted living facilities (ALFs) provide a less supervised care service. These facilities may provide occasional assistance in bathing, dressing and medication to residents, and meals are often provided in a dining setting. ALFs are "between independent living and nursing care" (Golant, 1992, p. 249) in a "home-like" environment. According to the AARP, 1998a, "the philosophy of assisted living emphasizes personal dignity, autonomy, independence, and privacy. The objective [is] to maintain or enhance the capabilities of frail older adults and persons with disabilities so they can remain as independent as possible in a home-like environment by providing services that intensify or diminish, as resident's needs change" (p. 1). These facilities comprise of private rooms and it is estimated that in the US, there are approximately over 20,000 such facilities providing residence for 1 to 2 million older adults (Kausler and Kausler 2001).

The Culture-Change Model consists of long-term care facilities aimed at rejecting the normative assumptions about aging. Facilities of the newer 'culture-change' model seek to improve and provide a less institutionalized environment for older adults. These facilities exemplify the following values: "responding to the spirit as well as the mind and body needs; putting persons before tasks; seeking to enjoy residents and staff as unique individuals; acting on the belief that as staff are treated so will residents be treated; beginning decision making with the resident; and accepting risk taking as a normal part of adult life (Fagan et al., 1997 p. 300 cited in Kane 2001). According to Roth (2005) "Culture change is a movement in the United States and other countries in terms of how we improve care for frail elders in institutional settings. It is a departure from the traditional medical model for elder care that tends to focus on physical or biological needs of residents" (p. 234). The Traditional Model comprises of care facilities that focus more on the medical component of providing care service to the elderly.

CHAPTER 3 - Methodology

Description of Sample

This chapter provides the methodology used to collect, analyze and quantify the data in the current study. The first part of the chapter provides a description that outlined the characteristics of the selected sample. The following parts explained the data collection and coding procedures. In previous studies, several advertising mediums are utilized in researching issues related to aging. Yet, no existing study has examined printed brochures in the context of aging research. Using brochure is a useful media for content analysis since it entails specific information that expresses profound beliefs and values an institution communicates as salient to a target audience (i.e. prospective residents or their families). Furthermore, brochures present an unobtrusive but relevant way to examine data pertinent to older adults.

Brochures were selected as the most appropriate unit of analysis because of the content characteristics and relevance to the research purpose. Their appearance ranged from the standard tri-fold design to packets containing glossy booklets and a few folder-styled layouts detailing the facility's intent. Some brochures included sketches outlining the architectural design, maps, and other organizational details. To ensure a representative sample of brochures, the database of all LTCFs made available by the Kansas Department on Aging Directory (KDAD) of Adult Care Homes 2009 was employed. The initial sampling frame consisted of 463 licensed care facilities. A simple random sampling technique produced an overall sample of n=27 brochures representing facilities in the 'traditional' model, and the total population of N=12 brochures representing facilities in the 'culture-change' model.

The brochures[3] selected from the 'culture-change' model were derived from a list provided by an expert.[4] These facilities were removed from the database. The remaining database represented facilities only within the 'traditional' model. Selection of facilities for the 'traditional' model was based on the following core stratifying variables I considered as salient for a relevant sample. These included: Management of premises (profit, not-for profit); Location

[3] No purposive sampling was needed for brochures representing the culture-change model. The total population of facilities was utilized.

[4] Prior to the commencement of the research, a meeting was held with Dr. Gayle Doll, the expert on "culture-change" model in the state of Kansas to obtain the facilities within the "culture-change" model.

(metropolitan, micropolitan, "other rural"); Facility size (large/small facility) and facility type. Of the 27 sampled facilities in the 'traditional' model, 16 (59%) were profit oriented and 11 (41%) were govern as non-profit management. A total of seven (26%) brochures represented facilities located in the metropolitan area, 10 (37%) located within the micropolitan counties, and 10 (37%) brochures represented 'other' rural locations. The bed size accounted for brochures representing 9 (33%) large facilities, and 18 (67%) smaller ones. For the last stratifying variable, 20 (74%) brochures represented NHF, 5 (19%) from ALF and only 2 (7%) represented RHCF. Taken together, all brochures used in the analysis (i.e. 'traditional' and 'culture-change' facilities) represented 39 facilities limited to Nursing Home Facilities (NHFs), Assisted Living Facilities (ALFs) and Residential Health Care Facilities (RHCFs). The distribution of all brochures is shown below (Table 1).

Table 1 Characteristics of Sample Data

	Model Type			
	Traditional	Total %	Culture-Change	Total %
Licensure Classification:				
NHF	20	74%	12	100%
ALF	5	19%	0	0
RHCF	2	7%	0	0
TOTAL	27	100%	12	100%
Location:				
Metro	7	25%	7	58%
Micro	10	37%	4	33%
Other Rural	10	37%	1	8%
TOTAL	27	100%	12	100%
Management:				
Not-for-profit	11	41%	11	92%
Profit	16	59%	1	8%
TOTAL	27	100%	12	100%
Facility Size:				
Large	9	33%	10	83%
Small	18	67%	2	17%
TOTAL	27	100%	12	100%

Data Collection

To establish consistency in this study, only printed brochures were utilized because several facilities do not allow for both online and print advertising. Using printed media for the

analysis was convenient, cost effective and readily accessible. Brochures were gathered via telephone contacts and were the units of analysis. These brochures represented facilities within the 'traditional' and 'culture-change' models. The rationale for using advertised brochures representing facilities within these two distinct models allowed for a more comparative analysis across long-term care facilities. As a whole the selected sample size was adequate in exploring the research questions. Each brochure was inspected by two independent coders to complete the analysis employing a systematic coding procedure.

Categorization and Coding Procedure

Despite several drawbacks often associated with content analysis, this method was appropriate in exploring the central questions under investigation. Before delving further, defining this method is important. Content analysis is described as a "technique for gathering and analyzing the content of text. The content refers to words, meanings, pictures, symbols, ideas, themes, or any message that can be communicated. The text is anything written, visual, or spoken that serves as a medium for communication. It includes books, newspapers or magazine articles, advertisements, speeches, official documents, films or videotapes, musical lyrics, photographs, articles of clothing, or works of art" (Neuman, 2003:310). Other scholars posit that the technique of content analysis improve inferences with the use of written text, and allows to objectively and quantitatively describe the manifest content of communication (Carney 1972).

Since no one model or consensus exist in discussing how best to conceptualize *successful aging*, the approaches employed were well suited for the purpose of this research. Because the concept was not directly apparent in the research material, it was conceptualized and measured from the perspectives of two major schools derived from the gerontology literature ('Psychosocial and Physiological' vs. the 'Emotional-Spiritual/Subjective States') via five core elements. The first school conceptualized *successful aging* by incorporating elements of (1) Social Health (SH) and (2) Physical Health (PH). Past research (primarily by Rowe and Kahn) has shown that these elements are pivotal to age successfully in later life. The second school included the core elements of (3) Spiritual-Emotional Health (SEH); (4) Autonomy/Personal Choice and Independence (APCI); and (5) Privacy/Safety (PS) in conceptualizing *successful aging*.

These five core categories were operationalized into subcategories. Formulating specific subcategories reduced the chance of low reliability when employing a content analysis

methodological approach. Several operational referents (i.e. specific indicators) were developed and used to empirically measure the core elements that were not easily observable to determine if the distinguishing core elements were reflected in the brochures. Budd et al., (1967) states that using indicators or subcategories are important to "point out a characterization that is not, itself, measurable" (p. 42). Specifically, this included coding for the image and written narrative content units in each brochure. It is presumed that coding the formal content of a brochure can elicit significant meanings and messages of the facility's/care providers intent. Budd et al., (1967) states, "you may be chiefly interested in content characteristics, [what] the content indicates about the source's [advertisers'] perceptions of his audience or the possible effect of the content on the audience" (p. 42). For example, the second image in the brochure representing 'Bethany Home' was coded for the element of 'social health' (Appendix G). In addition, the core elements were coded to compare facilities in the "traditional" and "culture-change" models as well as across other dimensions such as licensure classifications, residency cost and gender.

Before the actual coding process began, both coders participated in a pre-test session to establish interrator reliability as requisite in adding consistency to the methodology employed. Together, four brochures were analyzed which mirrored the categorical elements in the coding scheme for the actual study measured by 163 indicators. The interrator reliability score was computed using the coding results from the pre-test results. This pre-exercise was important in addressing potential questions or issues that may arise before the official coding procedure. After the preliminary coding process, the coder-assist was given a sample of the data materials for further review then we met to discuss the coding frame and other issues before the actual coding process.

In the actual coding process, the content units (i.e. written narrative and images) were quantified using the revised self-constructed coding scheme comprised of 126 indicators, encompassing all five core elements from both gerontological schools (See Appendix A). Observations for each brochure were first manually recorded using the constructed coding sheet after which I electronically transferred the information into a database using SPSS programming for further data analysis. All brochures in sample were double-coded to control for bias and establish reliability. The coder-assist first coded the brochures then submitted these to me to be coded. For the assigned task, both coders were instructed to scrutinize the content units in each brochure and record how they reflect the core elements of *successful aging*. To provide a common frame of reference and ensure accuracy in coding, definitions of the relevant core

categories and subcategories conceptualizing *successful aging* were developed and made available to both coders (See Appendix B & C).

In addressing the research questions, the core elements were re-coded to create new variables. Hence, RQ1 and RQ2 were measured using the indicators corresponding to each core element for the narrative and image contents. To code the written narrative, two analytical approaches were employed. Using the first approach, specific words or concepts (latent and manifest content) in the brochure that accurately corresponded to the indicators presented in the coding sheets were manually recorded for each core element. The scores for the total indicators in each category were summed to generate new variables *(Social Health1, Physical Health1, Emotional-Spiritual Health1, Autonomy/Personal Choice and Independence1, and Privacy and Safety1).* These new variables ranged in values from 0 (operationally defined if none of the indicators were present) to a very large number (operationally defined if the indicators were presented many times). The responses recorded were used to determine if there was an overall presence or exclusion of the core element of *successful aging* in the brochures.

Utilizing the first approach must be cautiously interpreted since it may not accurately represent the presence of the core elements (i.e. skewed variables) in conceptualizing *successful aging*. For instance, in the core category of *'Social Health1'* if an indicator was mentioned 9 times while no other was mentioned, this yielded a score of 9. Likewise, all nine indicators can yield the same score if the nine indictors were presented only once. Although the scores were of same numerical value, they do not report the same results. The first approach however yielded a larger range and variance and applied to measure of the core elements of *successful aging* to determine whether or not they were reflected in the overall sample of advertised brochures, as well as to explore RQ2.

Applying the second approach in coding the narrative content, a binary coding system of 1 (if an indicator was present at least once-regardless of number occurrences), and 0 (if the indicator was not mentioned), was used to create new variables. The new variables generated *(Social Health2, Physical Health2, Emotional-Spiritual Health2, Autonomy/Personal Choice and Independence2, and Privacy and Safety2)* were nominally measured and were the summary of these recoded variables, taking values between 0 to the total number of indicators within each category (for instance ranging from 0-9 in the case of the *Social Health* category). Keeping in mind the intent of research questions, this approach can easily report which school (s) was/were prevalent by the presence counts of the core elements in the brochures. These quantifications

were further used to make comparisons across brochures within 'traditional' and 'culture-change' models, by different licensure classifications and across cost categories.

Although the written narrative is an important content unit in exploring the conceptualization of *successful aging,* the image component is equally important. According to Budd et al., (1967) "the character is usually employed as a coding unit to find the answer to a highly specialized question" (p.34).To analyze the image content, two approaches were also used. In the first approach, the actual 'image' presence with perceived older characters (65+) indicating the core elements of *successful aging* was coded. Coding of these 'images' involved counting the total number of images that portrayed the indicators for each core element conceptualizing *successful aging* creating re-coded variable of *Social Health3, Physical Health3, Emotional-Spiritual Health3, Autonomy/Personal Choice and Independence3, and Privacy and Safety)*. For instance, in coding the image content for the element 'social health,' all 'images' that portrayed the indicators for the 'social interaction' subcategory were counted and divided by images with older characters. Approach one controlled for the difference in the ratio of images with or without older characters. Using the re-coded variables, the 'traditional' and 'culture-change' models were compared.

The second approach counted the actual physical presence of 'older characters' representing specific indicators for each core category. Coding by the actual 'older character' presence involved counting the number of 'older characters' that portrayed the indicators for the five core elements, divided by the total number of characters in the brochures that are older individuals. For instance, the element of 'social health' was coded by counting the number of 'older characters' that portrayed the indicators for the subcategory 'social interaction,' divided by the total number of 'older characters' in the brochures (creating part of Social Health4). The re-coded variables generated by the second approach were *Social Health4, Physical Health4, Emotional-Spiritual Health4, Autonomy/Personal Choice and Independence4, and Privacy and Safety4*. Utilizing both approaches indicate how actual 'images' and 'older characters' presented in the brochures featured the characteristics of *successful aging* established in the gerontology literature and which school (s) was/were most often emphasized.

