2015

Exploring the Lived Experiences of Seniors Aging in Place

Magaly C. Dante
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Magaly Dante

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Frances Goldman, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Karel Kurst-Swanger, Committee Member,
Public Policy and Administration Faculty

Dr. Kristie Roberts, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

Exploring the Lived Experiences of Seniors Aging in Place

by

Magaly C. Dante

MA, Nova Southeastern University, 2003

BS, Nova University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

August 2015

Abstract

Baby boomers are living longer, and as they age, they will need more supportive services that may include housing, mobility, nutrition, personal care, or health care. Despite the studies that have been conducted on baby boomers aging in place (choosing to stay in their home versus move to an institution), the focus has been on the old and frail and very little has been done to address the lifestyle of active (physically functioning) baby boomers. The purpose of this phenomenological study was to understand the lived, shared experiences of active baby boomers regarding their beliefs and attitudes about aging in place. The theoretical foundation of the study was based on Atchley's continuity theory. Data were gathered through in-person, semi-structured interviews with 11 participants, age 65 and older, living in a coastal area of a southern state. Data from the interviews were inductively coded and then organized around key themes. The themes from the content analysis indicated that the participants were embracing the concept of aging in place and adjusting to their limitations (i.e. physical, financial, emotional, and/or environmental) when present. Identified barriers to aging in place were access to services, financial constraints, and the inability to drive or inaccessibility of transportation. This study contributes to positive social change by providing policymakers and administrators with information to strengthen the argument that the current social service delivery system is overburdened and may not meet the demands of this population in order for them to maintain their independence and autonomy. Additionally, this study raises awareness among policymakers that driving longer will in itself possess its own challenges such as visibility concerns and roadway design not conducive to aging adults.

Exploring the Lived Experiences of Seniors Aging in Place

by

Magaly C. Dante

MA, Nova Southeastern University, 2003

BS, Nova University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

August 2015

Dedication

This project was inspired by a woman whom I have admired and looked up to my whole life. She helped raise me into the woman I am today. She instilled some very valuable gifts into me: integrity, determination, and perseverance. She watched me go through some of the most difficult times of my life and in the end still loved me as I am. She was the voice of reason when I made no sense and a source of strength when I thought I had none. She picked me up and dusted me off….a few times. As we mature and life happens, ironically, I became her voice of reason when she could no longer put together a full sentence and a source of strength for her when she could not fight anymore. This project is dedicated to my grandmother, Clara Perez Pardo, the classiest lady I have ever had the pleasure of knowing.

Acknowledgments

No true labor of love can be completed without the help and support of others. I need to acknowledge Dr. Frances Goldman, my committee chair, for supporting me through this long journey. She never gave up on me, and I will always treasure her guidance and mentoring. Dr. Karel Kurst-Swanger, my methodologist, for her support throughout the process. This research was dependent on the interviews conducted at the Boynton Beach Senior Center and the people who chose to participate in my study. Thank you so much for your participation. It was a great experience.

I need to give special thanks to several people: my in-laws, Otha and Vivian Jones. They accepted me from the beginning and allowed me to become part of their lives. They have been two of my biggest cheerleaders. Additionally, my husband Eric Jones for his neverending support during this process. I cannot thank him enough for his love and patience. My brother, Angelo Dante, my first cheerleader. He has always believed in my abilities and I appreciate him for being the man he is. My son, Angelo Riley. For most of his life, he has had to endure my career path and the sacrifices that went along with those choices. I can only hope that one day my son will understand the choices I have made and that he will put into practice the emotional and spiritual gifts I have instilled in him. I love him to the moon and back and all the stars in between.

Lastly, and most importantly, I acknowledge my creator, Jesus Christ. Through Him all things are possible, and He has shown me that there is nothing I cannot accomplish once I make it a priority in my life.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Two converging dynamics are reshaping the United States into an older society. The first is the aging of the baby boomers, and the second is the fact that they will need more supportive services (housing, mobility, nutrition, personal care, health care) as they age (The Florida Department of Elder Affairs, 2012). The size of the 65-and-older population is currently 40.3 million (Federal Interagency Forum on Aging-Related Statistics, 2012; Vincent & Velkoff, 2010). However, by 2030 all the baby boomers will have reached this age group (Howden & Meyer, 2011). The U.S. Census (2010) estimated, that, by 2030, 20% of the total population will be 65 years of age and older. Life expectancies past age 65 have increased, and those 65 and older can expect to live an average of 19.2 more years, or about 5 years longer than a similar population in 1960 (Federal Interagency Forum on Aging-Related Statistics, 2012). This phenomenon impacts everyone, but most importantly, the baby boomers who will need more supportive services as they age. Chapter 1 provides an overview of this growing social issue affecting the senior population. The chapter includes a background of the study, problem statement, purpose of the study, objectives, research questions, limitations, delimitations and assumptions, significance, and the theoretical framework.

Policymakers can no longer agree with the status quo when it comes to this social problem. The information provided from this research will not only contribute to the existing literature but strengthen the argument that retiring baby boomers will impact the nation's economy due to their growing needs as they live longer. To ignore this impending situation will yield profound social consequences, such as overburdening the

current social services structure, stressing the current health care system, and potentially institutionalizing older adults prematurely who could have remained independently in their homes (Federal Interagency Forum on Aging-Related Statistics, 2012; The Florida Department of Elder Affairs, 2012).

Background

The United States currently faces a population change dissimilar to anything ever seen. The population referred to as *baby boomers* represents 76 million persons born between 1946 and 1964 (Schuman & Scott, 1989). The number of births alone should merit attention. They are the fastest growing demographic, with 20% of the population entering this age bracket (65 and older) by 2030 (U.S. Census, 2010). The increase in population urged policymakers to increase the opportunities to them, something not afforded by their parents, such as graduating from high school and earning college degrees (Poulos & Nightingdale, 1997). Increased education led to increased income, and with the advantages of the GI bill and Veteran's Administration loans, many people took advantage of these programs and started living the American Dream (CNN Library, 2013).

In 2011 the first set of baby boomers turned 65 (Federal Interagency Forum on Aging-Related Statistics, 2012). The projections have been consistent that these baby boomers are going to live longer, and living longer means supporting this population in a way society has not experienced yet (Taylor, Morin, Parker, Cohn, & Wang, 2009). As an example, the U.S. health care system has never had to provide services to as many people as it will need to serve in the upcoming years through 2050 (The Florida Department of

Elder Affairs, 2012). More significantly, knowing that the older adult population is expected to reach close to 90 million by 2050, the costs associated with their health care will overwhelm the federal budget, which could place spending set for national priorities at risk (The Florida Department of Elder Affairs, 2012).

The long-term care system will not be the only system impacted by baby boomers growing older and living longer. Social security and Medicare have been the primary sources of support for seniors up to now (Johnson, 2013). Prior to the financial crisis of 2008, the data indicated that current baby boomers were more readily prepared for retirement compared to similarly aged households over the past 25 years (Reno & Veghte, 2011). However, currently, the combined effect of declining retirement accounts, home equity, interest rates, and the continuing increase in the Social Security full benefit age means that emerging seniors (age 50–59) are estimated to be at risk of falling short of maintaining their living standards in retirement (Gustman, Steinmeier, & Tabatabai, 2009; Helman, Adams, Copeland, & Van Derhei, 2013; Hurd & Rohwedder, 2010; Reno & Veghte, 2011; Urban Institute, 2009). If people in this demographic are unable to maintain their standard of living during retirement, the possibility of their having to leave their homes substantially increases. This would contradict the literature, which states that baby boomers want to stay in their homes as they grow older (Boldy, Grenade, Lewin, Karol, & Burton, 2011; Love 2010; Wadrip, 2010). In addition, as the needs of this demographic change, baby boomers' homes will need to be evaluated for barriers to successful aging (i.e., stairs, high cabinets, bathtub access, etc.). Subsequently, there is growing research to suggest that people are unaware of their options when it comes to

their home environment (home modification, home and community based services, relocation). As a result, individuals in this population are becoming prisoners in their own homes due to the limitations of their homes or, worse yet, are becoming prematurely institutionalized (Johansson, Josephsson, & Lilja, 2009; Oldman, 2008; O'Shaughnessy, 2010; Pynoos, Caraviello, & Cicero, 2009; Rosenberg, Jullamate, & Azeredo, 2009; Tang & Lee, 2010; Vasunilashorn, Steinman, Liebig, & Pynoos, 2012).

Problem Statement

Nationally, people are living an average of 19.2 years longer than they were 40 years ago (Federal Interagency Forum on Aging-Related Statistics, 2012), and Florida has the highest percentage of this aging 65-years-and-older population (U.S. Census Bureau, 2010). As the population ages, current social services are inadequate to meet their growing needs. Aging boomers are going to need affordable and accessible housing and transit, not to mention information hubs and leisure and educational services. All of these services come at a significant cost to local governments (Smith, Tingle, & Twiss, 2010). Furthermore, the economic downturn has presented new challenges for the aging population in terms of lost resources (O'Shaughnessy, 2011; Tenenbaum, 2010). Unemployment for older adults during the recession has decreased the amount of savings for retirement while increasing the chances of their using their savings to maintain their lifestyles (Johnson, 2013). Some Americans borrowed from their retirement plans and have since continued to work to finance their homes and maintain their lifestyles (MetLife Mature Market Institute, 2012; Reno & Veghte, 2011; Shapiro, 2010; Taylor, Morin, Parker, Cohn, & Wang, 2009). The problem is the number of aging baby boomers

who will impact the already stressed and overburdened social delivery system (e.g., nutrition, personal care, health care, mobility, to name a few). If this problem is not addressed in the near future, the system will struggle to meet the needs of older Americans, which may, in turn, lead to premature institutionalization and overutilization of already scarce services (Johansson et al., 2009; Nunn, Sweaney, Cude, & Hathcote, 2009; Oldman, 2008; O'Shaughnessy, 2011; O'Shaughnessy, 2010; Rosenberg, Jullamate, & Azeredo, 2009; Tang & Lee, 2010).

Purpose of the Study

The purpose of this study was to explore the lived experiences of a senior population by collecting their perspectives and experiences on aging in place. The study explored the lived experiences of this demographic in the hopes of gaining an understanding on their needs as they age. The research will contribute to the literature and to social change by providing information to baby boomers on how they can use the information to make informed choices. Additionally, this research provides policymakers and service workers with information to strengthen the argument that public health issues cannot be addressed without discussing the impact retiring baby boomers will have on the nation's long-term systems of care as well as the economy.

Regarding this social problem, a review of gerontological literature revealed an emphasis on the needs of the old and frail, people aged 85 and older (Aberg, Sidenvall, Hepworth, O'Reilly, & Lithell, 2005; Baltes & Lang, 1997; Baltes & Smith, 2003; Freund & Baltes, 1998; Klumb & Baltes, 2004; Li, Aggen, Nesselroade, & Baltes, 2001; Singer, Verhaeghen, Ghisletta, Lindenberger, & Baltes, 2003). In contrast, the body of

research that specifically addresses the 65 and older community is geared towards the entire life span and the concept of successful aging by studying young and older people (Freund & Baltes, 2002; Li, Lindenberger, Freund, & Baltes, 2001; Nimrod & Kleiber, 2007). This study contributed to the current body of research by examining an understudied population (active 65+ adults). The people in this particular age group are at the appropriate stage of their lives where they are mature enough to know what they want out of life and not so frail that they can no longer make proactive decisions.

Research Questions

The current qualitative study was guided by the following research questions:

1. What have the participants experienced in terms of aging in place (i.e., the decision to remain in one's home or community as one ages instead of opting for relocation to long-term care, assisted living, nursing home)?
2. What are the barriers (physical or mental) that impede successful aging in place?
3. What are the identified services needed to age in place?

To address these questions, I used an exploratory approach to understanding the life experiences of the population being studied. Using face-to-face interviews, I documented the lived experiences of the participants and gathered information that provided possible insight into their perceptions and realities that may lead to proactive decision making for their futures.

Theoretical Framework

Atchley's continuity theory (1989) provided the theoretical underpinning of this study. Continuity theory (1989) can shed light on how people react to their environment as they age, not only from a physical aspect but also from a psychological perspective (Kolb, 2004). Older adults adapt different perspectives when faced with challenging events. The current study was an inquiry into the complexities of aging and lived experiences of those living it.

Continuity Theory

Atchley's (1989) continuity theory looks at how people adapt to various types of change, ranging from the gradual (minor physical or emotional change) to the profound (sharp downturn in health and/or mood). Atchley's premise is on continuous adult development, including adaptation to changing situations. It presumes that individuals will adapt to their environment and/or circumstances based on their experiences. In order to utilize continuity theory, information over time is needed in four dimensions of an individual. They are idea patterns, lifestyle, personal goals, and adaptive capacity (Atchley, 1999). A more detailed explanation is described in Chapter 2.