To code the demographic of gender aimed at exploring how the image content unit featured the core elements in conceptualizing *successful aging*, the following definitions were developed: Gender was operationally defined as-Male (physical appearance of older men) and Female (the physical appearance of older women). To code for gender, similar approaches

mentioned above were employed. First, the actual 'images' (with older male and female characters) portraying the indicators of the core elements were summed and divided by the total images with older characters. This process generated variables of *Social Health5, Physical Health5, Emotional-Spiritual Health5, Autonomy/Personal Choice and Independence5, and Privacy and Safety5*. Second, the physical appearance of 'older characters' depicting specific indicators for the core elements were counted and recorded. This process generated recoded variables of *Social Health6, Physical Health6, Emotional-Spiritual Health6, Autonomy/Personal Choice and Independence6, and Privacy and Safety6*. For instance, to measure *successful aging* via the core category of 'physical health,' the number of times a particular older male or female appeared physically active (e.g. older adults seen playing, exercising etc.) was counted and recorded then divided by the total number of older male or female characters. These scores were used to compare gender of 'older characters' across the element of 'physical health' in conceptualizing *successfully aging* and across other variables.

As an important demographic, only I analyzed for socio-economic status (SES). While this variable was challenging to analyze in this study, it remained important in distinguishing between brochures representing facilities as less-expensive vis-à-vis more expensive in exploring the conceptualization of *successful aging*. I identified the relevant cost categories (if applicable) for each brochure in the sample. The categories were derived using the median of daily and monthly residency costs charges made available in the brochures. As a proxy of residential SES, the brochures were classified as: (1) Less expensive-operationally defined if the daily cost of residency is less than $175 per day or $2750 or less per month; (2) More expensive-defined as facilities that cost $175 or more per day or $2750 or more per month. Brochures that did not provide cost figures were marked as NA (See Appendix D). Using daily and monthly residency costs as a proxy for residential SES, the rationale seeks to distinguish which brochures (representing 'more' or 'less' expensive facilities) reflect the core elements of *successful aging*.

In this chapter, I presented a detail account of the methodological approach employed to measure the core elements in conceptualizing *successful aging*. The chapters that follow establish interrator reliability, data analysis, results and discussions believed to be both reliable and valid in conceptualizing *successful aging*, the conclusion and limitations, and implication for future research.

CHAPTER 4 - Data Analysis

Interrator Reliability Scores

To ensure that the coding instrument was reliable and to establish consistency and objectivity in this research, interrator reliability scores were derived. According to Budd et al., (1967), to establish reliability and control for random errors in the results, it is suggested to compute the "correlation coefficient of the results of two coders who coded the same material" (p. 67). Applying the core category sets in the coding sheet, four brochures were evaluated. Reliability scores of the two coders were determined by the coefficient of reliability formula developed by Holsti (1969) to assess whether the methodological approach yielded similar results among both coders. The interrator reliability score established between both coders was 0.86[5]. Since these are nominally measured variables, frequency agreement counts were used to determine the interrator score (Appendix E). This score was calculated by the number of times both coders assigned the same score to the content category (i.e. same counts for an indicator within a subcategory). The outcomes yielded acceptable pre-test reliability scores among the coders.

Data Analysis

To assess how the elements of *successful aging* were reflected in the content units and compared across a variety of facilities, the data was analyzed via five core elements derived from two major gerontological schools discussed above. To achieve a valid analysis, I re-coded the five core elements to create new variables. These variables were created to measure the conceptualization of *successful aging* within the narrative and image contents and to compare the brochures in the "traditional" and "culture-change" models. Other variables (licensure classification, and residency cost) were explored for further analysis.

The demographic of race was omitted from the study. This variable provided no practical meaning in establishing comparisons because older white characters disproportionately represented the images portrayed vis-à-vis non-whites. Beyond this demographic however, gender allowed for a more comparative analysis because there was a perceivable depiction of

[5] It takes into consideration the probability of chance.

equality within the data, reflecting more gender diverse images (but unrepresentative to the general older population) of older characters.

Since the variables in this research were scaled at nominal and ratio levels of measurement, the most appropriate statistical assessments include SPSS routines of descriptive analyses, frequencies and ANOVAs (analysis of variance) to analyze the data. Descriptive analyses were used to calculate the mean, and standard deviations of the variables. The actual frequencies were used to calculate the number of times each score of the core elements occurred in the brochures. ANOVAs were used to compare means of variables.

By the end of the statistical analysis, I was in a good position to reach conclusions about the proposed research questions that motivated this study. Thus, the results should challenge or support my knowledge about how the conceptualization of *successful aging* was depicted in advertised brochures across a selection of long-term care facilities (LTCFs). Exploring the data from the perspectives of both schools can show the degree to which brochures advance the tenets in each school mentioned. In addition, the results attempt to lay the foundation for further qualitative research in *successful aging* via long-term care advertising. The results and discussion are presented in the chapter that follows.

CHAPTER 5 - Results and Discussion

A comprehensive presentation and discussion of the research findings is now provided. In reference to the first central question, the research investigated how advertised brochures reflect the core elements of *successful aging* established from the gerontology literature. Five core elements were applied to analyze the narrative and image content units using a content analysis methodology. These elements include 'social health,' 'physical health,' 'spiritual-emotional health,' 'autonomy/personal choice and independence,' 'privacy and safety.' For the narrative content, two approaches were used. In the first approach, (using the actual frequency), it was reported that of the 39 brochures analyzed, 38 (97%) reflect the element 'social health1.' The range in presence of the element was from zero to 20 respectively. The frequency score for 'physical health1' indicate that 37 of the brochure (95%) reflected this core element at least once with a range in presence from 0 to 25. The element of 'spiritual-emotional health1' revealed that all but one brochure reflected this element 38 (97%). The two remaining elements were less reflected in the brochure. Of the 39 brochures, 34 (87%) promoted the element of 'autonomy personal choice and independence1.' Similarly, 33 brochures (85%) reflected the element of 'privacy and safety1.' The results suggested that the core elements of *successful aging* were advertised in brochures but the elements of social health1, physical health1, and spiritual-emotional health1 were most often reflected (See Table 2)

Table 2 Frequency Distribution for Core Elements for Narrative Content Gerontological Schools

	Psychosocial-Physiological		Emotional-Spiritual/ Subjective States	
	# of Brochures (39)		# of Brochures (39)	
CORE ELEMENTS	Present	Absent	Present	Absent
Social Health1	38 (97%)	1 (3%)		
Physical Health1	37 (95%)	2 (5%)		
Spiritual-Emotional Health1			38 (97%)	1 (3%)
Autonomy Personal Choice and Independence1			34 (87%)	5 (13%)
Privacy and Safety1			33 (85%)	6 (15%)

The data results in the second approach report similar findings. According to the data, of the 39 brochures, 38 (97%) reflected the element of 'social health2'. The element of 'social

health' was portrayed at least once in each brochure. 'Physical health2' indicators were reflected in 37 (95%) of the brochures. Of the remaining elements, 'spiritual-emotional health2' was evident in 38 (97%) brochures, 34 (87%) brochures indicated the element of 'autonomy personal choice and independence2' and 33 (85%) portrayed 'privacy and safety2' indicators. The results thus far illustrated that the core elements conceptualizing *successful aging* were reflected in the written narrative for the majority of brochures. Although all elements were present, to some extent, the results were consistent with the ideologies posited by Rowe and Kahn indicating that 'physiological and psychosocial' elements are imperative to age successfully.

The next research question concerned how the brochures (representing facilities in the 'traditional' vs. the 'culture-change' models) compared across core elements of *successful aging*. An inspection of the narrative results (1st approach), showed that there were no significant differences in the conceptualization of *successful aging* by model type (Table 3). Table 4 reports the results of the narrative content (2nd approach). The results also indicate that there were no significant differences in the core element conceptualizing *successful aging* by model type.

Table 3 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type-1st Approach

Variable	*Core Element*	*M*	*SD*	*Sig.*
MODEL TYPE:				
Culture-Change	SH1	7.25	3.745	
Traditional	SH1	7.11	4.758	
				.929
Culture-Change	PH1	8.58	7.012	
Traditional	PH1	5.44	3.042	
				.057
Culture-Change	SEH1	9.83	7.457	
Traditional	SEH1	7.70	4.898	
				.295
Culture-Change	APCI1	4.42	2.937	
Traditional	APCI1	3.41	2.872	
				.321
Culture-Change	PS1	5.75	4.673	
Traditional	PS1	4.00	3.187	
				.180

Table 4 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type- 2nd Approach

Variable	*Core Element*	*M*	*SD*	*Sig.*
MODEL TYPE:				
Culture-Change	SH2	4.08	1.676	
Traditional	SH2	3.74	1.933	
				.599
Culture-Change	PH2	2.75	1.422	
Traditional	PH2	2.59	1.248	
				.730
Culture-Change	SEH2	4.08	1.379	
Traditional	SEH2	3.67	1.641	
				.448
Culture-Change	APCI2	2.33	1.073	
Traditional	APCI2	2.07	1.466	
				.586
Culture-Change	PS2	2.42	1.379	
Traditional	PS2	2.04	1.315	
				.417

The same core elements conceptualizing *successful aging* were investigated for further comparison using the variable of 'licensure classification.' For the narrative content, the results indicate no significant difference at the .05 level in the conceptualization of *successful aging* by licensure classification (Table 5). Table 6 also showed no significant difference across brochures representing nursing home, assisted living and residential health care facilities when the second approach was applied.

Table 5 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Classification -1st Approach

	LICENSURE CLASSIFICATION			
CORE ELEMENTS	NHF	ALF	RHCF	*Sig.*
Social Health1				
M	7.22	7.00	6.50	
SD	4.470	5.244	3.536	.973
Physical Health1				
M	6.72	5.60	3.50	
SD	4.998	4.037	.707	.612
Spiritual-Emotional Health1				
M	8.81	4.20	11.50	
SD	6.029	2.280	3.536	.188
Autonomy Personal Choice & Independence1				
M	3.91	3.00	2.50	
SD	2.988	2.345	3.536	.682
Privacy & Safety1				
M	4.34	5.60	5.00	
SD	4.005	2.510	.000	.780

Table 6 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Classification -2nd Approach

	LICENSURE CLASSIFICATION			
CORE ELEMENTS	NHF	ALF	RHCF	*Sig.*
Social Health2				
M	3.88	3.40	4.50	
SD	1.737	2.304	3.536	.768
Physical Health2				
M	2.66	2.60	2.50	
SD	1.310	1.517	.707	.984
Spiritual-Emotional Health2				
M	3.81	3.20	5.00	
SD	1.575	1.483	1.414	.392
Autonomy Personal Choice & Independence2				
M	2.25	1.60	2.00	
SD	1.368	.548	2.828	.609
Privacy & Safety2				
M	2.09	2.20	3.00	
SD	1.422	.447	1.414	.655

Table 7 and 8 represent the results of the written narrative for the variable 'residency cost' in comparing the core elements of *successful aging*. The result in table 7 showed that there

was no significant difference in the conceptualization of *successful aging* by 'residency cost'. Table 8 indicate a significant difference at the.05 level in *successful aging* for the core element 'privacy and safety' by residency cost. Facilities that are 'more-expensive' reflected narrative for the element 'privacy and safety' than those that are 'less-expensive'.

Table 7 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Residency Cost -1st Approach

CORE ELEMENTS	Less Expensive	More Expensive	Unspecified	*Sig.*
Social Health1				
M	6.68	8.08	6.80	
SD	5.297	3.088	4.739	.691
Physical Health1				
M	7.17	7.25	5.13	
SD	6.658	2.800	4.224	.428
Spiritual-Emotional Health1				
M	6.75	11.00	7.53	
SD	3.864	8.345	3.944	.156
Autonomy Personal Choice & Independence1				
M	3.00	4.42	3.73	
SD	2.923	2.937	2.890	.499
Privacy & Safety1				
M	3.58	6.08	4.07	
SD	4.010	2.968	3.900	.218

Table 8 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Residency Cost -2nd Approach

CORE ELEMENTS	Less Expensive	More Expensive	Unspecified	*Sig.*
Social Health2				
M	3.92	4.00	3.67	.891
SD	2.466	1.651	1.496	
Physical Health2				
M	2.83	2.75	2.40	
SD	1.586	.965	1.298	.656
Spiritual-Emotional Health2				
M	3.58	4.33	3.53	
SD	1.311	1.614	1.685	.364
Autonomy Personal Choice & Independence 2				
M	2.58	2.58	2.27	
SD	1.084	1.311	1.486	.178
Privacy & Safety2				
M	1.67	3.08	1.80	
SD	1.155	.793	1.474	.010

The following findings illustrated the results of the image component in investigating how brochures reflect the core elements of *successful aging* established from the gerontology literature (research question 1). Table 9 shows the number of brochures with actual 'images' reflecting the core elements of *successful aging.* The two subcategories (social interaction and character position) for the element 'social health3' revealed that 22 (56%) brochures portrayed images of older characters reflecting the 'social interaction' indicators, and seven brochures (18%) reflect images for 'character position[6]' indicators. The frequency scores for 'physical health3' indicate that 20 brochures (51%) portrayed 'images' with older characters reflecting indicators of 'physical activeness' (i.e. subcategory 1), and 26 (67%) reflect 'images' for 'mobility' indicators (i.e. subcategory 2). Results for 'spiritual-emotional health3' indicate that of the 39 brochures investigated, 23 (59.0%) portrayed 'images' reflecting this element. Frequency scores reported that 17 (44%) brochures promoted 'images' for the element of 'autonomy personal choice and independence3', while 6 (15%) reflected the element of 'privacy and safety3.'

Table 9 Frequency Distribution for Core Elements by Image Content Unit-1st approach Gerontological Schools

	Psychosocial-Physiological		Emotional-Spiritual/ Subjective States	
	# of Brochures		# of Brochures	
	Present	Absent	Present	Absent
CORE ELEMENTS				
Social Health3				
Social Interaction	22 (56%)	17 (44%)		
Character Position	7 (18%)	32 (82%)		
Physical Health3				
Physical Activeness	20 (51%) 26	19 (49%)		
Mobility	(67%)	13 (33%)		
Spiritual-Emotional Health3			23 (59%)	16 (41%)
Autonomy Personal Choice and Independence3			17 (44%)	22 (56%)
Privacy and Safety3			6 (15%)	33 (85%)

[6] A subcategory used to measure the element of 'social health' which tells that for higher frequency scores, characters are positioned as more socially active in the brochures.

Table 10 illustrates results for the first research question using the actual physical appearance of 'characters' in the image content of brochures. According to the data results, 22 (56%) brochures portrayed older 'characters' reflecting the 'social interaction' indicators and 26 brochures (67%) reflect older 'characters' portraying 'character position' indicators. Together, both represented the element of social health4. The frequency scores for 'physical health4' indicate that 20 brochures (51%) portrayed the presence of older 'characters' reflecting indicators of 'physical activeness' (i.e. subcategory 1), and 26 (67%) reflect 'mobility' indicators (i.e. subcategory 2). Of the 39 brochures, 22 (56%) portrayed older 'characters' reflecting the element of 'spiritual-emotional health4.' The element 'autonomy personal choice and independence4', showed that 17 (44%) brochures portrayed older 'characters' reflecting this element. Only one brochure (3%) depicted older 'characters' for the element of 'privacy and safety4.'

Table 10 Frequency Distribution for Core Elements by Image Content Unit-2nd Approach Gerontological Schools

	Psychosocial-Physiological		Emotional-Spiritual/ Subjective States	
	# of Brochures		# of Brochures	
	Present	Absent	Present	Absent
CORE ELEMENTS				
Social Health4				
Social Interaction (SH4-SI)	22 (56%)	17 (44%)		
Character Position (SH4-CP)	26 (67%)	13(33%)		
Physical Health4				
Physical Activeness (PH4-PA)	20 (51%)	19 (49%)		
Mobility (PH4-M)	26 (67%)	13 (33%)		
Spiritual-Emotional Health4 (SEH4)			22 (56%)	17 (44%)
Autonomy Personal Choice and Independence4 (APCI4)			17 (44%)	22 (56%)
Privacy and Safety4 (PS4)			1 (3%)	38 (97%)

The findings listed in table 11, 12 and 13 are concerned with how brochures representing facilities across 'model type', 'licensure classification' and 'residency cost' compared across the core elements of *successful aging*. An inspection of the actual 'image' results (1st approach), showed that there were no significant differences in the conceptualization of *successful aging* by

model type (Table 11). The same result occurred when 'licensure classification' was investigated. The results showed no significant difference (Table 12). The results for variable 'residency cost' indicate that there were significant differences between 'more-expensive' and 'less-expensive' facilities for levels of 'autonomy personal choice and independence' and 'privacy and safety' (Table 13). The mean scores indicate that brochures representing facilities as 'less-expensive' placed more emphasis on the element of 'privacy and safety.' Those representing 'more-expensive' facilities however, emphasized the element of 'autonomy personal choice and independence'.

Table 11 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type-IMAGES

Variable	*Core Element*	*M*	*SD*	*Sig.*
MODEL TYPE:				
Culture-Change	SH3-SI	.2412	.27149	
Traditional	SH3-SI	.3492	.35518	
				.355
Culture-Change	SH3-CP	.1061	.28704	
Traditional	SH3-CP	.0382	.10887	
				.287
Culture-Change	PH3-PA	.3512	.25498	
Traditional	PH3-PA	.2896	.26265	
				.567
Culture-Change	PH3-M	.5352	.31715	
Traditional	PH3-M	.7403	.24071	
				.072
Culture-Change	SEH3	.7926	.19205	
Traditional	SEH3	.5511	.38183	
				.088
Culture-Change	APCI3	.3259	.28857	
Traditional	APCI3	.2038	.19142	
				.200
Culture-Change	PS3	.4111	.98545	
Traditional	PS3	.1389	.47140	
				.336

Table 12 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Classification –IMAGES

CORE ELEMENTS		NHF	ALF	RHCF	*Sig.*
Social Health4					
Social Interaction	M	.3449	.0571	.5000	
	SD	.32093	.12778	.70711	.143
Character Position	M	.0720	.0000	.0000	
	SD	.19862	.00000	.00000	.648
Physical Health4					
Physical Activeness	M	.3429	.0714	.0000	
	SD	.25277	.10102		.169
Mobility	M	.6755	.7143	.5000	
	SD	.28325	.40406		.820
Spiritual-Emotional Health4					
	M	.5975	.8571	1.0000	
	SD	.34998	.20203		.345
Autonomy Personal Choice & Independence4					
	M	.2572	.2143	.0000	
	SD	.23043	.30305		.558
Privacy & Safety4					
	M	.2583	.0000	.0000	
	SD	.71668	.00000		.836

Table 13 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Residency Cost –IMAGE

CORE ELEMENTS		Less Expensive	More Expensive	Unspecified	*Sig.*
Social Health4					
Social Interaction	M	.2308	.3507	.3564	
	SD	.33932	.33880	.33869	.577
Character Position	M	.0492	.0290	.0910	
	SD	.14434	.06790	.25988	.673
Physical Health4					
Physical Activeness	M	.2658	.4592	.2339	
	SD	.25512	.27605	.21661	.142
Mobility	M	.7432	.6680	.6229	
	SD	.28006	.22870	.32553	.670
Spiritual-Emotional Health4					
	M	.6476	.7163	.5584	
	SD	.32500	.25261	.42650	.629
Autonomy Personal Choice & Independence4					
	M	.2494	.4184	.1145	
	SD	.32109	.23175	.14174	.012
Privacy & Safety4					
	M	.7125	.0313	.0227	
	SD	1.14821	.08839	.07538	.050

Continuing to explore research question two, Table 14, 15 and 16 further illustrated results of how the image content in brochures representing facilities by 'model type', 'licensure classification' and 'residency cost' compared across the core elements of *successful aging*. The physical appearance of older 'characters' within the images were investigated which revealed that there were significant differences in the conceptualization of *successful aging* for variable 'model type'. The mean scores indicated that brochures representing the 'traditional' model placed more emphasis on the elements of 'social and physical health' (Table 14). Further results showed there were' no significant differences in the core element conceptualization of *successful aging* by 'licensure classification', and 'residency cost' (Table 15 & 16).

Table 14 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type-CHARACTER

Variable	*Core Element*	*M*	*SD*	*Sig.*
MODEL TYPE:				
Culture-Change	SH4SI	.3907	.33293	
Traditional	SH4SI	.6318	.32116	
				.031
Culture-Change	SH4CP	.7321	.31693	
Traditional	SH4CP	.8451	.15648	
				.222
Culture-Change	PH4PA	.3349	.29126	
Traditional	PH4PA	.2622	.27563	
				.531
Culture-Change	PH4M	.4471	.27907	
Traditional	PH4M	.7031	.28002	
				.034
Culture-Change	SEH4	.6767	.31524	
Traditional	SEH4	.4791	.37041	
				.183
Culture-Change	APCI4	.3097	.28382	
Traditional	APCI4	.2695	.27983	
				.729
Culture-Change	PS4	.0000	.00000	
Traditional	PS4	.0222	.09428	
				.490

Table 15 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Class. –CHARACTER

CORE ELEMENTS		NHF	ALF	RHCF	*Sig.*
Social Health4					
Social Interaction	M	.5620	.2000	1.0000	
	SD	.32691	.28284		.141
Character Position	M	.8000	.8000	1.0000	
	SD	.22631	.28284		.696
Physical Health4					
Physical Activeness	M	.3181	.0500	.0000	
	SD	.27812	.07071		.251
Mobility	M	.6186	.7500	.3333	
	SD	.30279	.35355		.545
Spiritual-Emotional Health4					
	M	.5047	.8000	1.0000	
	SD	.35544	.28284		.241
Autonomy Personal Choice & Independence4					
	M	.3016	.2000	.0000	
	SD	.27999	.28284		.530
Privacy & Safety4					
	M	.0167	.0000	.0000	
	SD	.08165	.000000		.944

Table 16 Means, Standard Deviations and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Residency Cost –CHARACTER

CORE ELEMENTS		Less Expensive	More Expensive	Unspecified	*Sig.*
Social Health4					
Social Interaction	M	.4110	.6339	.5936	
	SD	.37835	.32777	.31674	.380
Character Position	M	.6726	.8481	.8759	
	SD	.32849	.15324	.12909	.120
Physical Health4					
Physical Activeness	M	.2357	.4110	.2338	
	SD	.23819	.30465	.27906	.331
Mobility	M	.6744	.6274	.5695	
	SD	.28774	.28809	.33713	.764
Spiritual-Emotional Health4					
	M	.6384	.6504	.4003	
	SD	.32881	.30692	.39454	.229
Autonomy Personal Choice & Independence4					
	M	.2503	.4268	.2021	
	SD	.25562	.24609	.29293	.205
Privacy & Safety4					
	M	.0000	.0500	.0000	
	SD	.00000	.14142	.00000	.317

The next question investigated how the core elements conceptualizing *successful aging* compared across gender categories. Table 17 illustrates the number of brochures with actual 'images' (i.e. approach 1) of older males and females reflecting the core elements of *successful aging.* 18 (46%) brochures represented 'images' with older males, and 21 (54%) portrayed 'images' with older females for the element 'social health5' (i.e. 1st subcategory-social interaction). 22 (56%) brochures portrayed 'images' of older males, and 23 (59%) portrayed 'images' with females for 'social health5' (2nd subcategory -character position). The frequency scores for 'physical health5' indicate that 15 (39%) brochures portrayed 'images' with older males reflecting indicators of 'physical activeness' (i.e. subcategory 1), and 16 (41%) reflect 'images' with older females. 19 (49%) brochures portrayed 'images' with older males for 'mobility' indicators (i.e. subcategory 2), and 24 (62%) represented 'images' with older females. Results for 'spiritual-emotional health5' indicated that 15 (39%) brochures portrayed 'images' of older males, and 21 (54%) portrayed older females reflecting that element. Frequency scores reflecting the element of 'autonomy personal choice and independence5' showed 12 (31%) brochures represented 'images' with males, and 14 (36%) females. The core element of 'privacy and safety5' revealed that zero 'images' of older males were portrayed, and only 1 (3%) brochure featured 'images' of older females.

Table 17 Frequency Distribution for Core Elements by Gender-1st Approach (IMAGES) Gerontological Schools

	Psychosocial-Physiological		Emotional-Spiritual/ Subjective States	
	# of Brochures		# of Brochures	
	Present	Absent	Present	Absent
CORE ELEMENTS				
Social Health5				
Social Interaction				
Male	18 (46%)	21 (54%)		
Female	21 (54%)	18 (46%)		
Character Position				
Male	22 (56%)	17 (44%)		
Female	23 (59%)	16 (41%)		
Physical Health5				
Physical Activeness				
Male	15 (39%)	24 (62%)		
Female	16 (41%)	23 (59%)		
Mobility				
Male	19 (49%)	20 (51%)		
Female	24 (62%)	15 (39%)		
Spiritual-Emotional Health5				
Male			15 (39%)	24 (62%)
Female			21 (54%)	18 (46%)
Autonomy Personal Choice and Independence5				
Male			12 (31%)	27 (69%)
Female			14 (36%)	25 (64%)
Privacy and Safety5				
Male			0 (0%)	39 (100%)
Female			1 (3%)	38 (97%)

Table 18 illustrates results for gender using the actual physical appearance of older 'characters' in the image content of brochures. The results showed similar findings for the core elements reported above.