Nature of the Study

A phenomenological approach was selected to explore the lived experiences of people aging in place. The use of qualitative analysis allows for the exploration of the meanings of social phenomena as experienced by individuals in a more systematic and scientific way. The interview process lends itself to the potential for a better understanding of the relationship between an individual to his or her home environment.

A further discussion of the advantages of using a qualitative approach is presented in Chapter 3.

The population for this study consisted of males and females, age 65 and older, residing in Boynton Beach, Florida. The rationale for choosing this population starts with the fact that Florida has the highest percentage of people over the age of 65 (Federal Interagency Forum on Aging-Related Statistics, 2012). As a result, most of Florida's seniors are concentrated in five counties (Miami-Dade, Palm Beach, Broward, Pinellas, and Hillsborough; The Florida Department of Elder Affairs, 2009). For this reason, it made sense to conduct the study in an area where a larger percentage of people in this age bracket reside. I chose Palm Beach County and the city of Boynton Beach due to the fact that in the city of Boynton Beach the percentage of residents age 65 and older is 21.4% (U.S. Census Bureau, 2010). Selection of this particular county offers some advantages. First, Palm Beach County has a significant number of people age 65 and older and, currently, the largest number of people age 85 and older in Florida (U.S. Census Bureau, 2010). Secondly, the percentage of seniors in the city of Boynton Beach (21.4%) is significant compared to other Florida counties.

I recruited participants into the study using a convenience sample limiting the study to 11 participants. The interviews took place at the Boynton Beach Senior Center. The goal of the study was to explore the lived experiences of this population in the hopes of gaining an understanding on their needs as they age. Approximately 40% of voters in Florida will be 65 or older by 2030, and they will impact policies such as education and long-term healthcare (Dewey & Denslow, 2012). The goal of the study was to provide

policymakers and service workers with information to strengthen the argument that retiring baby boomers will have an impact on the nation's already stressed and overburdened social delivery system. If this problem is not addressed, the system will struggle to meet the needs of older Americans (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014; Johansson et al., 2009; Nunn, Sweaney, Cude, & Hathcote, 2009; Oldman, 2008; O'Shaughnessy, 2011; O'Shaughnessy, 2010; Rosenberg, Jullamate, & Azeredo, 2009; Tang & Lee, 2010).

Definition of Terms

Activities of daily living (ADLs): Routine tasks involved in personal care. These basic activities that support survival include feeding, dressing, bathing, transferring, toileting, and walking (Federal Interagency Forum on Aging-Related Statistics, 2012).

Adaptability or barrier free design: The ability of certain building spaces and elements, such as kitchen counters, sinks, and grab bars, to be added or altered so as to accommodate the needs of individuals with or without disabilities or to accommodate the needs of persons with different types or degrees of disability (Department of Justice, 2010).

Adaptive capacity: The ability adults have to adapt to their living situation based on the internal (i.e., positive attitude) and external (e.g., family relationships) patterns they have developed over time (Atchley, 1999).

Aging in place: Refers to a decision individuals make to remain in their homes or their communities as they grow older instead of opting for relocation to long-term care facilities such as assisted living and nursing homes (Tenenbaum, 2010).

Bridge employment: Part-time or short-duration jobs that occur between full-time employment and complete labor force withdrawal (Quinn, 2002, p. 295).

Developmental goals: Adult goals for developmental direction that are self-striving and address areas where one wants to evolve. For example, wanting to increase spiritual growth or improve family relationships (Atchley, 1999, p. 11).

External patterns: Relates to a person's social roles, activities, relationships, living environments, and geographic locations organized in a person's mind (Atchley, 1999, p. 10).

Internal patterns: Relates to the general framework represented in Atchley's (1999) continuity theory in which a person's constructs such as self-concept, personal goals, worldview, philosophy of life, moral framework, attitudes, values, beliefs, temperaments, and coping strategies represent a unique person which distinguishes them from another person.

Instrumental activities of daily living (IADLs): Indicators of functional well-being that measure the ability to perform more complex tasks. They include the use of the telephone (look up numbers, dial, and answer), traveling via car or public transportation, food or clothes shopping, meal preparation, housework, medication use (preparing and taking the correct dosage), management of money (write checks and pay bills; Federal Interagency Forum on Aging-Related Statistics, 2012).

Long-term services and supports (LTSS): Defined as assistance with ADLs and IADLs to people who cannot perform these activities on their own due to a physical,

cognitive, developmental, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more (U.S. Senate, 2013).

Natural occurring retirement communities (NORCs): These communities usually develop over time and over a period of time tend to have a higher concentration of older residents (Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011).

Successful aging: An objective concept of how a person sees themselves as they age. Factors attributed to successful aging are life satisfaction, good health, self-esteem, positive social support, and activity/functional level (Ferri, James, & Pruchno, 2009).

Universal design: Concept of designing products and environments to be attractive and usable by all people to the greatest extent possible, without the need for adaptation or specialized design regardless of age or ability (Mace, 2008).

Delimitations and Assumptions

There were several assumptions made in this study. The first assumption was that the participants would be honest and that my questions would measure the construct of interest. In other words, they would answer questions the way they would whether I was present or not. Based on the information provided in the interviews, I would agree that most of my participants were open, honest, and engaging in order to provide a rich interview. A few were hesitant and withheld some information but were able to give me enough information to answer the questions completely. The second assumption was that the participants would be cognitively intact and therefore not display cognitive impairments. An example of a cognitive impairment would be recurring, pronounced forgetfulness or losing one's train of thought during a thread of conversation. For the

most part, everyone was cognitively intact and did not display any major cognitive impairment.

A further assumption was that the participants would feel comfortable enough to provide feedback even if it was negative. When the question was asked of my Asian American participant about her relationship with her son, she was vague, and it was obvious from her body language she was uncomfortable answering the question. This was not the case with the other participants as most of them were forthcoming about their relationships and provided beneficial information regarding their background, upbringing, and perspectives on aging in place.

There were two situations that came up in the interviews I was not expecting. The first one was that I was not expecting my participants to have such active social lives. The second situation that came up in almost every interview was the ability to drive. A question asked if participants were still driving, and 9 out of 11 participants stressed the importance of being able to still drive. The literature on successful aging is clear that the feeling of independence is a key indicator for longevity in later life (Atchley, 1999; Baltes & Baltes, 1990; Baltes & Smith, 2003; Freund & Baltes, 1998); however, the specific topic of driving was not mentioned in the studies.

Limitations

The small number of interviews ($N = 11$) taken from one location within the county will limit the interpretation of the study results and the ability to generalize to the general population. Additionally, the convenience sampling may have created sampling bias where the sample was not representative of the population. If the convenience

sample is taken from one specific location, there is a higher probability that the population may have similar beliefs versus doing interviews in different geographical locations. Next, the employed self-report survey method may lead to a self-reporting bias where participants are less likely to answer honestly due to stigma or the desire for social acceptance (Rubin & Rubin, 2005).

Significance of Study

This study will add to the body of literature that addresses the effects of aging in place (Boldy, Grenade, Lewin, Karol, & Burton, 2011; Denton et al., 2009; Fisher, Johnson, Marchand, Smeeding, & Torrey, 2007; Keenan, 2010; Love, 2010; Mihailidis, Cockburn, Longley, & Boger, 2008; O'Shaughnessy, 2011; Pande, Laditka, Laditka, & Davis, 2007; Wardrip, 2010). More specifically, helps fill a gap in the literature that neglects discussing the impact the baby boomers will soon have on an already overburdened social delivery system. Research aimed at exploring people's lived experiences and perceptions about their living situation can help address the disconnect between this overburdened service delivery system and the growing needs of aging adults. Studying an individual's adaptation ability can lead to better decision making with regards to the types of accommodations presented to people choosing to age in place. Findings can be used to encourage individuals, families, and providers to consider the complexity of aging in place and the total environment of seniors as they plan for the future. The results of this study will provide policymakers useful information that can be applied to the long-term systems in care currently in place.

Transition and Summary

Baby boomers are living longer, and, as they age, they will require more services to meet their growing needs (Taylor, Morin, Parker, Cohn, & Wang, 2009). By 2030, 20% of the population will be 65 years of age and older (U.S. Census, 2010). Current service delivery systems are insufficient to meet the needs of this population, which is impacting the future of how these programs will look and function (Johansson et al., 2009; Nunn, Sweaney, Cude, & Hathcote, 2009; Oldman, 2008; O'Shaughnessy, 2011; O'Shaughnessy, 2010; Rosenberg et al., 2009; Tang & Lee, 2010). Public policymakers can no longer have a conversation regarding public health issues without considering the need to support extending quality of life for these emerging baby boomers. Ultimately, it is hoped that the current study will empower public administrators and decision makers to consider the views of seniors as they plan for programs and services to meet their growing needs as they age. The research will contribute to the literature and to social change by providing policymakers and service workers with information to strengthen the argument that retiring baby boomers will have an impact on the nation's already stressed and overburdened social delivery system. If this problem is not addressed, the system will struggle to meet the needs of older Americans, which may in turn lead to premature institutionalization and overutilization of already scarce services

In order to support the goal of understanding the population I am studying, this dissertation is organized into five chapters, references, and appendices. Chapter 2 contains a review of the literature to support this research study. The literature review includes a theoretical basis in relation to the senior population, aging in place, and

theoretical framework linking people with their environment. Chapter 3 contains the research methodology, procedures, and methods of data analysis. Chapter 4 gives a detailed analysis of the results, and Chapter 5 will provide a more in-depth analysis of the study's results and discuss implications for positive social change.

Chapter 2: Literature Review

Introduction

The literature review includes research on the theoretical framework of understanding person–environment relationships, current research on aging, the concept of aging in place, and the types of accommodations/services available for persons to stay in their home versus relocation to an assisted living facility or other type of facility. It is a comprehensive review of the relevant literature pertaining to aging in place and the public policies associated with this phenomenon. The purpose of this review is to demonstrate the gap in the literature that exists with respect to the research and study of aging in place and its importance for the provision of effective and sustainable policing services. This chapter is organized around three subsections: (a) theoretical framework, (b) profile of the senior demographic, and (c) successful aging.

Research Strategy

Various resources were used to search the literature. Articles from peer-reviewed journals, academic journals, and the following databases: EBSCO; Academic Search Complete/Premier; SAGE Premier 2010; PsychARTICLES; ProQuest Central; and Goggle Scholar. The following search terms were used: *accessibility*, *older adults, universal design, aging in place, aging, barrier free living, community services, aging policy, activities of daily living skills, instrumental activities of daily living skills, attachment theory, successful aging, life-span models, person-environment fit*, *continuity theory, NORC's, Older American's Act, life span theories, adaptation theory* and

inclusive environments. The selected databases provided citations from both scholarly sources and other publications across a broad range of disciplines and time frames. The majority of the literature was published in the last 7 years.

Theoretical Framework

Continuity Theory

According to Atchley's (1989) continuity theory of aging, the premise is on continuous adult development, including adaptation to changing situations. The theory assumes that as people age, they will strive to remain consistent in their behavior patterns (i.e., work schedule, leisure activities, etc.). Additionally, they will make adaptive choices in an effort to avoid disruption to these patterns of behavior (Atchley, 1999).

Atchley's (1999) longitudinal study explored a broad spectrum of factors that spanned 20 years and started with more than a thousand individuals. He used the longitudinal data to identify areas of continuity and stability. The data showed how people adapted to various types of change, varying from gradual and minor physical changes to profound disability. Continuity theory consists of internal and external patterns. Internal patterns include idea patterns and personal goals. External patterns include lifestyle and adaptive capacity (Atchley, 1999).

Idea patterns. The dimension of idea patterns represent a person's internal framework (i.e., attitudes, beliefs, values, coping strategies, etc.), which makes a person whole and distinguishable from another person (Atchley, 1999, p. 9). People are motivated to maintain their idea patterns when faced with life decisions and adapting to change (Atchley, 1999).

Personal goals. Continuity theory assumes that adults have personal goals for developmental growth. Adults use life experiences to make decisions about which aspects of their life they should focus their attention on, activities to engage in, careers to pursue, and so on (Atchley, 1999, p. 11).

Lifestyle. Lifestyle involves external patterns or social roles, relationships, and living environments. Over time, external patterns are what set people apart from each other. It is presumed that continuity of these roles, relationships and living environments can prevent or minimize the social, psychological, and physical losses that cultural concepts of aging might lead people to expect (Atchley, 1999, p. 11). An example of this is when a person decides to work part time after retirement. Employment after retirement offers an opportunity to maintain social contacts and daily routines (Von Bonsdorff, Shultz, Leskinen, & Tansky, 2009), which has been linked to successful aging (Minhat, Rahmah, & Khadijah, 2013; Shultz & Wang, 2011; Wang, 2007; Zhan, Wang, Liu, & Shultz, 2009).