Table 18 Frequency Distribution for Core Elements by Gender -2nd Approach (CHARACTER)

Gerontological Schools

	Psychosocial-Physiological		Emotional-Spiritual/ Subjective States	
	# of Brochures		# of Brochures	
	Present	Absent	Present	Absent
CORE ELEMENTS				
Social Health6				
Social Interaction				
Male	18 (46%)	21 (54%)		
Female	21 (54%)	18 (46%)		
Character Position				
Male	22 (56%)	17 (44%)		
Female	23 (59%)	16 (41%)		
Physical Health6				
Physical Activeness				
Male	15 (39%)	24 (62%)		
Female	16 (41%)	23 (59%)		
Mobility				
Male	18 (46%)	21 (46%)		
Female	24 (62%)	15 (39%)		
Spiritual-Emotional Health6				
Male			15 (39%)	24 (62%)
Female			21 (54%)	18 (46%)
Autonomy Personal Choice and Independence6				
Male			12 (31%)	27 (69%)
Female			14 (36%)	25 (64%)
Privacy and Safety6				
Male			0 (0%)	39 (100%)
Female			1 (3%)	38 (97%)

Table 19 and 20 present results concerned with how brochures representing facilities across the 'traditional' and 'culture-change' model and by licensure classification compared across the core elements of *successful aging* for the demographic of gender. An inspection of the actual 'image' results (1st approach), showed significant differences. The mean scores indicated that for the 'culture-change' model, when the core element of 'spiritual-emotional health' was portrayed, images with older males were represented more than images with older females. On

the other hand, the mean scores indicated that for the 'traditional' model, when the core element of 'physical activeness' was portrayed, images of older females were represented more than images of older males (Table 19). When 'licensure classification' variable was investigated, the results indicated no significant difference for gender (Table 20).

Table 19 Means and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type –IMAGES

CORE ELEMENTS		Traditional (Means)	Culture-Change (Means)	*Sig.*
Social Health5				
Social Interaction	Male	.2298	.1679	.534
	Female	.4295	.2623	.129
Character Position	Male	.3233	.4747	.236
	Female	.5878	.4444	.270
Physical Health5				
Physical Activeness	Male	.1692	.1630	.938
	Female	.1453	.2216	.352
Mobility	Male	.2694	.2586	.927
	Female	.5480	.3043	.033
Spiritual-Emotional Health5				
	Male	.1527	.5580	.005
	Female	.4280	.4784	.704
Autonomy Personal Choice & Independence5				
	Male	.1216	.1519	.664
	Female	.1693	.1963	.741
Privacy & Safety5				
	Male*	.0000	.0000	
	Female	.0139	.0000	.490

*No variance within groups- Statistic for Privacy and Safety Males (approach 1) cannot be computed.

Table 20 Means and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Classification –IMAGES

CORE ELEMENTS		NHF (Means)	ALF (Means)	RHCF (Means)	*Sig.*
Social Health5					
Social Interaction	Male	.2294	.0714	.0000	.462
	Female	.3669	.1429	1.0000	.024
Character Position	Male	.4086	.1429	.0000	.241
	Female	.5123	.6429	1.0000	.287
Physical Health5					
Physical Activeness	Male	.1880	.0000	.0000	.287
	Female	.1861	.0714	.0000	.513
Mobility	Male	.2931	.0714	.0000	.364
	Female	.4507	.6429	.5000	.670
Spiritual-Emotional Health5					
	Male	.3179	.0714	.0000	.502
	Female	.3962	.7854	1.0000	.041
Autonomy Personal Choice & Independence5					
	Male	.1887	.1429	.0000	.736
	Female	.0000	.1429	.0000	.633
Privacy & Safety5					
	Male*		.0000	.0000	
	Female	.0104	.0000	.0000	.944

*No variance within groups- Statistic for Privacy and Safety Males (approach 1) cannot be computed.

Table 21 and 22 also present results concerned with how brochures representing facilities in the 'traditional' and 'culture-change' model and by licensure classification compared across the core elements of *successful aging* for the demographic of gender. In this case, the physical appearance of older 'characters' was investigated which revealed significant differences for some elements conceptualization of *successful aging*. The results indicated that older male 'characters' were portrayed more for the 'spiritual- emotional health' element within the culture-change and traditional model (Table 21). Moreover, similar results were revealed when licensure classification was used as the independent variable. Older female characters portrayed more of the elements of 'social health' and 'spiritual-emotional health'. However, due to the small sample size, the findings seemed skewed.

Using two approaches, the results suggested little or no significant differences in the core elements of *successful aging* by model type and licensure classification for gender. The

frequency scores indicated that gender (i.e. males and females) was represented in the brochure for core elements established in the first gerontological approach and partly in the second school (less often portrayed by the core element 'privacy and safety').

Table 21 Means and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Model Type –CHARACTERS

CORE ELEMENTS		Traditional (Means)	Culture-Change (Means)	*Sig.*
Social Health6				
Social Interaction	Male	.1627	.1507	.891
	Female	.4459	.2400	.069
Character Position	Male	.2439	.3832	.199
	Female	.5650	.3488	.053
Physical Health6				
Physical Activeness	Male	.1123	.1330	.731
	Female	.1407	.1961	.547
Mobility	Male	.1853	.1690	.860
	Female	.4937	.2781	.072
Spiritual-Emotional Health6				
	Male	.1169	.3567	.031
	Female	.3621	.4311	.581
Autonomy Personal Choice & Independence6				
	Male	.0614	.1332	.158
	Female	.1834	.1706	.883
Privacy & Safety6				
	Male*	.0000	.0000	
	Female	.0222	.0000	.490

*No variance within groups- Statistic for Privacy and Safety Males (approach 2) cannot be computed.

Table 22 Means and One-Way Analysis of Variance (ANOVAs) for Core Elements of Successful Aging by Licensure Classification –CHARACTERS

CORE ELEMENTS		NHF (Means)	ALF (Means)	RHCF (Means)	*Sig.*
Social Health5					
Social Interaction	Male	.1744	.0500	.0000	.554
	Female	.3702	.1500	1.0000	.034
Character Position	Male	.3141	.1500	.0000	.383
	Female	.4588	.6500	1.0000	.108
Physical Health5					
Physical Activeness	Male	.1341	.0000	.0000	.324
	Female	.1749	.0500	.0000	.584
Mobility	Male	.2024	.0000	.0000	.338
	Female	.4065	.6500	.3333	.526
Spiritual-Emotional Health5					
	Male	.2173	.0500	.0000	.568
	Female	.3291	.7500	1.0000	.011
Autonomy Personal Choice & Independence5					
	Male	.0877	.1000	.0000	.786
	Female	.1932	.1000	.0000	.581
Privacy & Safety5					
	Male*	.0000	.0000	.0000	
	Female	.0167	.0000	.0000	.944

*No variance within groups- Statistic for Privacy and Safety Males (approach 2) cannot be computed.

Overall, this research demonstrated that all core elements were represented. From the frequency scores however, one can deduce that the core elements of 'social' and 'physical' health (i.e. physiological psychosocial school) were more frequently reflected in the brochures compared to elements of 'autonomy personal choice and independence', 'spiritual-emotional health' and 'privacy and safety'. These findings may coincide with explanations that the later elements are new to the literature conceptualizing *successful aging*, hence, less often incorporated into the dialogue for discussing *successful aging*. Other findings indicated that most of the associations were not significant but it was observed that there were instances of significance levels for example, as in the case of where more males portrayed the element of 'spiritual-emotional health' in culture-change facilities.

CHAPTER-6 Conclusion

The intent of this study was to conceptualize *successful aging* advocated by scholars within two camps established from the gerontology literature. Specifically, a content analysis was conducted to explore how printed long-term care brochures reflect the core elements of *successful aging*. Furthermore, this study sought to examine how do these core elements compare across facilities in the 'traditional' and 'culture-change models' in addition to other variables. Guided by the pervading perspectives from two major schools on gerontology (primarily by Rowe and Kahn and Baltes and Baltes), the data suggested that for most long-term care facilities, the elements conceptualizing *successful aging* were established as part of their advertising message. In essence, the reflection of the core elements indicated that both gerontological schools were represented in the content units (i.e. narrative and image). Furthermore, the results suggested that advertisers/care institutions can market and provide services that promote aging in positive, successful ways (i.e. optimal quality of life). To some extent, what this study established was the view that long-term care advertisers attached the meaning of quality and continuance of life in the aging process by making evident the tenets established from the gerontological schools.

Albeit the core elements were evident in these brochures, to some extent, the results were consistent with the ideologies posited by Rowe and Kahn indicating the importance of the physiological and psychosocial elements in aging successfully. The findings from the frequency scores revealed that the physical and social aspects of aging were commonly promoted in the brochures as marketing messages directed to an aging audience. Does this mean (for LTC marketers/advertisers) that for *successful aging* to exist, the physical-psychosocial dynamics need to be fulfilled? Or is this a minimum prerequisite? Or do other important elements constituting *successful aging* remain less marketable? These are questions that may be answered in future research. In essence, the results have confirmed that some long-term care facilities (LTCFs) promote the core elements used to conceptualize *successful aging* and which core elements were most important or promoted in the brochures.

The study also compared advertised brochures representing facilities in 'traditional' vis-à-vis the 'culture-change' models to empirical test whether or not these models were adhering to the core elements conceptualizing *successful aging*. Similar patterns were found for brochures representing facilities within both models. The brochures in the 'traditional' and 'culture-change'

models appeared to reflect the core elements of *successful aging* and in further analysis, the comparisons between these brochures revealed little or no significant difference in the portrayal of core elements for a majority of brochures. Moreover, it can be inferred that the ideologies of aging may be quite similar between facilities in the 'traditional' and 'culture-change' models. Looking at the results, it is apparent that 'traditional' facilities are in fact conforming to culture-change ideals even though they are categorized within the 'traditional' model. Furthermore, the 'culture-change' process in itself has labeled some facilities less fully transitioned, (those of which are in the residual stages), which may closely resemble the 'traditional' model. Hence, any differences between the 'culture-change' and 'traditional' models in conceptualizing *successful aging* remain less noticeable.

More importantly, from the results one can speculate that first, the underlying motive of long-term care facilities, regardless of model type (i.e. culture-change or traditional) is to market an idealized image of ones' facility to the aging public no matter what the reality is. Hence, the findings coincide with the belief that since LTCFs appear to direct appealing ads to the elderly, their real purpose may be jeopardized by marketing distorted images; Images that do not reflect the reality for many of these places in an effort to captivate a targeted audience. This assumption opens up new ideas for future discourse and research on the real purpose or motive of long-term care advertising.

Second, it may be possible that 'traditional' and 'culture-change' facilities possess more similarities linked to shared philosophies and ideologies of aging, specifically *successful aging*. One explanation suggests advertisers from the 'traditional' model understand the 'culture-change' language. These facilities may be implementing 'culture-change' standards and philosophies of aging. Moreover, there is no real difference between the two models since it takes several processes to fully transition to a 'culture-change' facility. It could be that facilities labeled as 'culture-change' are in fact not fully transitioned (as stated above). This reasoning implies that although these facilities are labeled as culture-change, in reality they are more representative of traditional facilities.

In essence, this study suggested that there are a variety of core elements ranging from subjective to objective states conceptualizing *successful aging.* It adds a new theoretical contribution to the gerontology literature on *successful aging*, establishing that the concept is part of the perspective established in long-term care advertising. In addition, this study also provided an empirical contribution by actually applying selected core elements to conceptualize and

measure *successful aging* in the content units. The empirical results indicated that in most cases there was no significant difference in conceptualizing *successful aging*. The results further revealed that not only was *successful aging* promoted across the brochures but the concept was in fact measurable. All of the core elements were viewed as extremely important because they entailed the essence for *successful aging* in later life as established from the literature. The research suggested that brochure advertising contains the elements conceptualizing *successful aging* within the image and written narrative contents-that is, the content units are describing and reflecting the preexisting elements of (social health, physical health, spiritual-emotional health, autonomy/independence and privacy/safety).

It is apparent that the results drew close connections to functionalism. Albeit functionalist discourse on aging explores three main approaches (disengagement, activity and continuity), this research closely reflected the tenets of activity theory. Activity theory suggests that older adults who remain active and participate in social relations appeared happier and more satisfied with life, contributing to a better quality of life (QoL) and well-being (Park, 2009). One can infer that advertisers have applied a functionalist perspective in framing the content of the brochures since their marketing messages (i.e. narratives and images) entail retaining levels of physical/social activeness and continuity, expressed as core elements in the discourse of *successful aging*. Other elements emphasized the importance of satisfaction and quality of life (QoL) for older adults. For instance, the subjective states posited by Baltes and Baltes. According to Friedrich (2001), activity theory focuses on "[the] physical, mental, and social lifestyles and adaptability in the later stage of life" (p. 57). It promotes the element of continuity of life which proposes that older adults adjust better to aging by continuing social ties (i.e. social health); an important element for *successful aging*.

Relating activity theory to the result, it was evident that long-term care organizations perceived the tenets discussed as important advertising elements, to be implemented in their marketing decisions and messages for the senior market. This theoretical perspective explicitly applied the elements of social, physical, mental health, three of the core elements used in conceptualization *successful aging* in this study. Its premise is directly part of the marketing approach used in advertising, geared toward departing from the ageist constructions often associated with aging.

The elements conceptualizing *successful aging*, however, are not tantamount to all advertised brochures representing facilities across model types, licensure categories or, residency cost.

Some of the findings in this research did not coincide with some of the rationales stated, indicating (in several cases) that there was no significant difference among nursing homes, assisted living and residential health care facilities (i.e. licensure classification). From the preceding chapter, it may be concluded that some print brochure advertisements were adhering to the gerontological tenets of *successfully aging*; a philosophy that departs from the caricatures or hegemonic discourses of aging (i.e. declines in aging, ageism and negative constructions of aging). In most cases, all five core elements show no significant difference for licensure classification, residency cost and gender. For brochures representing a more or less expensive facility, there exist few significant differences.

It was also evident by the results that the concept of *successful aging* was part of the advertising message promoted in long-term care advertising. Further delineations indicate that long-term care facilities (LTCFs) represent older characters, images and narratives in advertisements that depart from traditional and ageist constructions of aging. The findings provided useful information that can aid long-term care providers about the promotion of aging in a positive way. This study contributed to advancing a perspective that emphasized enhancement and promotion of quality of life (QoL) in later years. The findings offer important information and expand the body of knowledge and understanding of *successful aging* communicated via print long-term care advertising. The analysis rests on the premise that *successful aging* is an important ideology.

It can be inferred from the frequency results that a consistent pattern forms across the five core categories conceptualizing *successful aging*. It contributed to justifying the conclusion that the core elements of *successful aging* are evident in the advertised brochures which directly answers the first research question. Further, this showed that the perspective of the first school (i.e. physiological-psychosocial Rowe and Kahn) was discernible. The findings also indicated that within both the 'traditional' and 'culture-change' models, some core elements were more prominent than others such as 'social', 'physical' and 'spiritual-emotional' health. Although the elements of 'autonomy personal choice and independence' and 'privacy and safety' were evident, for several brochures within both models, these elements were not portrayed. This finding rests on the argument that these are relatively new elements within the *successful aging* construction, built into the last body of knowledge which has not yet make entry into the advertising/marketing language across long-term term care facilities. In essence, this explanation addresses the second research question focused on exploring how brochures in the traditional

model compare with those in the culture-change model across the core elements of *successful aging.*

Limitations of Study

There are several limitations in employing a content analysis technique in research. Carney (1972) states, "'scientific' deduction is not normally possible, and so the inferences of content analysis are probabilistic" (p.15). Since this was an exploratory study, a difficult part of it was the discernment for making inferences from the data. Another major limitation affecting this study was that of generalizability. Although the sampled brochures were randomly selected, they represented only the state of Kansas. Hence, the analysis cannot be generalized to all long-term care facilities in the U.S. There also exists the element of subjectivity in this study since developing themes for content analysis were based on what the researcher deemed most important. This may unintentionally omit other relevant coding categories. Another limitation was distortion of the content units. For instance, advertisers may disproportionately represent older adults portraying the elements of *successfully aging* or the brochure may advertise images portraying older adults in exceptional health. There also exists the limitation of sample totals. In this study the brochures were disproportionately distributed across LTCFs which may manipulate the results. In addition, the number of brochures analyzed (*n=39*) may influence the potential for arriving at significant results. A larger and more diverse sampling frame may yield better results.

Implication for Future Research

The conceptualization of *successful aging* has acquired a great deal of attention in the gerontological literature. The results indicated that there is the potential to explore future research in *successful aging* from the perspective of long-term care. The findings of this research should be seen as a preliminary step in understanding the dynamics germane to the aging process. As gerontological researchers, we need to reflect on the meaning of aging and ways to improve the quality of life (QoL) for an aging population. Reported earlier, the methodology applied in this study was based on a desire to explore elements conceptualizing *successful aging*. Ultimately, further analyzes conceptualizing *successful aging* need to be explored to go beyond the qualitative analysis and to make inferences. Marketers and advertisers can benefit from the information gathered in this research and future studies may offer better insights in

understanding the importance of marketing success in aging in later life. Utilizing brochures can be used as one social instrument for change in the ways the dynamic of aging is promoted.

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Appendix A - Content Categories & Code Sheet

Please fill in the following information for each brochure. Five core dimensions are categorized comprising of an image and written component. For the image component please code the questions for each sub-dimension that applies to general core dimension. For the written narrative, please follow the instructions provided. *The additional coder will code ONLY the specific coding categories.* Please code all brochures to the best of your ability. Record all answers on the coding sheet that is provided.

General Categories Coded: FOR RESEARCHER ONLY

ID number: _____

1. STATE: Current state the brochure represents

   KS_____

2. MODEL: What type of model does the brochure represent?

   Culture-change (1) _____ Traditional (2) _____

3. TYPE: What type of licensure classification the brochure represents?

   NH (1) _____ ALF (2) _____ RHCF (3) _____

4. MANAGEMENT: The brochure represents management as:

   For profit (1) _____ Not for profit (2) _____ Unspecified (3) _____

5. SIZE: The brochure represents the facility as a:

   Small facility (1) (less than 68 beds) _____ Large facility (2) (more than 68 beds) _____ Unspecified (3) _____

6. COUNTY: The brochure states the facility as located in:

   _____

7. NAME: What is the name of the facility?

   _____

   _____

Specific Coding Dimensions: BOTH CODERS

For this section, explore the image and written narrative contents in each brochure and code the following five core dimensions. Sub-dimensions are created within each core dimension and several pertinent questions are derived for each to analyze *successful aging*.

CATEGORY I – SOCIAL HEALTH/

Questions 8-9 correspond with the 'image component'

Question 10 corresponds with the 'written component'

Image component operationalized into:

Subcategory: *A. Social interaction*

8. How many total images are presented? _____

8a. How many older characters are portrayed in these images? _____

8b. How many of these older characters are seen engaged in the following social interactions/gatherings with others *(some characters may be counted more than once if they are present in more than one category)*?

Talking (1) _____

Dinning (2) _____

Group activity (3) _____

Holding hands (4) _____

Hugging (5) _____

Reading/Talking to children (6) _____

8c. How many older characters identified in (8a) are interacting with others in an:

Outdoor setting (1) _____

Indoor setting (2) _____

8d. How many of the total older characters identified in question **(8b)** are

Male (1) _____ Female (2) _____ Unsure (3) _____

Subcategory: *B. Character Position*

9. How many images from the total images depict older characters in a

Group portrait (two or more persons) (1) _____

Isolated (2) _____

9a. How many older characters are portrayed in the group portrait? _____

9b. How many older characters represent each gender category in the group portrait?

Male (1) _____ Female (2) _____ Unsure (3) _____

9c. Count the number of times a particular gender is positioned at the forefront in the group portrait.

Male (1) _____ Female (2) _____ Unsure (3) _____

SOCIAL HEALTH written component operationalized into:

10. How many times each of the following exact concepts/words measuring a sense of community are described in the brochure?

1. Community spirit _____
*(*community, care community,
community matters,
part of a family feeling of community,
homelike environment,
family oriented, family involvement,
family atmosphere, family*)*
2. Social interaction _____
3. Atmosphere of friendship _____
4. Close ties/strong bonds _____
5. Social activity/networking _____
6. Warm social setting _____
7. Welcome visits _____
8. Connect with community _____
(participate community activities,
community activity circle,
teamwork)
9. Supportiveness _____
*(*companionship, togetherness,
supportive environment,
not isolated/lonely,
sense of belonging,
social needs/allowing pet*)*

CATEGORY II: PHYSICAL HEALTH

Questions 11-13 correspond with the 'image component'

Question 14 corresponds with the 'written component'

PHYSICAL HEALTH image component operationalized into:

Subcategory: *A. Physical Activeness*

11. How many characters in the total images look physically active by engaging in the following tasks: *(characters may be counted more than once if they represent more than one task)*

Dancing (1) _____

Playing (2) _____

Fishing (3) _____

Exercising (4) _____

Reading/Crafting (5) _____

Swimming (6) _____

11a. How many of the total older characters identified in question **(11)** are

Male (1) _____ Female (2) _____ Unsure (3) _____

Subcategory: *B. Mobility*

12. Count the number of older characters that appear

Standing upright (1) _____

13. Count the number of older characters that appear

Lying down (2) _____

In a wheel chair (3) _____

With a cane/walker (4) _____

Supported by someone (5) _____

Sitting down (6) _____

13a. How many of the characters identified are

Male (1) _____ Female (2) _____ Unsure (3) _____

PHYSICAL HEALTH written component operationalized into:

14. How many times each of the following exact concepts/words measuring 'Physical Health' are described in the brochure?

1. Active engagement (active, full range of activities) _____
2. Life to the fullest (stay involve in life) _____
3. Productive members' _____
4. Enhanced/lifestyle _____

*(*opportunities for growth,
learn new things,
enrich stimulate lives,
meaningful activities,
stimulating activities*)*

5. Sense of well-being _____
(happiness)
6. Fitness/health _____
*(*physical wellness,
mobility, physical activities,
weight training programs,
diet, exercise, physical fitness*)*
7. Vibrant lifestyle _____
8. Optimal quality of life _____
(high quality of life)
9. Feel proud to live _____
10. Opportunities for creativity _____
(music, dancing, photography, writing, drama, textiles, painting and drawing, cooking, gardening, craft)

CATEGORY III: SPIRITUAL-EMOTIONAL HEALTH

Questions 15-15b correspond with the 'image component'

Question 16 corresponds with the 'written component'

SPIRITUAL-EMOTIONAL HEALTH image component operationalized into:

Subcategory: *A. Quality Care*

15. How many characters in the total images are shown: *(characters may be counted more than once if they represent more than one choice)*

Preparing meals (1) _____

Eating meals (2) _____

Using the amenities (3) _____
(libraries, laundry, spas, music etc.)

15a. How many of the total older characters identified are

Male (1) _____ Female (2) _____ Unsure (3) _____

SPIRITUAL-EMOTIONAL HEALTH written component operationalized into:

16. How many times each of the following exact concepts/words measuring 'quality of care to end of life' are described in the brochure?

1. Receive quality of care _____
(exceptional care)
2. Top-notch programs _____
3. Continuum of care _____
6. Resident centered care _____
7. Compassionate care _____
(kindness, treated with kindness and compassion everyday)
8. Supporting life _____
9. Amenities _____
10. Value of life, respect, (honor, honoring residents)
11. Stimulate senses _____
(aromatherapy)
12. Personal fulfillment _____
13. Spiritual/emotional needs met, (cognitive/mental functioning, wellbeing) _____
14. Full potential _____

CATEGORY IV: AUTONOMY/Personal Choice & Independence

Questions 17-17b correspond with the 'image component'

Question 18 corresponds with the 'written component'

AUTIONOMY/Personal choice & independence image component operationalized into:

Subcategory: *A. Sense of Control*

17. How many older characters in the total images look *(some characters may be counted more than once if they represent more than one category)*

Engaged in tasks without assistance (1) _____
(doing activities on their own playing an instrument alone)

Exercising independently (2) _____
(not leaning on others for physical support)

17a. How many of the total older characters identified are

Male (1) _____ Female (2) _____ Unsure (3) _____

AUTONOMY/Personal choice & independence written component operationalized into:

18. How many times each of the following exact concepts/words measuring 'personal choice and independence are described in the brochure?

1. Restoring control/autonomy _____
*(c*ontrol over routines/activities/
responsibilities,
control of information of oneself,
sense of control,
personalize living space
2. Choices in food/dinning _____
(exercise choice/opportunity,
free to make choices/decisions*)*
3. Independence _____
*(*individuality/being known as a person,
uniqueness, self-reliance,
express ones identity, sense of identity*)*
4. Foster spontaneity _____
5. Freedom/carefree living _____
6. Individualized activity programs _____

CATEGORY V: Privacy & Safety

Questions 19-20b correspond with the 'image component'

Question 21 corresponds with the 'written component'

PRIVACY & SAFETY image component operationalized into:

Subcategory: *A. Private/Safe Appearance*

19. How many images from the total image depict the physical appearance of

Private/partitioned rooms (1) _____

Security cameras (2) _____

Security locks, door bells, alarms (3) _____

Private/safe bathrooms (4) _____

20. How many older characters are portrayed using private/portioned rooms? _____

20a. How many of the total older characters identified are

Male (1) _____ Female (2) _____ Unsure (3) _____

PRIVACY & SAFETY written component operationalized into:

21. How many times each of the following exact concepts/words measuring 'privacy and safety are described in the brochure?

1. Peace of mind/convenient _____
2. Secure/safe environment _____
   (security, surveillance)
3. Comfortable accommodations _____
4. Place of refuge _____
5. Protection/risk free _____
6. Emotional safety _____
7. Enjoy a sense of privacy when needed _____
   (partitioned/private rooms, cozy area)

Appendix B - Definitions of Coding Categories Related to Successful Aging

For this study, elements to measure successful aging are organized into five specific core categories. Here are the definitions and examples for each.