Adaptive capacity. Adaptive capacity refers to the evolution of adults as they age, and through these experiences they will adapt based on their internal and external patterns (Atchley, 1999). For example, when people make the decision to age in place versus relocate, they will tap into their adaptive capacity, which is comprised of their lifetime of learning, adapting, and personal evolution (Atchley, 1999). The results are complex since everyone is different with regards to their personal experiences.

In summary, Atchley's (1989) continuity theory presumes that adults will adapt to their environment based on the dimensions listed above. Their decision making will take

into consideration the many factors of their lives and make determinations about the world around them based on those factors. The theory also suggests that adult development and aging are highly interrelated and how well a person adapts to the aging process is heavily determined by internal and external constructs.

Theory Contributions

The essential contribution of Atchley's (1989) continuity theory of aging is to indicate that adaptive behavior and/or positive affect may result from a wide variety of combinations of individual competence and environmental press (Lawton, 1980). Studies have centered on (a) aging in the private home environment (Danziger & Chaudhury, 2009; Tanner, Tilse, & de Jonge, 2008), (b) residential decisions (Fields, Anderson, & Dabelko-Schoeny, 2011; Stark, Landsbaum, Palmer, Somerville, & Morris, 2009), and (c) bridge employment (Feldman & Beehr, 2011; Mohamed, 2012; Peterson & Murphy, 2010; Shultz & Wang, 2011; Wang, 2007; Zhan et al., 2009). Bridge employment refers to the concept of working after career employment ends but before full retirement begins (Quinn, 2002). Other studies have focused on describing home modification and adaptive device use, examining environmental risk factors for deleterious outcomes (i.e., falls), behavioral and cognitive adaptational strategies that occur within the home, and evaluating the effectiveness of home-based interventions designed to enhance aspects of well-being (Denton et al, 2009; Erkal, 2010; Kruse et al., 2010; Petersson, Kottorp, Bergstrom, & Lilja, 2009; Tinker et al., 2008). This theory focuses on the relationship between behaviors and their psychological functions (Nimrod & Kleiber, 2007).

It is difficult to draw generalizable conclusions from many studies on aging, but that has to do in part to all the different approaches utilized to examine the phenomenon of aging in place. Applications have explored the relationship between person–environment fit and ADL dependence. However, many have focused on the very old or frail (Aberg, Sidenvall, Hepworth, O'Reilly, & Lithell, 2005; Denton et al., 2010; Freund & Baltes, 1998; Hallrup, Albertsson, Tops, Dahlberg, & Grahn, 2009; Johansson, Lilja, Petersson, & Borell, 2007; Singer, Verhaeghen, Ghisletta, Lindenberger, & Baltes, 2003; Stineman et al., 2011). These studies suggested that as people age they have more accessibility problems due to their declining functioning versus issues with the environment. With that said, such studies strengthen the argument that home modifications are helpful in the short run for the very old, but as people reach significant decline in functioning, in-home services become more useful and/or needed.

Lawton's ecological theory of aging (Lawton & Nahenow, 1973) is most closely related to continuity theory but takes the reverse perspective. The ecological theory of aging is the most frequently cited to represent the theoretical argument that the quality of the house setting occupied by older persons will influence their psychological well-being and behavioral functioning (Edwards, Cable, Williamson, Lambert, & Shipp, 2006; Golant, 2008a, 2008b; Oswald, Wahl, Schilling, & Iwarsson, 2007; Tanner, Tilse, & de Jonge, 2008). The theory evolved from the work of Kurt Lewin (1951) who was the first psychologist to attempt to conceptualize the person–environment relationship by developing an ecological equation, $B = f(P,E)$, which translates into behavior equals the interaction between people and their environment. Lewin argued that behavior can be

viewed generally as a function of the interaction between people and the environment (Lawson, 1980). Lawton (1980) adapted Lewin's ecological equation and took the two elements and interfaced them to reflect an interactional perspective. Although Lawton (1973) spoke of the importance of adaptation as a key concept in the aging process, he was more focused on the physical environment versus the psychological components and lived experiences of the person.

Collectively, these studies suggest that there is merit in adapting one's home as competencies decrease. On the other hand, there is also a relationship between making sure the home adaptations are individualized to the resident as well as supplementing the resident with in-home and/or community services. (Cohen, Mulroy, Tull, Bloom, & Karnas, 2007; Johansson, Lilja, Petersson, & Borell, 2007; Nygren et al., 2007; Oswald, Wahl, Schilling, & Iwarsson, 2007). Finally, continuity theory adds to the richness of the literature by exposing the vulnerabilities of people as distinct individuals with free will and idiosyncratic choices based on experiences.

Profile of the Senior Demographic

In recent decades, the United States has experienced a remarkable growth in the senior population. Much of this growth can be attributed to the baby boom generation, which is comprised of 76 million people in the United States (Howden & Meyer, 2011; U.S. Department of Health and Human Services, 2011). Twenty percent of the total population will be 65 years of age or older by 2030, which is twice their number as in 2007 (U.S. Department of Health and Human Services, 2011).

In 2010, the percentage of adults 65 years of age and older was 13%. In Florida alone, the percentage was 17.8%. These rates are projected to rise to 18.2% for the United States and 24.7% for Florida by 2025 (Federal Interagency Forum on Aging-Related Statistics, 2012; U.S. Department of Health and Human Services, 2011).

People over the age of 60 are a significant factor in Florida's economy. The average Florida retiree contributes $2,000 more in revenues than he or she consumes in public services (The Florida Department of Elder Affairs, 2012). Despite the benefit of having elder residents, approximately 1 in 10 of those 60 and older in the state live in poverty, and over 800,000 are medically underserved (The Florida Department of Elder Affairs, 2012). The major concern with such an influx of adults over the age of 65 are the challenges the county will face in determining how to expand existing service delivery programs that are currently insufficient to meet the needs of the present population (Kemper, Weaver, Short, Shea, & Kang, 2008; O'Shaughnessy, 2011; Tenenbaum, 2010). These challenges will also affect families, businesses, and health care providers (Vincent & Velkoff, 2010). The more people over the age of 65, the fewer working age people to assist with their needs (Vincent & Velkoff, 2010; Zayac & Salmon, 2007).

Aging As a Process

There will be new and different needs and demands for services from the new senior population (Malonebeach & Langeland, 2011). These seniors have a wider range of life experiences and expectations for their future than previous generations as they are more educated and have higher incomes (Johnson, 2013). They also appear to be less prepared for retirement (Meschede, Sullivan, & Shapiro, 2011). The economic crisis of

2008 left many baby boomers in a situation where they will need to continue to work, even if it is part time (Federal Interagency Forum on Aging-Related Statistics, 2012). More recently, AARP conducted a survey among a nationally representative sample of 801 individuals who turned 65 in 2011. Their study showed that people will continue to work well into retirement age (Bookman, 2008; Love, 2010; Malonebeach & Langeland, 2011; Taylor, Morin, Parker, Cohn, & Wang, 2009). As Atchley's (1989) continuity theory indicates, aging adults will seek continuity with their past to prepare for future challenges. Remaining in a familiar environment is a primary way to provide continuity to the environmental context of one's past. It suggests that individuals who have been deeply involved in their work will try to sustain their daily routines by participating in activities which they highly value (Von Bonsdorff, Shultz, Leskinen, & Tansky, 2009).

To compound the issue of aging, older people are faced with the reality that they are living longer. However, living longer means they are more susceptible to needing more assistance as they age (Taylor et al., 2009). More specifically, women are living longer than men, by an estimated 6 years (Federal Interagency Forum on Aging-Related Statistics, 2012; Onolemhemhen, 2009; Taylor et al., 2009). Women age 65 and over are 3 times as likely as men of the same age to be widowed. In 2008, 76% of women age 85 were widowed compared to 38% of men (Federal Interagency Forum on Aging-Related Statistics, 2012, p. 5) These women are more likely to outlive their private resources, which may be one of the reasons they will continue to work after retirement (Meschede, Cronin, Sullivan, & Shapiro, 2011). Another explanation is that older women who were in the workforce during their younger years may not have accrued benefits in the social

security system because they generally earned less than their male counterparts and, therefore, are not entitled to as much income when they retire (Meschede, Cronin, Sullivan, & Shapiro, 2011; Onolemhemhen, 2009, p. 730). The current long-term care system in the United States is not equipped to handle these situations in a proactive manner. The system functions in crisis mode (Kaup, 2009). In addition, nearly 85% of long-term care decisions are made after an older person has already reached a medical crisis (Neal, 2007; Pope & Kang, 2010).

Functional limitations, which can be defined as not being able to perform certain daily living activities (examples are dressing oneself, reaching over head, and lifting heavy objects) may be prevalent in later years if illness, chronic disease, or injury limits physical and/or mental abilities. In 2007, 42% of people age 65 and over reported a functional limitation (Federal Interagency Forum on Aging-Related Statistics, 2012). This percentage does not include adults with psychiatric disorders such as depression and dementia. People who report depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care resource utilization (Federal Interagency Forum on Aging-Related Statistics, 2012; Skoog, 2011). Furthermore, arthritis, sensory impairment, heart disease, diabetes, and respiratory disorders are the leading cases of activity limitations (Federal Interagency Forum on Aging-Related Statistics, 2012; Potter 2010; U.S. Department of Health and Human Services, 2011). There are factors associated with age, including the loss of close relatives, social network, sensory functions and health that affect a person's mental health and ability to live on his or her own. This is not to say that as people age, they will not be

in good health, but it should be noted that these same individuals have or will have at least one chronic condition and some will have multiple conditions.

Every year, millions of unwilling older Americans move to institutional facilities prematurely because there are limited resources available to help them continue to live at home (Bookman, 2008; Miller, Olson, & Garner, 2007). An increasing number of older Americans will receive home care from paid helpers, especially as family caregivers become less available because future generations of older Americans had fewer children than the current generation, and middle-aged women are now working more than in the past (Johnson, 2013). Many older adults will also end up in nursing homes. Despite the decline in nursing home admission rates, the chances of receiving nursing home care at some point after age 50 still exceeds 50% (Johnson, 2013). Although Medicare covers nearly all the costs associated with coverage (premiums and deductibles), many Americans are left with substantial out-of-pocket expenses (Johnson, 2013). In 2040, health care costs will comprise more than 20% of household incomes for about 7 to 10 adults ages 65 and older in the bottom two-fifths of the income distribution (Johnson, 2013).

Health characteristics are the strongest predictors of independence in the performance of ADLs. Limitations in ADLs such as bathing, dressing, eating, getting in and out of chairs, walking, or using the toilet or IADLs such as using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money assist in determining if a person can age in place or if other accommodations need to be implemented (Federal Interagency Forum on Aging-Related Statistics, 2012; Tang &

Lee, 2010; Tenenbaum, 2010). When a person's ability to perform routine tasks begins to deteriorate, the reality of living independently becomes much more difficult (Pope & Kang, 2010). Long-term costs are prohibitive. The latest estimates from the 2012 MetLife Mature Market survey indicated that a year of nursing home care in a semiprivate room now averages about $80,000 nationwide, with average costs as much as 75% higher in certain parts of the country (MetLife Mature Market Institute, 2012). The desire to stay in one's home may be significant; however, the relationship between independence and housing has a greater impact than a person's age in many cases. It is important to discuss individuals' ability to perform their ADLs independently as they grow older.

Factors Associated with Successful Aging

Successful aging has different meanings to different people. There is very little consensus on a definition for successful aging although researchers agree it is worth evaluating to determine longevity in older adults (Angus & Reeve, 2006; Ferri, James, & Pruchno, 2009; Rowe & Kahn, 1997). Conceptually, successful aging refers to an "objective assessment of an individual's status on biopsychosocial factors compared with peers or an older adult's subjective assessment of how they are aging" (Ferri, James, Pruchno, 2009, p. 380). In one study, older adults defined successful aging as including good physical health, good psychological health, social support, and activity/functional ability (Ferri et al., 2009, p. 385). Additional studies also support successful aging to be attributed to positive social support, activity/functional ability, as well as good psychological health (Aldwin & Igarashi, 2015; Atchley, 1999; Baltes & Baltes, 1990; Baltes & Smith, 2003; Dahany et al., 2014; Freund & Baltes, 1998). These studies have

spurred the need for programs that encourage successful aging. OASIS is one of those programs. Founded in 1982, OASIS partners with community agencies to educate and promote successful aging within neighborhoods by offering programs that promote health and active lifestyles (Kerz, Teufel, & Dinman, 2013).