Core Dimension	Definition/Description	Category Examples
Category I- Social Health	A sense of interaction in a social context. Promoting a sense of community friendship, family networks, group cohesiveness, belonging and togetherness	Written text: Family, sense of belonging, friendship, helping others. Images: Group and family portraits, shows individuals communicating with others, holding hands together or hugging others, interacting
Dimension II – Physical Health	States of physical activeness, mobility, functionality and awareness.	Written text: active lifestyle, spiritual, growth, social, and emotional wellness, optimal quality of life, stimulating activities, recreational programs, activities and events that enrich the lives of residents Image: character appears physically active and engaged, persons completing tasks such as grooming, dancing, reading, exercising, playing, praying and dancing.
Dimension III – Spiritual-emotional Health/Quality of Care to End of Life	States of spiritual, emotional and cognitive wellness. Meeting the spiritual and emotional needs. The degree of top notch/excellent care in a respected, loving and way until end of life.	Written text: continuance of residents valuable contributions, care is promoted in an ethical way, dedication and commitment to loving care, full continuum of care; exceptional care, Image: characters engaged in activities, preparing meals, eating

Dimension IV-Autonomy/ Personal Choice & Independence	Allowing for states of autonomy, variability in care freedom, self-sufficiency, individuality and freewill for residents. Independence is defined as "acting for oneself (i.e. freedom from control in physical functioning, and/or in the ability to organize one's day-to-day life" (Bowling 2005: 189).	Written text: restoring control and autonomy to residents, control of activities, fostering spontaneity, individuality and independence Image: depicts individuals engaged in completing tasks on their own, character is depicted as more independent such as not leaning on others for physical support
Dimension V-Privacy and Safety	The ability to protect and be protected from the risk of harm and danger. Promoting states of financial and emotional security and assurance. The ability to provide an atmosphere for private, confidential living. Kahn it is "being able to be alone when one wishes, to be together in private with others when one wishes, and to be in control of information about oneself (p. 298). As developed by Kane et. al., (1997), private rooms and compatible roommates are reported as making residents lives better.	Written text: emphasize the importance of personal privacy and safety of the elderly, emotionally secured, secure environment and premises, private environment with peace of mind Image: surveillance, security cameras, partitioned rooms

Appendix C - Definitions of Subcategory Indicators for Core Categories: Image Component

Category/Subcategory	Indicators	Definition
SOCIAL HEALTH: Social Interaction	Images of older characters	Physical appearance of an older individual seen engaged in social activities with others
	Talking	Older individual perceived as talking with others
	Dinning	Older individual perceived as eating/dinning with others
	Group activity	Older individual perceived as engaged in any form of work/task with others
	Holding hands	Older individual perceived as holding hands with others
	Hugging	Older individual perceived as hugging others
	Talking/reading to children	Older individual perceived as talking/reading to small children
	Interacting outdoor	Older individual perceived as engaged in outdoor activities or interacting with others outside
	Interacting indoors	Older individual perceived as engaged in indoor activities or interacting with others inside
	Female character	Physical appearance of older individual perceived as women and socially interacting
	Male character	Physical appearance of older individual perceived as men and socially interacting
	Unsure of gender	Unable to identify gender of older character
	Other character	Physical appearance of older individual perceived as Asian, Hispanic or American Indian ancestry socially interacting
	Group portrait	Physical appearance of two or more older individual in an image
Character Position	Isolated portrait	Physical appearance of older individual alone in an image
PHYSICAL HEALTH: Physical Activeness	Dancing	Physical appearance of older individual perceive actively dancing
	Playing	Physical appearance of older individual perceive actively playing

Mobility	Fishing	Physical appearance of older individual perceive actively fishing
	Exercising	Physical appearance of older individual engaged in any form of exercise excluding aqua aerobic
	Reading/crafting	Physical appearance of older individual perceive actively reading or crafting
	Swimming	Physical appearance of older individual in swimming pools or engage in aqua
	Female character	Appearance of older individual perceived as women and physically active
	Male character	Appearance of older individual perceived as men and physically active
	Unsure of gender	Unable to identify gender of older character
	Standing upright	Physical appearance of older individual perceived as standing without assistance
	Lying down	Physical appearance of older individual perceived as lying down
	Wheel chair	Physical appearance of older individual perceived using a wheel chair
	Cane/walker	Physical appearance of older individual perceived as using cane/walker as formal support
	Supported	Physical appearance of older individual perceived supported by someone
	Sitting down	Physical appearance of older individual perceived as sitting excluding wheel chairs
SPIRITUAL-EMOTIONAL HEALTH: Quality Care	Preparing meals	Physical appearance of older individual perceived preparing meals
	Eating meals	Physical appearance of older individual perceived eating meals
	Using amenities	Physical appearance of older individual perceived using amenities (beauty shops, library, laundry, TV, internet, phones etc.)
	Female character	Appearance of older individual perceived as women preparing, eating, using amenities
	Male character	Appearance of older individual perceived as men preparing, eating, using amenities
	Unsure of gender	Unable to identify gender of older character
AUTONOMY/ INDEPENDENCE: Sense of Control	Engaged in activities	Physical appearance of older individual perceived as engaged in activities without assistance
	Exercising independently	Physical appearance of older individual perceived as engaged in any type of exercise

		on their own
	Male characters	Appearance of older individual perceived as men exercising or engaged in activities on their own
	Female characters	Appearance of older individual perceived as women exercising or engaged in activities on their own
	Unsure of gender	Unable to identify gender of older character
PRIVACY & SAFETY: Private/Safe Appearance	Private/partitioned	Appearance of private or partitioned rooms, bathrooms and other living space
	Security and Safety	Appearance of security cameras, surveillance, alarm and safety handles
	Male characters	Appearance of older individual perceived as men portrayed in private rooms
	Female characters	Appearance of older individual perceived as women portrayed in private rooms
	Unsure of gender	Unable to identify gender of older character

Appendix D - Cost Categorization of Facilities

The median (based on the costs provided) is used to classify the brochures into the following types of facilities as a measure of socio-economic status (SES). The cost can reflect the economic statuses of residents or prospective residents these facilities cater to, or represent.

Type of Cost	Amount	Type of facility represented
DAILY:	$50 $100	Less expensive (1) (<$175 a day)
	$150 $200	More expensive (2) (>$175 a day)
	$250 $300	
	NA	NA (3) Brochure does not applicable
MONTHLY:	$500, $1000	Less expensive (1) (<$2750 a month)
	$1500 $2000	More expensive (2) (>$2750 a month)
	$2500 $3000	
	$3500 $4000	
	$5000 $6000	
	NA	NA (3) Brochure does not apply

Appendix E - Interrator Reliability

Coding Decisions	Coder 1	Coder 2	Coding Decisions in Agreement	
CATEGORY: I				
Private/partitioned rooms	0	0	1	
Security cameras	0	0	1	
Security locks etc.	0	0	1	
Private/safe bathrooms	0	0	1	4
Gender:				
Male	0	0	1	
Female	0	0	1	
Unsure	0	0	1	3
Race:				
White	0	0	1	
Black	0	0	1	
Other	0	0	1	3
Place of Refuge	1	2	0	
Comfortable Accommodation	1	2	0	
Cozy Area	0	0	1	
Emotional Safety	0	0	1	
Privacy when needed	1	0	0	
Feeling of home	3	3	1	
Peace of mind	1	1	1	
Secure environment	4	5	0	
Partitioned/private rooms	1	1	1	
Protection	0	0	1	
Surveillance	1	2	0	
Wonderful place to live	0	0	1	7
CATEGORY: II				
Choice and discretion	2	1	0	
Race:				
Black	1	1	1	
White	2	2	1	
Other	0	0	1	3
Gender:				
Male	1	1	1	
Female	2	2	1	
Unsure	0	0	1	3
Exercising independently	1	1	1	
Carefree	0	1	0	
Choice/opportunity	6	4	0	
Express identity	0	0	1	
Spontaneity	0	0	1	

Make decisions	3	3	1	
Individualized Programs	2	1	0	
Restoring control	3	3	1	
Freedom	1	1	1	
Independence	2	2	1	5
CATEGORY: III				
Gender:				
Unsure	0	0	1	
Male	4	4	1	
Female	5	5	1	
Talking	0	0	1	
Outdoor	6	6	1	
Indoor	7	7	1	
Group activity	2	1	0	
Hugging	2	3	0	
Holding hands	0	0	1	
Dining	0	0	1	
Welcome visit	2	2	1	
Supportiveness	2	3	0	
Warm setting	0	0	1	
Sense of belonging	1	1	1	
Community activities	1	1	1	
Community spirit	2	3	0	
Friendship	2	4	0	12
CATEGORY: IV				
Gender:				
Female	2	2	1	
Male	1	1	1	
Unsure	0	0	1	3
Eating meals	1	1	1	
Using amenities	1	1	1	
Stimulate senses	1	3	0	
Dignity	3	4	0	
Good nutrition	4	4	1	
Resident centered	3	3	1	
Supporting life	0	0	1	
Top-notch program	3	2	0	
Active engagement	3	3	1	
Continuum of care	1	1	1	
Receive quality care	7	7	1	8
CATEGORY: V				
Sitting	8	8	1	
Cane/walker	1	1	1	

Swimming	0	0	1	
Reading	0	0	1	
Mental functioning	2	2	1	
Enrich lifestyle	2	3	0	
Full potential	0	0	1	
Life to the fullest	0	0	1	
Honoring residents	0	0	1	
Opportunity for creativity	4	3	0	
Quality of life	3	3	1	
Productive members	0	0	1	
Wellness	4	4	1	
Well-being	3	3	1	12

C.R. = $\frac{2M}{N_1+N_2}$

Coding decisions in agreement M= 63

Coding decisions made by N_1= 84

Coding decisions by N_2= 84

Computing agreement = 2(63)/84+84, or 0.75

The average interrator reliability score is:

Composite Reliability score is = 2(0.75)/1+ [1(0.75)] = 0.86

Appendix F - Names of Sample Facilities Used in Data Analysis

MODEL: 1-CULTURE-CHANGE
2-TRADITIONAL

MANAGEMENT: PROFIT
NOT-FOR-PROFIT

SIZE: 1-SMALL
2-LARGE

LOCATION: 1-METRO
2-MICRO
3-OTHER RURAL

LICENSURE: NHF-NURSING HOME FACILITY
ALF-ASSISTED LIVING FACILITY
RHCF-RESIDENTIAL HEALTH CARE FACILITY

Model	Management	Size	Location	Name	Licensure Class
2	profit	1	2	Atchison Senior Village	NF
2	profit	1	2	Angel Arms	RHCF
2	not for profit	1	2	Asbury Village	ALF
1	not for profit	2	1	Asbury Park	NF
1	not for profit	2	1	Brewster Health Center	NF
2	not for profit	2	1	Bethel Health Care Centre	NF
2	not for profit	1	3	Bethel Home	NF
2	not for profit	2	2	Bethany Home Association	NF
2	profit	2	1	Brandon Woods At Alvamar	NF
2	not for profit	1	3	Bethesda Home	NF
2	profit	1	3	Crestview Manor Nursing Home	NF
2	not for profit	1	3	Chapman Valley Manor	NF
2	profit	1	2	Cedarview Assisted Living	ALF
2	not for profit	1	1	Cedar Lake Village	ALF
1	not for profit	1	1	Cheney Golden Age Home	NF
2	profit	1	2	Dignity Care Home	RHCF
2	profit		3	Fowler Nursing Home	NF
2	profit	1	3	Golden Heights Living Center	NF
1	not for profit	2	1	Kansas Masonic Home	NF

2	profit	2	1	Lakepoint Nursing Center	NF
2	profit	2	1	Lakewood Senior Living Of Seville	NF
2	profit	1	1	Lexington Park Assisted Living	ALF
2	profit	1	2	Liberal Springs	ALF
1	profit	2	1	Larksfield Place	NF
1	not for profit	2	2	Meadowlark Hills	NF
1	not for profit	2	2	Mennonite Friendship Manor Inc	NF
2	not for profit	2	2	Parsons Presbyterian Manor	NF
2	profit	1	1	Peterson Nursing Home	NF
2	profit	2	3	Pleasant Valley Manor	NF
1	not for profit	2	2	Pleasant View Home	NF
1	not for profit	2	1	Schowalter Villa	NF
1	not for profit	1	3	Salem Home	NF
2	not for profit	2	3	Sunset Home, Inc.	NF
1	not for profit	2	2	The Cedars	NF
1	not for profit	2	1	Village Shalom Inc	NF
2	not for profit	2	2	Westy Community Care Home	NF
2	profit	1	2	Woodhaven Care Center	NF
2	profit	1	3	Golden Keys Nursing Center	NF
2	not for profit	1	3	Dawson Place	NF

Appendix G - Sample of Brochures Used in Study

Bethany Home is first and foremost a Christ centered home, guided by Christian values and reflected in the Christian fellowship shared by residents of all faiths.

Since opening in 1911 with eleven residents, Bethany Home has grown as an enriching and rewarding residential community, with focus on resident choice, comfort and security.

Bethany Home is owned and operated as a not-for-profit residence by the Central States Synod of the Evangelical Lutheran Church in America. A Board of Directors provides it leadership. Board members, who come from various denominations, are confirmed by the Central States Synod and serve without pay.

Bethany Home is not included in the budget of the Central States Synod. It depends upon the generous support of our many friends and families.

BETHANY HOME

Providing a Community of Christian Love and Concern

Bethany Home residents and staff enjoy a family atmosphere in a clean, comfortable living environment. Scattered throughout the Home are are cozy areas where friends and family can enjoy quiet times together.

For additional information contact:
Administrator or Admission Representative

Bethany Home
321 N. Chestnut
Lindsborg, KS 67456
785-227-2334

website: www.bethanyhome.com
email: info@bethanyhome.com

Individual care services are designed by each resident and family with our professional staff.