Aging in Place

The concept of aging in place has existed since the late 1990s, and the term was coined by Ron Mace and the Center for Universal Design at North Carolina State University. Although not a new concept, much of the literature available depicts the public as unaware of its meaning and its significance (Denton et al., 2009; Johansson et al., 2009; Miller, Olson, & Garner, 2007; Tang & Lee, 2010).

Aging in place refers to a decision individuals make to remain in their homes or their communities as they grow older instead of opting for relocation to long-term care facilities, such as assisted living and nursing homes, with the emphasis on modification of home environments to compensate for limitations and disabilities (Pynoos, 1993). A more recent definition has included not only remaining in their homes but also maintaining independence where they choose to live, even as their needs change over time (Kaup, 2009). This concept translates into options for many older adults who otherwise may leave their homes due to lack of information on the subject. Many reasons exist for encouraging older persons to remain in their own homes. The strongest argument is that adults are reporting that they want to grow old in their homes and communities (Boldy, Grenade, Lewin, Karol, & Burton, 2011; Fisher, Johnson, Marchand, Smeeding, & Torrey, 2007; Keenan, 2010; Love, 2010; Wardrip, 2010).

AARP (2010) published a study in which three-quarters of their 1,616 participants stated they wanted to stay in their home as long as possible and would like to remain in their local community as well. Only a quarter of the respondents stated they could not afford to move as the reason for remaining in their current home (Keenan, 2010).

Another reason to encourage aging in place is evidence to suggest that a person's home is more than just a place to live. Aging in place offers numerous social and financial benefits. Research shows that independent living promotes life satisfaction, health, and self-esteem, three keys to successful aging (Danziger & Chaudhury, 2009; Maisel, Smith, & Steinfeld, 2008; Pappas, Sink, & Jamison, 2014; Rioux & Werner, 2011; Stafford, 2009; Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Aging in place is closely related to the notion that a person's home is a symbol of independence. People who must leave their home may see this as giving up a level of independence they are accustomed to and in turn see it as a loss of control over their own ability to take care of themselves (Mihailidis, Cockburn, Longley, & Boger, 2008; Stafford, 2009). A supportive environment, such as a home that has been adapted to the needs of the individual, can compensate for declining functioning and lessened competency, as stated in Atchley's (1989) continuity theory. Adjusting the home as a means to increase access to supportive features and restore a manageable balance between competency and the demands of the environment is an option that can assist older adults to maintain independence in their home (Birkeland & Natvig, 2009; Denton et al.., 2009; O'Shaughnessy, 2008, 2010, 2011; Pande, Laditka, Laditka, & Davis, 2007).

Historically, the theoretical framework that would be used in this study has normally been geared towards how individuals react and function when modifications are made in their homes. For example, when Nunn, Sweaney, Cude, and Hathcote (2009) conducted a study on consumer receptiveness to universal design features, they were studying how the residents reacted to modifications made in their homes. These modifications were made based on what the literature stated was needed to make a home "elder friendly" (Nunn, Sweaney, Cude, & Hathcote, 2009). These modifications were supposed to make their lives more manageable and increase independence. One critical aspect of the study that the researchers were not expecting was the comments from the participants. The participants argued that the modifications to their homes were for their best interest; however, a thorough assessment was not conducted of the home. Furthermore, the participants were not asked what their needs and/or preferences were for increasing their independence in the home. As a result, some of the participants stated they felt like the modifications made them feel dependent and less capable of taking care of themselves. One important conclusion they reached is that consumer education is key to improving receptiveness but also conducting a thorough assessment of the home before any modifications are made (Nunn, Sweaney, Cude, & Hathcote, 2009).

None of the research articles reviewed for this study specifically addressed whether the residents understood what modifications, services, or resources are needed in order to age in place. The studies were more focused on outcomes after services and/or modifications put into place. However, my study sought to highlight people's current experiences at home and what barriers, if any, exist for them to remain aging in place. If a

person is able to acknowledge what they perceive to be barriers, they, in turn, would better understand their needs in a more realistic manner. When the time comes, they can be more involved in their choices for services versus someone else telling them what they need, which has shown to be ineffective and individuals underutilize services available (Tang & Lee, 2010; Tenenbaum, 2010).

Boldy et al. (2011) found that some of the primary reasons people choose to remain in their homes and age in place are because they are comfortable where they live, they feel safe and secure in their home, it is financially viable (especially if the house is paid in full and the expenses are manageable), they like the neighborhood, and they are in a good location. The problem with aging in place becomes more apparent when age-related changes occur. The changes are often a function of a decline in personal health or the health of a spouse or loved one, as well as the possible deterioration of the home. When assessing the appropriateness of current home settings, older adults need to make choices about what actions they will or will not make regarding adaptations to their physical environment. As an example, many people who live in a two-story house will wait for an accident or fall before they consider leaving (Neal, 2007). Regnier and Denton (2009) examined emerging trends in residential group living environments. Their study showed the majority of couples often stay in their homes and age in place because they have compensating competencies that allow them to stay independent by depending on each other. However, when one of them dies, it can become increasingly more difficult to remain in their home without the support they once had. Women, on the other

hand, who are divorced or widowed are less likely to relocate than their married counterparts (Hendrick, Wells, & Faletti, 1982).

Another study conducted by Carpenter et al. (2007) evaluated the possibility of people worried about relocation. In this study over 26% of the participants were worried they would need to move in the next few years and mostly because of financial insecurity. The typical residents were women, unmarried, and living alone with chronic health problems. Mortgages account for almost half the value of all debt held by adults ages 65 and older (Karamcheva, 2013) and one of the main reasons people cannot relocate. The percentage of outstanding mortgages for this population rose from 16.2% in 1998 to 23.1% in 2010 (Karamcheva, 2013).

One of the primary reasons people age 65 and older choose to relocate is finances, whether it is less expensive housing or related to employment (The MetLife Mature Market Institute & National Association of Home Builders, 2011). Statiscally, people are living well into their 80s, and there is the possibility that these older adults would prefer to relocate to a more appropriate dwelling which could be seen as more manageable, better designed, and easier to maintain (Golant, 2008a). Accessibility barriers within homes often lead to the need for extensive and expensive renovations or home modifications (Maisel, Smith, & Steinfeld, 2008). When there is a poor fit between a person and his or her environment, it can lead to additional health consequences.

Concerns about the physical environment are found to be strong motivators of relocation within the community or into senior housing later in life (Pope & Kang, 2010). Some people choose to relocate because they are at a reduced capacity to maintain the

current property whether it be financially or physically (The Florida Department of Elder Affairs, 2013). Sometimes the house where someone has raised their family becomes too spacious to maintain, and when adding declining health as a potential factor, it becomes more motivating to seek alternative housing (Boldy et al., 2011; Carpenter et al., 2007). As pointed out by Golant (2008), there is a fallacy in making generalized comments about everyone over the age of 65 wanting to age in place. Specifically, Golant sheds light on those people living in homes that are over 50 years old with significant environmental barriers and how those environmental barriers can impede daily functioning of an individual. Environmental barriers can include anything from poor lighting, inadequate ventilation, and slippery floors to unsteady furniture, broken stairs, etc. (Erkel, 2010).

Recent research has expanded to include a more complex view of residential settings and conceptualization of quality of life for long-term occupying of residential environments versus the earlier definitions that simply focused on older persons' preference to grow old in their own home (Fields, Anderson, & Dabelko-Schoeny, 2011; Kemper, Weaver, Short, Shea, & Kang, 2008; Regnier & Denton, 2009).

The Older Americans Act

Congress passed the Older Americans Act (OAA) in 1965. This was in response to a lack of community social services for older persons (Administration on Aging, 2014). It was during the same time period that the OAA enacted Medicare and Medicaid (Administration on Aging, 2014). The OAA provides essential services to seniors in an effort to assist them to age in place. The goal is to provide a continuum of care that would

allow seniors to maximize their independence within their home and in their communities (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014; O'Shaughnessy, 2014).

The law also established the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the federal focal point on matters concerning older persons. Today, the OAA is considered to be the major vehicle for the organization and delivery of social and nutrition services to this group and their caregivers. It authorizes a wide array of service programs through a national network of 56 state agencies on aging, 629 area agencies on aging, and nearly 20,000 service providers (O'Shaughnessy, 2011). The OAA also includes community service employment for low-income older Americans; training, research, and demonstration activities in the field of aging; and vulnerable elder rights protection activities (Administration on Aging, 2014).

Title III funding of the OAA provides services to persons 60 years of age or older, regardless of income or assets. The OAA mandates that preferences be given to providing services to older individuals with the greatest economic or social needs and identify at risk persons for institutional placement (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014; O'Shaughnessy, 2014). The individual States determine the manner in which they distribute the funds to area agencies on aging. Each state receives OAA funds according to a formula based on the state's share of the U.S. population (Colello, 2006; Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014). In 2006, OAA legislation added the requirement that the Administration on Aging establish Aging and Disability Resources Centers (ADRCs) in every state (single point of entry information and referral

centers; O'Shaughnessy, 2010). These centers can provide information and referrals to agencies that address such issues as transportation, home health, homemaker and chore services, and home-delivered meals (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014; Golant, 2011; O'Shaughnessy, 2014; U.S. Department of Health and Human Services, 2011). Title III accounted for 70% of the Act's total FY2006 appropriations ($1.24 billion out of 1.78 billion). There are six programs authorized under Title III. They are as follows: (a) supportive services and senior centers, (b) congregate nutrition services, (c) home-delivered nutrition services, (d) nutrition services incentive grants, (e) disease prevention and health promotion services, (f) family caregiver support services (Colello, 2006).

As the major vehicle for promoting the delivery of social services to the aging population, OAA funding is not keeping up with the growth of the aging population (O'Shaughnessy, 2014) Federal appropriation for OAA services was 1.88 billion for FY 2014 in comparison to funding in 2004 which was 1.80 billion (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014). Considering the aging population has grown significantly since 2004 and the projected increase between 2004 and 2020 is more than 55 percent (O'Shaughnessy, 2014), it appears that the current funding for the OAA will leave much to be desired in terms of adequate services. There was a slight increase in 2009-2010 due to temporary stimulus funding from the American Recovery and Reinvestment Act (ARRA) during the great recession (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014). However, in 2013 funding declined roughly by 5 percent

due to congressional sequestration budget cuts (Fox-Grage, Vjvari, & AARP Public Policy Institute, 2014).

The authorization for most of the OAA program expired in 2011, but they have continued to receive appropriations each year since that time. Those programs received discretionary appropriations totaling 1.3 billion for 2015. Congressional Budget Office (CBO) estimates the bill would authorize appropriations totaling $5.8 billion for fiscal years 2016-2018. CBO estimates the implementation of Bill S.192 would increase outlays by 2016-2020 period. That equals 1.16 billion a year for the next 5 years. That is a significant decrease from the current 1.3 billion this year.

Home Community Based Services (HCBS)

In 2006, the OAA enacted Home Community Based Services (HCBS) (O'Shaughnessy, 2011). Home Community Based Services (HCBS) were created by policymakers in response to projected growth in long-term needs for older adults (Chen & Thompson, 2010, p. 530). HCBS are part of the Aging and Disability Resource Centers (ADRCs). By having the HCBS under the ADRCs, the service system is able to move closer to facilitating access for all populations seeking long-term care information and supports, which will allow them to live as independently as possible in their community or setting of choice (Chen & Thompson, 2010; The Florida Department of Elder Affairs, 2012). The supportive services program is one of the programs under the Older Americans Act which funds a wide range of services. Some of the services available are personal care, homemaker, chore and adult day care services. Unfortunately, there is limited funding so the amount of services provided is relatively small (O'Shaughnessy,

2011). Current funding for the OAA leaves many needs unmet increasing reliance on more expensive medical and institutional care (O'Shaughnessy, 2014). Medicare is a primary source of funding for older Americans. However, Medicare excludes certain services, such as long-term care (National Council on Aging, 2015). Medicaid provides the safety net for those with little to no resources. The Medicaid program pays for nearly two-thirds of the cost of long term services and supports (LTSS) (United States Senate, 2013).OAA funding is relatively small compared to the 136 billion spent on Medicaid services and supports in 2011. However, Medicaid only serves low-income people with minimal assets. Many seniors are ineligible for Medicaid.

The concept of living longer means living longer with functional disabilities (Malonebeach & Langeland, 2011; Taylor, Morin, Parker, Cohn, & Wang, 2009). One of the most significant risks facing older Americans is the prospect of becoming disabled and needing expensive long-term care (Johnson, 2013). One estimate indicates that 7 in 10 Americans who survive to age 65 will eventually need long-term services and supports, and 1 in 5 will need help for five or more years (Johnson, 2013). Most will receive assistance from family and friends, which often creates significant financial, physical, and emotional burdens for their caretakers (Johnson, 2013; United States Senate, 2013). Research indicates that people in need of home based services do not utilize the services, primarily due to lack of awareness that the services exist and financial barriers (Casado, Van Vulpen, & Davis, 2011; United States Senate, 2013). The relationship between disability and increased age should not be ignored. There is a strong relationship between disability status and reported health status (Federal Interagency

Forum on Aging-Related Statistics, 2012; Potter, 2010; Stineman et al., 2011; U.S. Department of Health and Human Services, 2011). As a person's physical capacity decreases their chances of feeling depressed or anxious increases. Conditions such as depression are associated with adverse outcomes, such as stroke, disability and mortality (Skoog, 2011). Older age (over the age of 75), living alone, chronic disease, decreasing hearing, and foot problems are just examples of risk factors that contribute to a decrease in functioning and increase in accidents (Erkal, 2010; United States Senate, 2013).

In 2007, two percent of the Medicare population age 65 and over resided in community housing with at least one service available. Their numbers reflect the availability of services but not the number of people who actually used them. Over half of the residents reported that although services were available in many cases there was a separate charge to access them (Federal Interagency Forum on Aging-Related Statistics, 2012). This is a concern given the limited financial resources seniors are faced with as they age. Home health care costs on a national average are $21 per hour, which is a financial barrier for those on a fixed income (MetLife Market Institute, 2012).An opposing argument exists that when frail older adults do receive services they do not always receive the most appropriate care in their current homes (Golant, 2008a; Kemper, Weaver, Short, Shea, & Kang, 2008).

Naturally Occurring Retirement Community

Naturally occurring retirement communities (NORCs) develop when neighborhoods, over time, transform into communities of primarily older residents who are aging in place (The Florida Department of Elder Affairs, 2012). NORCs can be an

effective way to increase socialization and reduce social isolation among older adults, which has been shown to improve health and overall well-being and contribute to successful aging (Bookman, 2008; The Florida Department of Elder Affairs, 2012, p. 23). Programs should be based on assessments of residents and community needs and provide a wide range of services (Cohen, Mulroy, Tull, Bloom, & Karnas, 2007; Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011). Unfortunately, only about six States encourage the use of NORCs, even though studies have noted that older residents who live in this type of environment are healthier than their counterparts who do not live in an environment that promotes active living (Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011). Florida currently does not actively participate in promoting the use of NORCs, although funding is available to promote the utilization of such communities (Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011). The Older Americans Act is a primary funding source for NORCs (Golant, 2011).

Conclusion

In conclusion, literature in the field of gerontology and psychology support further evaluating a person's lived experiences while aging in place. With that said the main vehicle for promoting aging in place revolves around the OAA which expired in 2011 and is up for reauthorization this year. Program cuts are being made at the expense of economically disadvantaged seniors. More seniors than ever need assistance and supports to make ends meet. Given the statistic that seniors are living longer, it would be presumed that governments would make the OAA a priority. When in fact the literature reinforces the problem that supports are highly fragmented and difficult to access, lacking

form and appropriate coordination (O'Shaughnessy, 2014). Early awareness of unmet needs could lead to early adaptation to their environment as well as early resource and service seeking (Chen & Thompson, 2010; Tang & Lee, 2010). The methodology used for this research is presented in Chapter 3.

Chapter 3: Research Method

The purpose of this study was to explore the lived experiences of a senior population by collecting their perspectives and experiences on aging in place. An exploratory approach was used to understand the life experiences of the population being studied.

In Chapter 1, I described my research strategy, potential themes, the theoretical framework, as well as the limitations of the theories. Chapter 2 provided a detailed literature review that included an overview of the aging process, aging in place and attributes of successful aging. Chapter 3 describes the research design and the statistical methods that will be used to analyze the data in this study as well as the study's design, sample, instrumentation, data analysis, and ethical considerations. The overview of this study includes a rationale for the particular research design selected. It also includes sample characteristics, size, and a description of the instrumentation, as well as a description of the data collection process and analysis.

The research questions are as follows:

1. What have the participants experienced in terms of aging in place?
2. What are the barriers (physical or mental) that impede successful aging in place?
3. What are the identified services needed to age in place?

Research Design

To explore the lived experiences of the senior population aging in place, the theory of continuity was used (Atchley, 1999). A phenomenological approach was implemented using open-ended (but structured) questions, as a method to gather an in-depth understanding of the relationship of an individual to his or her home environment. According to Young, et al. (2006) and Opdenakker (2006) the use of qualitative analysis allows for the exploration of the meanings of social phenomena as experienced by individuals in a more systematic and scientific way. The interview process lends itself to the potential for a better understanding of the relationship between an individual to his or her environment.

Rationale for using a qualitative approach

Babbie (2007) described qualitative analysis as the "examination and interpretation of observation for the purpose of discovering underlying meanings and patterns of relationships" (p. 378). Asking open-ended questions and listening to the participants are part of a good, qualitative design and will help tell a story, one that will unfold as the participants share their experiences (Creswell, 2007). Therefore, when considering the construct of this study, which is rooted in exploring how people's thoughts, feelings, and experiences impact their decision making, it is appropriate to engage in qualitative rather than quantitative research. A quantified measurement is not the optimal method to discuss lived experiences (Giorgi, 2009).

Qualitative analysis allows the researcher the ability to experience what the participants are experiencing in their natural setting versus in a controlled environment.

The naturalistic environment in which subjects offer a lens into their world is considered to be one of the defining features of qualitative study. It also allows for multiple sources of data such as interviews and observations versus relying on a single data source (Creswell, 2007). In the case of this study where complex variables exist, a qualitative research design allowed the researcher the flexibility to ask open-ended questions that provided the participants an avenue to share their perceptions and beliefs about aging-in-place (Creswell, 2007).

Rationale for using a phenomenological approach

Husserl utilized phenomenology to describe "experiences." Physical things, values, moods, activities, and feelings are the central focus for phenomenology (Daly, 2007, p. 94). Husserl applied phenomenology to the field of psychology where clinicians could use this approach to focus on meaning and experiences when working with people. His approach relied on having an open mind to examine people's opinions, perceptions, and in essence their life experiences (Giorgi, 1997; Giorgi, 2005). In creating a qualitative research design it was determined that a phenomenological study would be a more appropriate method than say, grounded theory considering that the study was not trying to generate new theories but simply trying to understand how the existing theory relates to the phenomenon. Giorgi (2012) described phenomenology more specifically in terms of investigating human experiences and behavior. Phenomenology is more descriptive than interpretative, however, that is not to say interpretations cannot take place. It does not dictate to the phenomena being studied but rather seeks to understand how the phenomenon is presenting itself (Giorgi, 2012). The participant's experiences

capture the essence of the research. The idea of interviews is a way to connect with subjects and experience their perspective through the details in their responses (Creswell, 2007). Interpretive research seeks to determine a meaning from the participants (Giorgi, 2012). The goal is neither to replicate or theory test but instead to understand and gain a deeper understanding of the phenomenon which can only be done by the participant's experience as he or she see it (Shah & Corley, 2006). Phenomenology is meant to be viewed with an unbiased description of its subject matter (Wertz, 2005). The interview process should feel safe and trusting for the participant. If those elements are present, the participants are allowed to genuinely participate in the process (Giorgi, 2005). On the other hand, the researcher is required to set aside any preconceived notions or explanations for the phenomenon (Wertz, 2005). This does not mean that the researcher's ego or subjectivity will not be an issue. The researcher still has the responsibility to remain "open" to the experience just as the participant has a responsibility to remain open to the interview process (Giorgi, 2005).

Literature Related to Phenomenology

Exploring life experiences is what makes phenomenological research different from other approaches. Hallrup, Albertsson, Tops, Dahlberg, and Grahn (2009) used a phenomenological approach to interview older women in their homes that were at high risk for falls. These were women that had already suffered a fall previously and due to their age (76–86) were at high risk to suffer another fall. The objective was to use a reflective lifeworld approach which meant the researchers wanted to investigate the phenomena without devising any preconceived theories to explain it (Hallrup et al.,

2009). Although the interviews were geared towards potential for them to fall again, there were several factors that attributed to how the women reacted to their previous fall which had an impact on their current behavior. When the researchers provided the women with information on how to maintain their competency in the home, the researchers learned that the women themselves identified their needs according to the situation. The women also sought strategies to compensate for the limitations in order to live with their insecurities of a potential fall again (Hallrup et al., 2009). The information gained from this study allowed the researchers to improve how services could be provided to the women using the feedback provided.

The importance of a supportive home environment to successful aging contains many facets such as the feeling of autonomy, control over one's environment, and independence. The study listed above illustrates how people can assess their needs and make changes based on those needs. In another study, Tanner, Tilse, and Jonge (2008) examined the experiences of older people who received a home modification service. In this study, instead of focusing on the modifications themselves, the researchers wanted to gain insight on the meaning behind the modifications. For some participants they equated the modifications with creating a place called "home." The aesthetics were more important than the functionality of the modification. For them, the emotional connection to the home was paramount. For others, they appreciated the modifications because their connection to their home was significant, to the point where they stated in the interviews they planned on staying in their home until they die (Tanner, Tilse, & Jonge, 2008). The

use of phenomenological research gives the researcher the flexibility to experience all the different facets of one phenomenon.

Rationale for Eliminating Other Qualitative Designs

Grounded theory was not appropriate since it is utilized to generate theories (Babbie, 2007). As an illustration, Kruse et. al (2010) used semi-structured interviews to speak to people age 60 and older about fall risks in their homes. The researchers utilized home assessment tools and checklists to determine older adults' attitudes toward fall risks and potential home modification to reduce these risks. Notably, they conducted home inspections and interviews which included probing them for information on their fall history and their perception of personal risk from falls. Surprisingly, almost every participant was unwilling to undertake home modifications to reduce their risk of falling. If the researchers would have utilized a phenomenological approach, they could have shared the experiences of the participants by viewing their world through their lens versus utilizing a checklist to determine their needs. If the participants were given the opportunity to tell the researchers their perceived needs, they might have been more willing to accept the modifications in their home.

Similarly, ethnography was evaluated and discarded since the primary focus is not to examine one cultural group. After reviewing the literature on qualitative studies, the case study tradition was not considered to be an appropriate design for inquiry. Furthermore, the nature of this tradition necessitates that there is a measurable degree of knowledge present about the case prior to the study (Creswell, 2007). This is in contrast

to a phenomenological investigation in which the researcher will suspend preconceived notions and beliefs in an effort to understand that which is communicated by participants.

Similar to a biographical study, phenomenology is implemented when the focus is on examining how experiences connect to a given phenomenon (Creswell, 2007). However, the primary difference is that a biographical study deals with one individual whereas a phenomenological study deals with the experiences of several individuals. Considering the nature of the problem across the targeted population, it is more appropriate to use a phenomenological approach. The ability to target the experiences of several individuals rather than just one individual is what provides an in-depth understanding of the phenomenon being studied: an important feature of phenomenology (Creswell, 2007).

A questionnaire and interview constituted the data collection tools. The software package ATLAS.ti was used to facilitate analysis by the researcher, primarily as a means of sorting coded segments of data for ease of comparison among participants. This program easily adapts to the data provided whether it be structured, unstructured, and/or observational data (Friese, 2012).

Study Population

As noted in Chapter 1, Florida has the highest percentage of people age 65 and older (17.8%) in the United States (Federal Interagency Forum on Aging-Related Statistics, 2012). As a result, most of Florida's seniors are concentrated in five counties: Miami-Dade, Palm Beach, Broward, Pinellas, and Hillsborough (The Florida Department of Elder Affairs, 2009). For this reason, it made sense to conduct the study in an area

where a larger percentage of people age 65 and older reside. People age 65 and older represent 21.6% of the population in Palm Beach County (U.S Census Bureau, 2010). The city of Boynton Beach alone consists of 68,217 residents. Out of the 68,217 residents, 21.4% are age 65 and older, 17.9% of the households are owned by people age 65 and older, 36.3% of the households have at least one member age 65 and older, and 36.2% of residents age 65 and older have a disability (U.S. Census Bureau, 2010).

Setting

The setting for this study was located in the city of Boynton Beach in Palm Beach County, Florida. Selection of this particular county offers some advantages. First, Palm Beach County has a significant number of people age 65 and older and currently, the largest number of people age 85 and older in Florida. From 2000-2010 this population grew 40.7% (Federal Interagency Forum on Aging-Related Statistics, 2012). Secondly, the city of Boynton Beach has 14,567 people 65 and older which equal 21.4% of the County. This is a significant percentage compared to other Florida counties. In addition, 35% of the city's households are 65 and older (The Florida Department of Elder Affairs, 2009). Thirdly, the city of Boynton Beach has created 55+ communities which closely resemble a naturally occurring retirement community (NORC) which is an area of interest for this study (The Florida Department of Elder Affairs, 2009).