In-house services include:

- Physical Therapy
- Horticulture Therapy
- Mental Health Services
- Physicians Clinic, *bi-weekly*
- Audiologist, *bi-monthly*
- Podiatrist, *monthly*

Bethany Home is conveniently located near a critical access hospital for emergent care needs.

Giving Opportunities:

- Chaplaincy
- Technology Development
- Medical Care
- Activities
- Development
- Building Enhancement

Financial Sources:

- Annual Gifts...from individuals
- Memorials...in honor of loved ones
- Estate Gifts...allow Bethany Home to continue the mission of quality care.

Annuities, bequests, memorials, life insurance, trusts, and wills are particularly encouraged and appreciated

Our corporate name is:

Bethany Home Association of Lindsborg, KS

Photographs by Jaderborg Photography - Lindsborg

ACTIVITIES & SERVICES

A wide variety of activities and services are offered through a daily schedule of social, cultural and spiritual programs. These include: worship and chapel, Bible study, exercise classes, bingo, dominoes, scrabble, cards, pool, songfests, fiddlers, baking days, story hour, bookmobile, crafts, current events, concerts, movies, sporting events, bus tours, quilting bees, surrey rides and many other special events.

Bethany Home is more than a peaceful home. It is a community of active residents and professional staff enjoying life together. The existing family atmosphere, along with the planned programs, provide stimulation and opportunities for social, cultural, spiritual and intellectual growth.

BETHANY HOME

Lindsborg, Kansas

...Providing a community of Christian love and concern.

785-227-2334

www.bethanyhome.com

Kidron Bethel Village retirement community is an attractive, 27-acre campus in a quiet residential area of North Newton. This friendly community is near a state-of-the-art medical center, specialty care facilities and clinics, Bethel College and shopping in Newton. Activities and programming are designed to promote opportunities for personal fulfillment, maximum independence and optimum health.

Kidron Bethel Village is operated by Kidron Bethel Retirement Services Inc., a not-for-profit corporation, and is sponsored and supported by area Mennonite Churches. Admissions and services are provided regardless of race, color, national origin, religion, sex or disability. Memberships include the Kansas Association of Homes and Services for the Aging and the American Association of Homes and Services for the Aging.

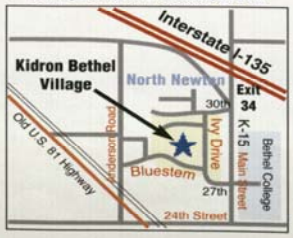
OUR MISSION

Kidron Bethel Village
is a progressive retirement community
that provides residential choices
and offers personalized services
with Christian compassion.

www.kidronbethel.org

Call 316-284-2900 for more information and current pricing.

Kidron Bethel Village
3001 Ivy Drive, North Newton, KS 67117



Kidron Bethel Village
3001 Ivy Drive
North Newton, KS 67117

Bethel Health Care Center

Kidron Bethel Village

A Vital, Active Community

INDEPENDENT LIVING

The Village Centre complex includes the Information Centre, administrative offices, chapel, branch bank, Wellness Centre and Harvest Table dining room.

The Harvest Table is the dining room for independent living residents. Three meals are served daily, and socials and special events also are held there.

Entertainment, educational and spiritual programs, activities and events are offered to enrich the lives of Kidron Bethel Village residents. Independent living residents also enjoy day trips to places of interest, including concerts and dining out in central Kansas.

The assurance living services program offers housekeeping, laundry, grocery shopping, meal preparation, correspondence and bill-paying assistance, for reasonable fees.

Choose a home on the campus to suit your lifestyle and personal preferences.

- **Residential Addition**

Campus Woods Estates is the newest residential addition at Kidron Bethel Village. Nestled in a 15-acre residential area of North Newton, residences are built as reserved, and construction is underway. Five townhome designs, from 1,350 to 1,630 square feet, are available with options including addition of a bonus room, sunroom and gas fireplace. These choices allow you to create the home that's right for you.

- **Townhomes**

Townhomes line the attractive streets on the perimeter of the main campus. Options include 2 bedrooms with 1 or 2 baths, and several 3-bedroom, 2-bath homes. Large, single-car garages offer plenty of storage space. Kitchen appliances and washer-dryer hookups are provided.

- **Apartments**

Village Heights offers apartments with patio or balcony and available carports. There are 1-, 2- and 3-bedroom options in this 3-story building. Kitchen appliances are provided, and a laundry facility is located on each floor. Carports may be rented. Village Heights adjoins the Village Information Centre.

The 400 Building features spacious 2-bedroom, 2-bath, ground-floor apartments with oak cabinetry and woodwork, kitchen appliances, washer-dryer hookups and private patios. Carports with roomy storage units are accessible through an enclosed walkway that also leads to the Village Information Centre.

Kidron Inc. federally subsidized rental apartments are available in 1- or 2-bedroom or handicap units. Six fourplexes are on Bluestem Street at the southern perimeter of the campus. 31 apartments are located in the main facility, as well as a community room, post office and coin-operated laundry.

WELLNESS CENTRE

Kidron Bethel Village Wellness Centre offers safe, supervised land and water exercise programs. The centre is equipped with an exercise pool and lift for those who have difficulty entering and exiting the pool, a hot tub, exercise room, and restrooms with showers. Fitness equipment includes treadmills, Nu-step recumbent steppers, a recumbent bike, upper- and total-body weight machines, and an ab-back machine.

Kidron Bethel Village residents may use the Wellness Centre at no additional charge. Independent exercise and swimming is available, as well as classes for water aerobics, lap swimming, water volleyball, strength training and the Arthritis Foundation aquatic exercise program. In addition, free blood pressure checks are offered each month, as well as fitness assessments, educational programs and other special classes.

ASSISTED LIVING

Suderman Centre for Assisted Living features spacious, 1-bedroom apartments. Elegant décor greets visitors to the living and dining commons, and French doors open to the private dining room for special times with family and friends. The courtyard provides a secure area to enjoy nature, take a stroll or sit near the water feature. Residents enjoy privacy along with services and assistance if they are needed. The campus beauty shop is located in the Assisted Living area.

HEALTH CARE

Bethel Health Care Centre, a licensed 60-bed, full-care nursing facility, employs professionals dedicated to quality, compassionate care. Residents enjoy all-private rooms and person-centered care to promote independence and sense of control in a homelike environment. The continuum of care includes restorative therapies and adult day care.

HOME HEALTH SERVICES

Professional nurses and certified home health aides provide quality care. Some patients may require continuing assistance with activities of daily living. Kidron Home Health Care works with you to assess your needs. Assistance is available for medication set-up and monitoring, treatments, dressing changes, injections, Accu-Checks, bathing, grooming and care planning.

Our Mission

BETHESDA
SEEKS TO BE A COMMUNITY FORMED BY THE SPIRIT OF JESUS CHRIST TO FULFILL THE LIVES OF ADULTS WITH SPECIAL NEEDS IN A PLACE THAT IS *HOME*

Our Vision

Bethesda will be a regenerative community for all residents, staff, Board and families.

Bethesda will achieve its Mission by honoring these

Core Values

1. Treasure every person
2. Practice daily welcome and hospitality
3. Listen with the heart, hold confidences, forgive
4. Name losses and celebrate joys
5. Foster choice, creativity and playfulness
6. Develop servant leaders who seek supervision and foster excellence
7. State goals, accept risks, be accountable
8. Change unjust practices and negotiate conflicts
9. Enlarge, develop and complete life, receiving and giving blessings

Typical comments from a family member...

"Moving Aunt Marie into a nursing home was a traumatic experience for me, made much easier by the care and concern demonstrated by the staff and management at Bethesda.

I appreciated how you cared for Aunt Marie, the cleanliness of the home, and the understanding shown in answering my questions.

The feeling that each of you wanted us to be a part of the Bethesda family was felt and appreciated."

Consider Bethesda.

Come visit us.

We believe that when you see the difference between Bethesda and other adult care facilities... you will choose Bethesda.

BETHESDA HOME
408-412 East Main, PO Box 37
Goessel, KS 67053
(620) 367-2291
Fax (620) 367-2294
www.bethesdahome.org

HERITAGE of Care

BETHESDA
H • O • M • E

The difference between Bethesda and other adult care facilities...

Independence, Respect and Dignity since 1899

...is a tradition of quality care

You've heard that line before.

But have you seen it defined and lived out the way we do at Bethesda?

Consider:

- **100+ years experience in care-giving**
  Bethesda was established in 1899 by Mennonites in Goessel who were concerned about providing quality long term care for their elders. Bethesda has been building a tradition through the 20th century that means as much to the community today as it did when Bethesda was founded. Ensuring that this legacy continues is a board and management staff made up of community people who are not only proud to be part of the Bethesda tradition, but who work hard to keep up with current trends and requirements in nursing home care.

- **Private Rooms**
  The Board of Trustees believe that residents prefer their privacy. Rooms are spacious, individually heated and cooled, with large windows providing a bright cheery atmosphere. Two double rooms are also available for specific needs.

- **Residents treated with dignity**
  Bethesda residents are treated as if they are our parents and grandparents, and often they are. Residents enjoy the choices provided by buffet dining at all three meals and the freedom to make many other choices affecting their daily activities. So when we talk about treating people with dignity and respect, we back our words with actions.

- **Comprehensive care for residents**
  Bethesda Home is a Medicare and Medicaid certified facility. Professional personnel on staff provide comprehensive care for residents. Licensed nurses 24 hours a day, a certified activities director, licensed social worker, chaplain, and registered dietitian all contribute to the physical and emotional well-being of our residents. A pharmacist, registered physical therapist, audiologist, podiatrist, optometrist, psychiatrist and psychologist are some of the professionals who serve Bethesda on a consultant basis.

Lifestyle Options

INDEPENDENT LIVING at Bethesda means a well designed home with a one or two car attached garage in the peaceful small town of Goessel. A grocery store, service station, post office, church and senior center are all within walking distance. Meals, activities, and medical assistance are all available through the main facility close to your home. Independent living residents have first priority to assisted living and nursing care should those needs arise. Choose from several financial options to best suit your retirement budget, including the option to build a new unit in the Emma Creek Retirement Village.

ASSISTED LIVING is the security of having someone nearby, yet the freedom to maintain as much independence as you choose. Bethesda residents in the assisted living apartments enjoy homey rooms with kitchenette, a cozy lounge and optional activities.

NURSING CARE at Bethesda includes skilled care and therapies for individuals recovering from recent hospitalization, Adult Day Care, and specialized activity programs for Alzheimers residents and others needing one-on-one attention and stimulation. Exercise programs, whirlpool baths, a variety of activities, and professional medical personnel all contribute to our goal of enhancing the health and well-being of our residents.

Facility Info

Crestview Manor Nursing and Residential Living is a privately owned facility that is nestled among a quiet residential neighborhood in Seneca, just one block North of 36 Highway. A local family built Crestview Manor, and it is still a privately owned facility, with management believing in the tradition of community-based care. This is implemented by caring staff, volunteers, families, and friends who dedicate themselves to the care of the elderly. For the resident's safety, comfort, and well being Crestview Manor provides 24 hour nursing care by licensed nurses, certified nurses aids, and multiple level trained support staff. We believe in providing quality care and protecting the dignity of each of our residents. The staff provides great tenderness and concern for our residents, making every effort to alleviate pain and to promote comfort.

Staff

Crestview is a small intimate facility with a dedicated staff that strives to provide the highest quality of care to the elderly, in a home-like atmosphere. Crestview Manor has Skilled Nursing Home beds and Residential Living beds, and prides itself for instituting the cutting edge Nursing Home Culture Change programs. These programs are developed on the foundation of "Resident Centered Care," which helps create a relationship with familiar staff members performing the same daily routines with our residents. Our staff remains very consistent; with several staff members being at Crestview for ten or more years. Due to our low employee turnover rate, our staff can learn each resident's needs and limitations to help them maintain their highest level of functioning. Our reputation for the highest level of quality care offers comfort and peace of mind for our residents' families.

At Crestview Manor

We believe in being one **BIG FAMILY.**

Family Support:

Crestview believes in the dynamic relationship between residents and their families. Crestview's staff works to retain this relationship while creating a safe and comfortable environment. Families are encouraged to attend Care Plan meetings to discuss the care being given. Crestview Manor holds various family parties throughout the year, in addition to an annual Family Appreciation BBQ.

Crestview Manor does not discriminate on religious affiliation, age, sex, race, color, creed, national origin, or payment source.

We encourage you to stop in and tour our home, and judge for yourself if we would meet the needs of your loved one.

"Crestview Manor- Respecting your past and caring for your future."

ACH For Profit 34

NURSING & RESIDENTIAL
⇐ LIVING ⇒

Crestview Manor

Respecting Your Past and Caring for Your Future

808 N 8th Street
SENECA, KANSAS 66538
Phone: 785-336-2156

Activities

Our daily activities provide diversified recreation that caters to the individual preferences of our residents, allowing them the choice of how to spend their day. Various activities, such as musical entertainment, exercise classes, bingo, parties, and luncheon outings are favored ways our residents pass the time. In addition, our Activity Director also holds Resident Council meetings that are vital to giving each resident the opportunity to voice their thoughts, suggestions, and opinions.

Religion

Crestview's comfortable Chapel provides religious services for all denominations. Residents may attend church services, participate in Holy Communion, group Rosary, or time for private contemplation. The Chapel is a favorite gathering spot for private visitations.

Savings

Crestview Manor believes in providing quality care at competitive prices. We offer a new-resident discount for the first month of care. We also provide transportation for appointments and hair styling at no additional charge. Crestview Manor is not just a place to live, it is a home.

Dining

Crestview Manor's spacious dining room allows all residents to dine at the same time. Meals are served from plates, not trays. We feel it is important that our residents are served foods they enjoy, thus our kitchen always prepares substitutions to accommodate personal preferences. Refreshments are also available as desired. A private dining room allows flexibility when family members come to eat with their loved one, and for intimate holiday gatherings.

Respite/Day Care

Crestview's staff realizes it can be challenging caring for a loved one in your home, and we respect your need for personal time. Day Care allows you to bring your loved one to Crestview Manor for eight hours, at a minimal charge. This gives caregivers the opportunity to run errands without the guilt of leaving your loved one home alone.

Respite Care means a scheduled short term stay (less than 30 days) with nursing care, delicious meals, and social activities. Respite exists to give caregivers a break and time for themselves. Families deserve the chance to "Breathe Easy" knowing their loved one is in capable hands.

Rehabilitation

Crestview Manor is a Skilled Nursing Home, which means Crestview can provide services under Medicare for those who need rehabilitation and have been in the hospital for three nights within the last 30 days. This is a short-term situation under Medicare, not to exceed 100 days. Crestview specializes in rehabilitation; our staff is dedicated to working toward the common goal of maximum independence for each and every one of our residents. We have no bed-bound residents, due to the dedication of our staff and Restorative Aid. Our Restorative Program has an outstanding preventative and maintenance routine for our residents, and our Restorative Aid works in conjunction with our therapist. Together we have been successful at rehabilitating our residents and sending several back home.

Outdoor Setting

Our grounds are equipped with gardens and sitting areas for outside entertainment. Crestview Manor strives to provide a high quality of life in an environment which promotes human dignity, self-esteem, and an inner peace. At Crestview we believe that it is your future and your choice, so we strive to make each day enjoyable.

Residential Living

Residential Living is a bridge between independent living and the Nursing Home. Crestview's Residential rooms are spacious, allowing residents to bring in personal belongings to fostering independence while giving assistance and security. Crestview's staff takes care of laundry and housekeeping so residents may focus on socialization and enjoyable activities. Our residents feel relief from the worry of cooking and cleaning, and appreciate the fact that help is only seconds away.

Alzheimer's Disease/Dementia

Crestview Manor's physical plant is completely alarmed for residents who are at risk for wandering. Crestview's specialized care setting is safe and allows freedom for residents to move about in a secured environment, both indoors and outdoors. Crestview's staff is trained to effectively address the challenging behaviors manifested by the Alzheimer's and/or Dementia resident. The staff strives to help the afflicted resident maintain their highest level of physical and social functioning, from early to late stages of Alzheimer's and Dementia.

Ideal Location

Set on four acres of beautifully landscaped grounds with a courtyard and walking trails, Liberal Springs is considered one of the premier senior living communities in this part of Kansas. Located close to Highways 83 and 54, our community offers 44 apartments on two floors.

Our common areas – including our lovely dining room, TV room and library – give residents and their loved ones the opportunity to get to know one another. We also offer a wide range of activities each month, including our Red Hat Society club, exercise classes and community outings to area museums and parks. Liberal Springs is conveniently located in a residential area near Dillons, Walgreen's, Braum's, Wal-Mart, as well as near Blue Bonnet Park and the Lake Meade Recreation area. Southwest Medical Center and a nursing home rehabilitation facility if ever needed are also close by.

MISSION STATEMENT:

We are passionately committed to making a difference in people's lives by providing service of the highest quality and value in a safe, supportive environment, promoting the health, independence and social interaction of seniors.

LIBERAL SPRINGS
1500 Terrace Ave.
Liberal, KS 67901
(620) 624-8000

EMERITUS
Senior Living

www.Emeritus.com

LIBERAL SPRINGS

An Emeritus Senior Living Community

Assisted Living

All the comforts of home.

Our Family is Committed to Yours.

"We have promised ourselves that we shall always treat our residents as we would our own loved ones. Nothing less than our best will do." - Emeritus Employee

Assisted Living

Quality care for quality of life

As we get older, many of us naturally need a helping hand – perhaps someone to help us get ready for the day, help manage our medications or prepare special meals. Sometimes that's all we need to live safely on our own.

Our staff is here to offer that helping hand, but only when and if you need it. Our full range of assisted living services are designed to help you maintain your health, so you can live as independently as possible. These include:

- Daily assistance with bathing and dressing
- Medication management
- Dining assistance and special diets
- Assistance with reminders and redirection
- Escorts and assistance with walking
- Emergency response call system
- Rehabilitation services (Physical, Occupational Therapy)

To ensure we meet your needs, we use a state-of-the-art computerized assessment system, called the Vigilan Resident Evaluation Program. This helps us accurately evaluate, predict and monitor assisted living services for each resident. In addition, our Director of Resident Care will visit with you on a regular basis to personally discuss health-related issues and to monitor your progress.

Friendship Suites

Just right for many seniors

Perhaps you'd love to live here, but you're concerned about your budget. Or maybe you no longer want to live alone. Either way, we offer the perfect solution – friendship suites. Seniors are brought together to share an apartment and cost savings, while receiving the same outstanding services and amenities all residents enjoy.

Short-Stay

A great way to get to know us

If you want to experience living at an Emeritus community before making a permanent move, or you're being discharged from a hospital or nursing care facility and aren't quite ready to go home, consider our short term stay program. You'll receive the same services all residents enjoy – home-cooked meals, scheduled transportation, outstanding service and more. Taking advantage of our short term stay program is a great way to decide if our community suits your lifestyle and fits your needs!

Right at Home

To all of our residents we make a simple promise: a promise to be compassionate and kind, understanding and respectful; a promise to become extended family to the seniors entrusted in our care and to our retirees who have chosen our community for its active lifestyle.

We invite you to come home to Liberal Springs.

For more information or to arrange a tour, call us at (620) 624-8000 or visit us online at www.Emeritus.com.

LIBERAL SPRINGS

An Emeritus Senior Living Community

Our Family is Committed to Yours.

These are more than words. This is a deeply held belief shared by all of our employees. It is our commitment to make a positive difference in the lives of the people we serve by fostering an atmosphere of community – a sense of place and belonging of home. Here at Emeritus, our residents truly are family to us as we are to them.

FINANCIAL ARRANGEMENTS ...

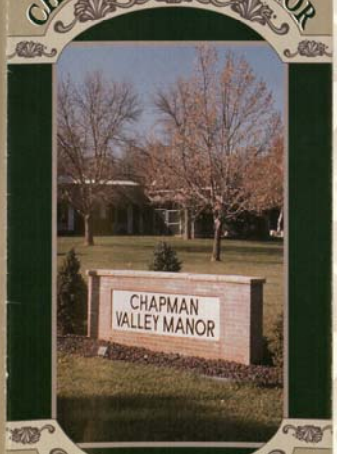
Upon entering the home, the person, persons, or agencies responsible for payments for nursing care will be given a detailed copy of the anticipated monthly charges. All questions will be answered and any detail requested will be provided by us in writing. The first month charges are paid in advance unless other agency arrangements are made.

We care!

CHAPMAN VALLEY MANOR
P.O. Box 219
Chapman, Kansas 67431
Administrator's Office: (785) 922-6525
Nursing: (785) 922-6594

Brochure furnished by Memorial Fund

CHAPMAN VALLEY MANOR



All the comforts of home!

Chapman, Kansas

60-Bed, Non-Profit, Community Owned

The objective of the Home is to provide care for persons who are unable to care for themselves in any or all facets of daily living.

Our staff is trained to provide the necessities for each resident's safety, comfort, well-being, and nutritional needs; to show and practice watchful regard, interest and concern; and to perform these functions with kindness and personal involvement, in a diplomatic and relaxed manner, and in a home-like atmosphere.

ADMISSIONS ...

Upon request for admission, the administrator and nurse-in-charge will confer with the applicant, relatives, or representative so that all responsible parties will understand the requirements of both the applicant and Chapman Valley Manor, and at that time determine the feasibility of the applicant's admission to Chapman Valley Manor. Rates and charges, also dates of payment and refund policy, will be discussed.

✔ Certain requirements for admission to Chapman Valley Manor are set by the State Board of Health. Forms may be obtained from our office.

- A current physical examination by the applicant's physician.
- A Medical History form with current diagnoses completed by the physician.
- A Client Assessment, Referral and Evaluation (CARE). 1-800-432-2703
- Physician's Orders, including specific medications, treatments, diet, recommendations, etc.

✔ All wearing apparel and personal belongings are to be inventoried and marked identifiable with the name of the owner. Gifts and items purchased after admission are also to be marked and added to the inventory. If the marking is inadequate upon admission, our staff will mark each item.

✔ Laundry of personal clothing is done at the facility, but dry cleaning service is not provided. Therefore, it is recommended that all daily wearing apparel be washable. We offer the following suggested minimum list of washable clothing and equipment:

Women	
Slacks, skirts, blouses or dresses	7
Slips	3
Underwear	12
Hose	7 pair
Shoes	2 pair
Nightgowns	3
Robe or duster	1
Washable bedroom slippers	2 pair

Men	
Shirts	7
Pants	7 pair
Underwear	12
Socks	7 pair
Shoes	2 pair
Nightshirt or pajamas	3
Lightweight robe	1
Washable slippers	2 pair
Electric razor (preferable rechargeable)	1

Toothbrush and toothpaste, deodorant, comb and brush

Hospital-type gowns are available if preferred or required.

✔ The mailing address is P.O. Box 219. Cards for changing your address may be procured from your post office. Incoming mail addressed to the resident is delivered intact and immediately. Outgoing mail addressed from the resident is dispatched with a minimum of delay.

1) Resident Room 2) Dining Room 3) Living Room
4) Care Plan Team 5) 18-Passenger Wheel-chair Lift Van
6) Physical Therapy

MOVING DAY ...

Let us know when we may expect you so that we will have all necessary arrangements made. We prefer to admit new residents Monday-Friday at 11:00 a.m., however, other arrangements may be made.

✔ Each room is furnished with living necessities, including furniture, bedding, towels, closet space, bathroom supplies, etc. Clocks, small radios, and portable television sets are items that you may wish to bring with you. Cable television is not included in the room rate and will appear as an additional charge each month.

✔ All electrical appliances must be checked by the facility personnel to assure their safety. Old or frayed appliance cords can be the source of fires or electric shocks. The State Fire Codes do not permit the use of extension cords in nursing homes.

✔ All medicines belonging to the resident will be checked in at the nurses' station, where they will be properly marked for the resident and stored under lock. All medications are usually administered by qualified nursing personnel, as required by the State Board of Health, unless other instructions are received by the resident's doctor.

✔ Adequate storage is provided for clothing and personal items. However, it is recommended that luggage and large cartons be stored at the home of a relative or representative.

AT HOME ...

It is our desire to maintain a friendly, homelike atmosphere for our residents, with a minimum number of rules. We will always maintain an adequate staff to meet the needs of each resident. We solicit both residents' and visitors' cooperation in careful use of facilities. We have a beautiful building and, working together, we can keep it in this condition.

✔ All residents will take their meals in our dining room unless acutely ill. When seating residents, personalities and compatibility are considered. Menus and food preparation are under the supervision of a registered consulting dietician, and are approved by the State Board of Health. Special diets are provided as ordered by the physician. A resident's religious dietary restrictions will be honored.

✔ We are licensed by the State Board of Health, and as such we maintain professional nursing personnel and medical consultants. Each resident may choose his personal physician. In case of illness, if the personal physician cannot be reached, another physician will be called. Also, relatives will be called when the resident is hurt, becomes ill, or needs any medical intervention.

✔ All residents are encouraged to take part in special activities. These include church services, programs, crafts, projects, entertainment, tours, etc.

✔ Rehabilitation Services are a part of the everyday activity for all of our residents. Selected personnel are trained by registered therapists to carry out this function. Physical therapy and speech therapy have to be prescribed by a physician and are available. A licensed dietician and social worker consult each month.

✔ With the cooperation of our churches and ministers, religious services are conducted each Sunday. All residents are welcome and encouraged to attend.

✔ Barber and beautician services are available on a regular schedule. Residents are responsible for payment for these services.

✔ All residents are bathed regularly, as necessary for comfort and health. Those who are unable to take showers or tub baths are given bed baths. Men are assisted with shaving or are shaved as is necessary to keep them neat and well groomed.

✔ Visitors are welcome at any time with the resident's consent. We ask only that they do give proper consideration to the resident's needs and to our staff's work schedule. Members of the clergy shall be admitted at all hours.

✔ As a statement of policy, be it known that this care facility provides care on a nondiscriminatory basis. All residents are admitted to Chapman Valley Manor without regard to the following: *race, color, national origin, religion, sex, or handicap.* This policy is known to our staff.