Participants were recruited using a convenience sample limiting the study to males and females 65 and older living in the city of Boynton Beach, Florida who also live in their own home or with family. The rationale for recruitment is further discussed later

in this chapter. When the participants agreed, an interview was held at the Boynton Beach Senior Center.

Role of the Researcher

My role as the researcher is to conduct personal interviews to gather information on participant's experiences on aging in place. A central element of qualitative studies is to indicate and disclose any bias in the role of the researcher. In this study, I did not have any professional or personal experience with the participants.

I tape-recorded the interviews and also observed body language, facial gestures, changes in environment, and the participants own behavioral and verbal cues. The objective was to capture the participant's story in the best representation possible. Since it is not possible to account for every detail of a person's life, I looked for critical incidents that could have shaped his or her thoughts, feelings, and beliefs.

My role as evaluator/researcher is overt (Creswell, 2007). I used my knowledge to interview insight-oriented participants for this research. One benefit of interviewing the participants face to face was that as a researcher I was able to see social cues (Opdenakker, 2006). Social cues such as intonation and body language can provide beneficial information when added to their verbal answer (Opdenakker, 2006). The purpose of the research was fully disclosed to the participants to assure confidentiality, anonymity, and protections from culpability. I acknowledged the participant's contribution to the study and maintained a relationship of trust by actively listening to the interviewee and acknowledged their contribution to this phenomenon without sharing opinions or judgments.

Ethical Considerations

The participants in this study were voluntary and were not placed in situations that would cause harm. Deception was not used in this study. The interviews were to obtain information, not alter it. The participants were given a fact sheet (Appendix A) prior to the consent process. During the consent process I explained to the participants the purpose of the study and informed them about their rights to confidentiality.

All statements published in the research are an accurate account of what each person said using as many of the participants own words as possible. The participants were treated with respect and their dignity was not be compromised during the research. All rights to privacy were protected (Creswell, 2007).

Protection of Human Participants

The participant interviews will remain confidential. Tapes and transcripts will be kept for a period of 5 years on a password protected flash drive stored in a locked box in my home office. The interviews were coded with a number to protect confidentiality. Prior approval was obtained from the Internal Review Board of Walden University before proceeding with interviews. Participants had access to call or write me, my committee chair, or the research participant advocate with any concerns. The participants were able to withdraw at any time without consequence.

Informed Consent Forms

The informed consents were signed with the researcher present. The consent form is provided in Appendix B. This study did not offer compensation. The rationale for this study is detailed in the consent form. The participants were told that the purpose of the

research was to explore their perceptions and lived experiences regarding their understanding of the identified concept (aging in place). My hope was to gain understanding on how these participants view their future and if they even consider the benefit of making changes to their lifestyles in order to be more comfortable in their home as they age.

Confidentiality and Data Collection

Participants were given a distinctive identifier number. This number was noted on any material used by the researcher and throughout the process which provided confidentiality of the participant. The numbers were entered on a form used to record all study participants. This form was secured at all times to avoid accidentally providing the identifier of the participant. All materials were kept secure in a locked box in the researcher's home office.

The primary method of data collection were semi-structured interviews in addition to participant observation. The interview guide (Appendix D) utilized predetermined demographically oriented questions and followed up with open-ended questions based on gathering background information on the phenomenon. The use of follow-up questions focused on the specific phenomenon under investigation. The aim of the follow-up questions was to allow the participants to reflect over the phenomenon. Data was collected at the designated interview site: The Boynton Beach Senior Center. Recorded interviews lasted approximately 45-60 minutes in length. Decisions about cognitive ability were made subjectively by the researcher. Since the participants live independently, the assumption was that they are cognitively intact.

Study Procedures

Recruitment of Participants

I recruited participants into the study through the Boynton Beach Senior Center. This is a community center geared towards the demographic being studied in a city that encompasses a significant number of people age 65 and older. I contacted the social director of the community center and she agreed to allow me to present to groups during the day. I chose a few of the activities on the schedule and presented my study at the end of each activity. By being attached to an already scheduled activity, this increased attendance at my presentation. The flyers (Appendix A) gave a demographic overview of the 65+ population and an invitation to participate.

Presentations were made at the beginning or end of a scheduled activity held at the community center. Sign-up sheets were made available during the presentations. Those who expressed a desire to participate were provided with an invitation letter that explained the study in complete detail. Of those who participated, a brief screening took place to determine eligibility. Anyone interested in participating in the study met three criteria: (a) they must reside in Boynton Beach, (b) are 65 years of age or older, and (c) live in their own home or with family. Interviews were scheduled with those that met the eligibility requirements. I made appointments for the interviews to take place at the senior center. The social director agreed to allow me to utilize one of the available spaces for interviews.

The duration of the observation was a single interview lasting approximately 45-60 minutes. The interview was semi-structured to focus on the participant's individual

story. I started with a list of demographically oriented questions then followed up with open-ended questions that revolved around certain themes (See Appendix D). Sub questions were utilized if a participant's response to the initial question did not cover certain topics of interest. Due to time constraints, a single session was utilized versus multiple sessions.

During the conversation establishing trust and rapport was important. While doing the interview I tried to stay in the present and maintain naiveté. Interviewers cannot assume that they know all the answers. Staying open to the experience allowed me to minimize bias. There should be a balance between gathering information during the interview in a "matter of fact" way and building rapport with the participant to elicit engaging, truthful experiences (Daly, 2007). The goal in the interview process was to remain objective and neutral while guiding the interview where the participant feels safe and comfortable enough to share their lived experiences with you. This process is called reflexivity whereby the researcher continues to be aware of their preconceptions concerning what might be found in the actual research project (Carlson, 2010; Hallberg, 2008). By recognizing bias and keeping a journal during the interview I was able to record thoughts, feelings, uncertainties, and assumptions that surface throughout the research process (Carlson, 2010). Another way to minimize the possibility of bias in the research is by gathering the data in more than one way. I completed a de-briefing after the interview was completed. This procedure is often referred to as triangulation (Carlson, 2010). There are different ways to triangulate however triangulation is usually the combination of two or more data sources, investigators, methodologic approaches,

theoretical perspectives, or analytical methods within the same study (Denzin, 1978; Mathison, 1988; Thurmond, 2001).The interpretations and conclusions drawn from the various data are more likely to be trustworthy if the data substantiate each other versus having one set of data with nothing to compare it to (Carlson, 2010).

Sampling Frame and Sample Description

Creswell (2007) utilizes Moustakas (1994) approach to conducting phenomenological research. According to Moustakas (1994), the objective is to collect data from enough people who have experienced the phenomenon. Creswell (2007) concurs that the criterion for a phenomenological study will be that all participants have experienced the same phenomena. What is not clear is how many participants are sufficient in a phenomenological study. Mason (2010) evaluated sample size and saturation in PhD studies using qualitative interviews. He noted that all of the phenomenological studies (57) identified at least six participants. This number is supported by Creswell (2007) who states five to 25 is acceptable and Morse (2000) who states at least six are sufficient. The objective whether five participants are selected or 25 is that collection of new data does not shed any further light on the issue under investigation. This is known as saturation (Glaser & Strauss, 1967). Although there are no real patterns for saturation there are some factors to consider. The scope of the study is important to consider. The broader the scope of the research question the longer it will take to reach saturation (Morse, 2000). The nature of the study should also be considered. It is not always possible to determine the required number of participants before conducting the research and carrying out analyses (Wertz, 2005 p. 171). Rosenberg,

Jullamate, and Azeredo (2009) stated their data collection ceased when redundancy of themes occurred and no new information was forthcoming (p. 404). When no new themes, findings, or concepts are evident in the data collection it is referred to as data saturation. Data saturation is important within research studies because if adequate sampling is conducted there is a higher probability that saturation was achieved which increases the likelihood of adequate content validity (Francis, et al., 2010; Mason, 2010). If the topic is intriguing but more difficult to grasp it will need more participants to reach saturation. The clearer and more obvious the topic the easier it will be to obtain the information and therefore fewer participants are needed (Morse, 2000). Mason's (2010) research stated that there was no real pattern as to how the guidelines for saturation were established. Bertaux's (1981) guidelines suggest at least 15 participants.

Given that the range is so broad I used a purposeful sample size of 11 participants for my study. This is primarily due to time and financial constraints. Purposive sampling is a type of nonprobability sampling therefore the results will not be representative of all seniors in the United States but it is useful for exploratory purposes (Babbie, 2007).

Instrumentation and Materials

A formal instrument was not used however the interview was semi-structured using topics to guide the conversation and specific questions were asked of every participant to account for reliability (See Appendix E). The questions were organized in several categories: demographic information. access to healthcare, relationships, and attachment. The questions attempted to gather a background of the phenomenon with follow-up questions that focused on the specific phenomenon under investigation. The

aim of the follow-up questions was to deepen the information by letting the participants reflect over the phenomenon.

Data Collection and Storage Procedure

I recruited 11 participants to be part of the study through the Boynton Beach Senior Center. I contacted the social director of the community center and she agreed to allow me to present to groups during the day. The flyers (Appendix A) gave a demographic overview of the 65+ population and an invitation to participate.

Presentations were made at the beginning or end of a scheduled activity held at the community center. Sign-up sheets were made available during the presentations. Those who expressed a desire to participate were provided with an invitation letter that explained the study in complete detail. Of those who participated, a brief screening took place to determine eligibility. Anyone interested in participating in the study met three criteria: (a) they must reside in Boynton Beach, (b) are 65 years of age or older, and (c) live in their own home or with family. Interviews were scheduled with those that meet the eligibility requirements. I made appointments for the interviews to take place at the senior center. The social director agreed to allow me to utilize one of the available spaces for interviews.

Prior to the interview, the informed consent form was signed and the participants were given a distinctive identifier number. This number was noted on any material used by the researcher and throughout the process which provided confidentiality of the participant. No data were collected for this study until it received approval from Walden University IRB (approval# 09-12-14-0039992).

The interview consisted primarily of open-ended (semi-structured) questions to elicit open conversation from the participants. It is the researcher's role to create an environment where the participants feel at ease, and which will begin with an informal conversation to establish rapport. Interviews were designed to: (a) explain the project and set the context, (b) for people to talk about their experiences, and (c) have time for reflection. The interview was recorded using a battery operated tape recorder, transcribed, and formed into "profiles."

The interviews are based on self-report and organized in 3 stages: main questions, follow-up questions, and probes (Rubin & Rubin, 2005). The interview began with questions that facilitated rapport building with the participant. Rapport building helps to create a relationship between the interviewer and the interviewee. This is also known as responsive interviewing (Rubin & Rubin, 2005). The goal of responsive interviewing is to obtain a solid, understanding of what is being studied and so depth is achieved by asking follow-up questions to initial questions (Rubin & Rubin, 2005). Then the research was introduced by discussing the purpose of the study, confidentiality, and consent issues. At this point, the interview began. During the interview, key questions were used to explore areas of interest. Questioning must remain flexible to accommodate new information and to adapt to unexpected situations. The order of the questions asked was determined by the participant's sharing. During several of the interviews, I requested clarification on a word used to ensure the understanding. This is part of member checking (Carlson, 2010). The interview was recorded using a battery operated tape recorder,

transcribed, and formed into "profiles." The duration of the observation was a single interview lasting approximately 45-60 minutes.

This process of double checking was done during the interviews to ensure that all was understood. I made notes during the interviews as well. I noted nonverbal actions, facial expressions, and lack of emotions when appropriate. As the interview came to a close, I asked questions that gave the participant the opportunity to ask or answer questions not addressed. One of the most common sources of error in self-reports is recall bias, where the respondent does not accurately recall the reported event. A nonresponse error (respondent refuses to answer the question or does not answer truthfully) can also distort the results of the survey. A number of sources of error are associated with utilizing questionnaires in research. Among these errors are ambiguous wording of questions and question order bias, where the respondent answers the questions differently, depending on the questions order. The length of the interview can also influence the responses, when the respondent puts less effort in answering the last questions in a lengthy interview. An error can be generated also in the coding of the responses. For example, the results can be distorted, if the utilized codes are not mutually exclusive, or if the person processing the data misinterprets the answer or marks an incorrect response code (Rubin & Rubin, 2005). Errors in the sampling procedure can not only distort the results; they can invalidate the entire study. Due to the fact that the study used a convenience sample, the results of the survey cannot be generalized on the entire population.

Data Transcription and Analysis

The unanalyzed segments of experience or raw data, which are the transcripts themselves call for a practical, systematic approach. The way transcriptions are done can raise important questions about reliability and validity of the data (Daly, 2007). I completed my own transcription which gave me an appreciation for the challenges associated with turning talk into text (Daly, 2007). Transcription took place as soon as possible after the interview. By transcribing the interview sooner rather than after some time has passed, I was able to more easily remember the conversation and include important social cues if they existed (Rubin & Rubin, 2005). From the profiles collected, I developed themes and created stories around key themes using ATLAS.ti software.

Analysis of the interviews involved reviewing identified meaning across cases and clustering similar typologies. Once the typologies were identified, it provided a strategy for organizing findings that showed similarities, differences, and overlaps between and within classes of phenomena (Daly, 2007; Rubin & Rubin, 2005).

Once I found, refined, and integrated my concepts and themes, then I coded them. Coding involves systematically labeling concepts, themes, and events so that I can readily retrieve and examine all of the data units that refer to the same subject across all my interviews (Babbie, 2007; Rubin & Rubin, 2005; Saldana, 2012). After the coding process was completed, the ATLAS.ti software was used to analyze the coded data (Rubin & Rubin, 2005).

Data Reliability and Dependability

To ensure the trustworthiness of the study, each participant was given the opportunity to review their transcripts and narrative analysis. Measures were taken to ensure the quality of transcription by sending each participant a copy of the transcribed interview for their review and approval. Each participant was included in a review of the draft of their completed interview, sometimes called member checking (Carlson, 2010; Creswell, 2007) and provided with a copy of the completed narrative text and asked to read through their interview prior to the end of the study. Member checking allows the participants to review inaccuracies, and/or make clarifications to the narrative text.

Trustworthiness of the Study

In this study, the phenomenological research design contributed toward truth. I consciously attempted to understand the perspectives of each participant. The audio recordings also contributed to the trustworthiness of the study. Participants received a copy of the text to validate that it was true, accurate, and reflected their perspective regarding the phenomenon that was studied.

External Validity

Credibility was established through the participant's responses and my confidence that the findings were not biased. To achieve confirmability, I used member checking and reanalysis of the data, thus ensuring that the themes identified were objective and would make sense to another reader.

Summary

This chapter provided a detailed description of the methodology used in the data collection process. An introduction was presented to demonstrate the importance of this study. Included are the main research questions. A qualitative methodology was utilized to understand the lived experiences held by the participants. Phenomenology was chosen as the qualitative foundation for this study to obtain an understanding of the aging in place phenomenon. Several audiences would benefit from the information discovered in this research. Publication of the results of the study may be used to contribute to a deeper understanding of the aging in place phenomenon in the particular region studied. I also discussed the ethical considerations of informed consent forms, confidentiality, data collection, data transcription, data analysis, data reliability, and data dependability, as well as data collection and storage procedures. The description of these participants is the topic of Chapter 4 and 5.

Chapter 4: Findings

Introduction

The purpose of this phenomenological, qualitative study was to explore the lived experiences of a senior population aging in place. This chapter presents the analysis and findings (themes) of the data collected from 11 men and women choosing to age in place in Boynton Beach, Florida.

The research questions and probing questions for this qualitative study were developed to discover the shared meanings of the lived experiences of the participants who chose to age in place. The goal was to explore the lived experiences of this population in the hopes of gaining an understanding of their needs as they age. The research answered the following questions:

1. What have the participants experienced in terms of aging in place?
2. What are the barriers (physical or mental) that impede successful aging in place?
3. What are the identified services needed to age in place?

Transcripts of individual interviews from the study were analyzed. Careful attention was paid to similarities and differences of the participants. Through the stories, shared themes were introduced. Data from all questions and across participants were coded and placed into categories and subcategories. Demographic variables of participants, such as gender, marital status, age, and education were entered into ATLAS.ti to describe participants.

This chapter provides the details about this study from the phenomenological profiles and stories of the participants. It documents research results including the research setting, demographics of the participants, data collection process, data analysis, and trustworthiness of the data. Also, presented are the themes that emerged from the 11 interviews. The chapter concludes with a synopsis of the themes generated from the research questions asked during the interviews.

Setting

The setting for this study was in the city of Boynton Beach in Palm Beach County, Florida. Participants were recruited using a convenience sample limiting the study to males and females 65 and older living in the city of Boynton Beach, Florida who also live in their own home or with family. Once the participants agreed, an interview was held at the Boynton Beach Senior Center. Each interview began with a series of informal questions to establish rapport (See Appendix E, Questions 1-4) (Moustakas, 1994). The interviews followed a script and in some instances follow-up questions were asked for clarification of a particular topic or to allow the participate to elaborate further. As an example, one of the health questions asked, “When you need medical care, how often do you get it?” One of the participants answered, “When I need it.” Follow-up questions to that response included, “Could you elaborate on how often a year you see a medical professional?” and/or “Do you see a medical professional on a regular schedule and if so, is it weekly, monthly or quarterly?” The interviews were conducted in a private room at the Senior Center away from distractions. The participants chose a time and date for the interview, which was convenient for their schedule. My personal computer was

used to store and keep track of the data. The computer is password protected as well as the files where the interviews are kept. The name of each participant was removed after the data collection and coded with a nickname of their choosing. There were no organizational conditions that influenced participants at the time of the study that might affect interpretation of the study results.

Participants and Demographic Variables

I used a purposeful sample size of 11 participants. This was primarily due to financial and time constraints. Of the 11 participants that agreed to be interviewed, all met the criteria for participation and were successfully interviewed. As shown in Table 1, out of 11 participants interviewed, seven were male and four were female. In the group, four were divorced, one was married, three were widowed and the rest (4) were widowers. Nine participants live alone, one with a roommate, and one with family. The ages of the participants ranged from 67 to 92, average age being 77. All of the participants (11) were retired; some (3) were volunteering to stay busy, while one was working part-time to make ends meet.

Table 1

Participant Demographic Information

Case ID	Gender	Age	Marital Status	Ethnic Background	Education	Employment Status	Household Composition	Income
Mrs. D	Female	82	Widowed	Caucasian	Masters	Retired	Living Alone	50,000-75,000
Racehorse	Male	87	Widowed	Caucasian	Masters	Retired	Living Alone	50,000-75,000
Mrs. S	Female	86	Widowed	Caucasian	HS	Retired	Living Alone	50,000-75,000

Gramps	Male	92	Widowed	Caucasian	HS	Retired	Living Alone	125,000+
Mr. K	Male	67	Divorced	Caucasian	HS	Retired	Lives with Friend	Under 15,000
Po	Female	69	Married	Asian	Some College	Retired	Living Alone	50,000-75,000
Buz	Male	80	Widowed	Caucasian	Masters	Retired	Living Alone	75,000-125,000
Francois	Male	76	Divorced	Haitian	Some HS	Retired	Living Alone	25,000-35,000
J.J.	Female	78	Widowed	Haitian	Some HS	Retired	Living with Daughter	Pass
Rocky	Male	71	Divorced	Caucasian	Some College	Retired	Living Alone	15,000-25,000
Jack	Male	67	Divorced	Caucasian	HS	Retired	Living Alone	15,000-25,000

Provided in the following paragraphs are descriptions of participant's individual life situation as pertinent to his or her aging in place story. To ensure confidentiality, pseudonyms were created by each participant to protect their privacy

Participant Profiles

Participant 1 (Mrs. D.)

Mrs. D. is an 82 year old, widowed, White female. She lives alone, is retired and has a Master's degree. Mrs. D. was married twice and widowed twice. She has one daughter and one son that passed away about seven years ago. She has an extended step family that she remains close with and five grandchildren.

Mrs. D. has lived in Florida 52 years and prefers to age in place versus moving to an assisted living facility or similar type facility. She is socially active, volunteers at her church, and travels whenever possible. Her hobbies include, wood carving, dancing, working out and traveling. She is able to perform all of her ADLs and IADLs independently. She rates her overall health as good, is financially stable, and does not

depend on others for assistance. She believes in her independence and autonomy and feels that as long as she is able to drive she will remain that way.

Possible barrier to aging in place is her concern for losing her ability to drive. She is socially active and is very involved in her church. If she was unable to drive she would consider moving to an assisted living facility to maintain her social activities. Mrs. D. described her home as an important place for her. She has a woodcarving shop in her garage and finds that activity very therapeutic to her well-being. Mrs. D. updated her kitchen to include new appliances and upgraded the wiring to meet code. She is not interested in modifying her home at this time. If she did upgrade the home it would be for resale. Mrs. D. is looking forward to prolong her life as long as possible and maintain her current lifestyle for as long as she is able.

Participant 2 (Racehorse)

Racehorse is a 87 year old, widower, White male. He lives alone, is a retired school teacher and coach, and has a Master's degree. He has four children, six grandchildren, and six great grandchildren.

Racehorse is socially active. He enjoys woodcarving and has presented his work at woodcarving competitions. He tries to swim daily and reads the paper every morning. He would prefer to age in place versus moving to an assisted living facility if possible. He is able to perform all of his ADLs and IADLs independently. He does his own housework, grocery shopping, and cooks for himself. He does have someone that comes to clean the house monthly but for the most part maintains his home himself. Racehorse has some minor health issues but goes to his physician regularly.

Possible barrier to aging in place would be his inability to drive. Racehorse stated that if he couldn't drive, he would consider alternatives. He enjoys his days and is looking forward to travelling as much as possible in the future.

Participant 3 (Mrs. S.)

Mrs. S. is an 86 year old, widowed, White female. She lives alone, is retired, and is high school educated. Mrs. S. was married over 50 years. She has four daughters and nine grandchildren.

Mrs. S. is socially active. She loves dancing and cards. She would prefer to age in place versus moving to an assisted living facility if possible. She is able to perform all of her ADLs and IADLs. She does her own housework, grocery shopping, and cooks for herself. She has some health issues but rates her overall health at this time as good. In 2009 she had three strokes and a heart attack in 2011. She recovered, however she quit golfing and playing tennis at that time.

Possible barrier to aging in place would be her inability to drive. Mrs. S. stated that if she couldn't take care of the house and she couldn't drive, she would consider alternatives. She likes everything about her day and is looking forward to being happy and healthy in the future.

Participant 4 (Gramps)

Gramps is a 92 year old, widower, White male. He lives alone, is retired and is high school educated. Gramps has three children, five grandchildren, and two great-grandchildren. Gramps moved to Florida 13 years ago after the death of his wife.

Gramps is socially active. He likes to play cards, shoot pool and go golfing. He also comes to the Senior Center where he works three days a week in the kitchen when he is not playing pool there. Gramps would prefer to age in place versus moving however he stated that if he couldn't drive anymore, he would consider moving. He is able to perform all of his ADLs and IADLs independently. He does not have any assistance from others and considers himself independent.

Gramps has not made any modifications to his condo other than modernizing the kitchen with new appliances and cabinets. The only modification he would like to do is add a washer and dryer in the condo. Currently, he has to go to the other end of the building to do laundry. When asked what he is looking forward to in the future, he stated he wants to keep doing what he is already doing.

Participant 5 (Mr. K.)

Mr. K. is a 67 year old, divorced, White male. He is a retired auto body worker, lives with a friend and is high school educated. He was once married for three years but stated that was many years ago. He has two children that live out of state.

Mr. K. enjoys coming to the senior center to socialize and have lunch. He uses the fitness room and sometimes plays pool. He used to play pool a lot better but stated he needs to take care of his cataract issue in order to resolve his vision problems. He is able to perform all of his ADLs and IADLs independently. Mr. K. would prefer to age in place versus moving to an assisted living or other similar type facility.

Mr. K. is socially active and considers himself independent. He does his own grocery shopping, cooks for himself, and takes care of his home. He considers his

independence and autonomy very important. The only barrier to aging in place would be if he could not handle his day to day activities. He stated he would then consider moving to an assisted living facility.

Mr. K. volunteers at a local Eagles club washing dishes one night a week and bartends on Saturday mornings for tips to assist in making ends meet financially. He also enjoys his recliner and his flat screen television. He is looking forward to his future.

Participant 6 (Po)

Po is a 69 year old, married, Asian female. She lives alone, is a retired real estate agent, and has some college education. Po grew up in China and Hong Kong and moved to the United States in 2000. She is currently married however her husband is in a nursing home in Canada. Po has two sons, one who lives in Florida and one in Canada. She has two grandchildren locally and enjoys spending time with them. She likes taking care of her grandchildren and takes them to school when she can. Po's hobbies include swimming and dancing.

Po keeps herself busy during the day by coming to the Senior Center, spending time with her grandchildren and doing things around the house. She does her own grocery shopping, cooking and cleaning. Po has no health concerns and is able to perform all of her ADLs and IADLs independently. Independence is important to Po and she does not feel dependent on others. She would prefer to age in place versus going to an assisted living facility.

Po does not see any barriers to aging in place. She believes in being happy and going with the flow. She has not made any modifications to her home because she feels

they are too costly but also stated she doesn't need any modifications yet. When asked about the future, she is looking forward to another 30 years of life.

Participant 7 (Lucky 4 Guys)

Lucky 4 Guys is an 80 year old, widower, White male. He lives alone, is retired and has a Master's degree. He was a teacher for 18 years and a principal for 25 years in the Palm Beach County school system. Lucky 4 Guys was married 58 years to his wife before her passing. They had four sons, three of whom live locally. Lucky 4 Guys prefers to age in place versus moving to an assisted living or other similar type facility.

Lucky 4 Guys is socially active and considers himself independent. He does his own grocery shopping, takes care of his home, and considers himself quite the cook. He has had some health issues but considers himself in pretty good health at this time. He is able to perform all of his ADLs and IADLs without assistance. Independence and autonomy are important to him and he does not feel dependent on others.

Lucky 4 Guys would prefer to remain in his home as he ages and states that the only barrier to doing so would be not being able to function on his own. He describes his home as an important place for him but does not see the need to add any modifications to improve efficiency until the needs arises. He is looking forward to traveling in 2015 and continues to live his life and share experiences with his friends and family.

Participant 8 (Francois)

Francois is a 76 year old, divorced, Black male. He lives alone, is a retired custodian and has some high school education. Francois is originally from Haiti and has

been in Florida for 40 years. Francois was married for a little less than 20 years and has four children.

Francois is socially active but does prefer time alone. He likes to exercise and working the garden. He enjoys watching television and stated that watching television assisted him in learning the English language.

Francois has no major health issues and is able to perform all his ADLs and IADLs independently. He considers himself very independent and does not feel he depends on anyone at this time. Francois plans on aging in place versus going to an assisted living or other similar type facility. He is confident his children will take care of him if necessary to prevent such a move.

Francois does not see any barriers to aging in place. He feels financially capable of maintaining his current home and feels his children will be supportive of that decision. Francois has not made any modifications to his home but stated that he would if he needed them. He is looking forward to a long and healthy future.

Participant 9 (J.J.)

J.J. is a 78 year old, widowed, Black woman. She lives with her daughter and their family. She is retired and has some high school education. J.J. has been in Florida since 1981. She has her own home in Haiti however has been living with her family since she has been in Florida. J.J. prefers to age in place versus moving to an assisted living or other similar type facility.

J.J. likes to exercise and watch television. She comes to the Senior Center to work out and socialize. She is able to perform all her ADLs and IADLs independently however

her daughter does help her with cooking and cleaning when needed. She does not have any significant health issues. J.J. does feel dependent on her daughter for support. J.J. stated she wouldn't live alone anymore and that she would continue to live with her daughter or one of her other children. She enjoys her room, her television, and her recliner. She is looking forward to a healthy future and visiting her other daughter in Tampa.

Participant 10 (Rocky)

Rocky is a 71 year old, divorced, White male. He lives alone, is retired and has some college education. Rocky was married 17 years the first time, single for 18 years, and then remarried for another 18 years before divorcing in 2013. He has four children. They are all grown and live out of state. Rocky has been in Florida for nine years and prefers to age in place versus moving to an assisted living or other similar type facility.

Rocky is socially active and his faith is a central source of strength for him. He is able to perform all his ADLs and IADLs. He has some health issues and due to financial constraints is unable to obtain his medications consistently. He believes in his independence and autonomy and does not feel he is dependent on others.

Possible barriers to aging in place are his concern of maintaining a healthy lifestyle (due to financial hardship) and preventing his home from going into foreclosure also due to financial difficulties. Rocky described his home as an important place for him. Common modifications such as upgrading of appliances is needed however not an affordable option at this time. Rocky is looking forward to a peaceful future and helping others through his ministry.

Participant 11 (Jack)

Jack is a 67 year old, divorced, White male. He lives alone, is retired, and is high school educated. Jack was married twice, 10 years the first time and 10 years the second time. He has three children between his two marriages. Two of them live in Pennsylvania and one lives in Florida locally.

Jack considers himself socially active. He comes to the senior center to play pool and play cards. He rides motorcycles and has a large social circle. He has some health concerns and rates his overall health as a "6" on a scale of 1 to 10, 10 being above average health. He is able to perform all of his ADLs and IADLs independently. Jack is able to care for himself, take care of his home, and run errands for himself.

Jack would prefer to age in place however financially he is struggling to make ends meet. He stated his children may assist him from having to leave his home. His home is an important place for him and enjoys the view from the third floor. Jack is looking forward to remaining healthy.

Data Collection and Storage

As explained in Chapter 3, the interviews were based on self-report and organized in 3 stages: main questions, follow-up questions, and probes (Rubin & Rubin, 2005). An example of each is as follows: "Has your home been an important place for you over the years?" (main question); "If so, can you share examples?" (follow-up question); "Tell me a little more about that example (i.e. holidays spent with family, etc.) (probe question). The interview was structured to focus on the participant's individual story. I started with a list of demographically oriented questions then followed up with open-ended questions

that revolved around certain themes (See Appendix D). Sub questions were utilized if a participant's response to the initial question did not cover certain topics of interest. Although the questions were structured, I allowed the participants to take the discussion in the direction that was most meaningful to them. I felt this added to the experience and produced a richer interview. Due to time constraints, a single session was utilized versus multiple sessions.

Questions were grouped in various categories: demographic information, access to healthcare, relationships, and attachment. Twenty-eight questions were specific to their lived experiences as they age in place. Four questions were specific to barriers and four questions were specific to services needed as they continue to age in place.

Data Analysis

The purpose of the interview questions were meant to answer the following research questions:

Research Question 1 (R_1) What have the participant's experienced in terms of aging in place?

Research Question 2 (R_2) What are the barriers that impede successful aging in place?

Research Question 3 (R_3) What are the identified services needed to age in place? These research questions were formulated from the understanding that was extracted from a comprehensive review of the literature and an analysis of the conceptual framework that is the foundation of this study. Each of the study's research questions was addressed by analyzing the sorted codes. Codes in qualitative research are words or short

phrases that figuratively assigns a principle characteristic for a portion of data, in this case words from interview transcripts (Saldana, 2009). In this section, I presented how I moved from inductive coding to larger representations to themes and the coding techniques. Five main themes emerged from the codes (see Table 2). Subthemes are also listed as appropriate. These themes are further examined later in this chapter.

Table 2

Identified Themes, Subthemes, and Codes

Theme	Sub-Theme	Codes
Successful Aging	Active Lifestyle	Hobbies
		Daily Routine
		Entertainment
		Spirituality
		Enjoys Life
		Positive Outlook
		Looking forward to Future
	Good Health	Regular Medical Care
		Has Insurance
		Health Diet
		Exercise
	Positive Social Support	Has friends
		Meets with friends
		Family Support
		Travels with Friends
	Feeling of Independence	Self-sufficient
		Autonomy
		Drives
		Cooks
		Does Housework
		Independent ADLs
		Independent IADLs

(continued)

Control over one's Environment	Connection to Home	Childhood home Current Residency Home modifications AIP Preference Fall Precaution/Risk
Access to Services		Financial factors Fixed Income Frequency of Medical Care Not interested
Existing Support System		Family Support Limited Support Dependent on Support Relationships with Others Relationships with Clubs
Barriers to AIP		Financial factors Home modifications Loss of Independence

Each interview was assigned a code, for example “Participant 1 (P1).” I recorded each interview on a separate cassette. I labelled each cassette with the assigned interview code and as soon as possible after each interview I listened to the recording and made notes.

I read the transcripts of the interviews and ascertained the meaning units and I compiled the meaning units and the essential themes. Themes were evaluated, and a descriptive statement was written which tied them to the phenomena of aging in place in Boynton Beach, Florida.

The recording of each interview was transcribed using the Dragon Naturally Speaking 11.0 software to simplify the process. The process took an average of 5 hours for each interview. The completed transcriptions were placed on the researcher’s personal computer under password protection for access. A printed copy was also placed in the

researcher's home office in a locked cabinet for safety. All audio and computer data will be retained for a period of seven years, which complies with American Psychological Association ethical guidelines (APA, 2007). The files will be shredded after the seven year period has expired.

I used data analysis software to systematically organize and analyze the data. The data analysis software used was ATLAS.ti. This software is designed to organize and classify data. The software lends credibility to my findings by uncovering the connecting themes through a systematic interrogation process providing the evidence needed to support the total phenomena. Each transcript was entered into the data analysis software (ATLAS.ti), where a hermeneutic unit (HU) was created, named Dissertation Project. The HU: Dissertation Project holds all the documents, including transcripts of the interview and field notes for analysis (Friese, 2012). Most of the field notes were observational notes that focused on non-verbal mannerisms and facial expressions. Each transcript was reviewed line by line and assigned codes to units of words. Codes were reviewed several times to eliminate redundancy. Memos are text that can be used to link codes or just to make notes about something of significance (Friese, 2012). Several revisions were made to codes and memos during the review process. To ensure the trustworthiness of the study, each participant was given the opportunity to review their transcripts and narrative analysis. Each participant was provided a copy of the completed narrative text and asked to read through their interview prior to the end of the study. A validity check was conducted by mailing each participant a copy of their transcript for verification purposes. (Moustakas, 1994). This is called member checking (Carlson,

2010; Creswell, 2007). Member checking allows the participants to review inaccuracies, and/or make clarifications to the narrative text. This is done to determine if the essence of the interview had been correctly captured which delayed the coding process since many participants took up to 2 weeks to return the corrected transcript. Although it took more time than expected, it was important for the participants to review their story to ensure their perspective was captured and any inaccuracies corrected. The final transcripts reflect participant's edits and/or additions. Several participants (5) made some changes but they were mostly misspellings of conditions or medications. None of the content was changed. Due to the small size of the study, the findings may not prove to be factual for all persons aging in place. However, it does provide a solid addition to the factors of what they perceive to be successful aging. This may, in turn assist policymakers with making informed decisions about funding and programming for this population at least in this community.

The categorization of the data's contents was done utilizing the ATLAS.ti software program to analyze the uploaded interviews. I reviewed each interview individually and assigned codes to the data as needed, for categorization. As I reviewed the data, I added memos and comments about the data to use later for reference purposes. To achieve an overview of the collected data, I placed each of the codes into families. Families are a clustering of units of meaning to form themes. Cluster of themes are typically formed by grouping units of meaning together (Moustakas, 1994). These themes began to emerge during the multiple passes over each participant's interview responses. These themes are further examined later in this chapter.

Incongruent Findings

All of the participants were able to respond to the interview questions with a range of descriptions of their experiences. As the interviews progressed, there seemed to be a correlation between socioeconomic status and level of education. It appeared that the participants with Bachelor and Master degrees felt more financially stable versus the participants with a High School diploma. Another finding that was of interest was that although the literature (Nygren, et. al, 2007; Tang & Lee, 2010; Tenenbaum, 2010) stresses the importance of people assessing their needs for home modifications in later life, none of the participants felt making modifications to their home was important unless they were upgrading their home to sell it. Only 2 participants had made any modifications to their home and it was only because their spouses were ill and the modifications were necessary. Lastly, the most unexpected finding was the overwhelming response each participant had towards driving. Except for one participant, every participant felt the need to be able to drive. Each participant shared how driving was part of feeling independent and losing the ability to drive would have significant consequences for each of them. Not being able to drive was the number one reason for relocation for the participants. Most participants stated if they could not drive they would relocate somewhere where transportation needs would be met.

Trustworthiness of the Study

Credibility

To ensure the trustworthiness of the study, each participant was given the opportunity to review their transcripts and narrative analysis. I asked probing and

clarifying questions to ensure the participant's stories accurately reflected the audio recordings and field notes. Each participant was included in a review of the draft of their completed interview, sometimes called member checking (Carlson, 2010; Creswell, 2007). Each participant was provided a copy of the completed narrative text and asked to read through their interview prior to the end of the study. Member checking allows the participants to review inaccuracies, and/or make clarifications to the narrative text (Carlson, 2010; Creswell, 2007).

Participants were recruited using a convenience sample limiting the study to males and females 65 and older living in the city of Boynton Beach, Florida who also live in their own home or with family. Although I conducted the interviews at the Senior Center, the experience did not influence the data. Each participant voluntarily participated. Credibility was established through the participant's responses and my confidence that the findings were not biased.

Transferability

I used a purposeful sample size of 11 participants for my study. This is primarily due to time and financial constraints. Purposive sampling is a type of nonprobability sampling therefore the results will not be representative of all seniors in the United States but it is useful for exploratory purposes (Babbie, 2007). However, it does provide a solid addition to the factors of what they perceive to be successful aging.

Dependability

Values and feelings are part of the central focus of phenomenology (Giorgi, 2012). Exploring life experiences assists participants in sharing their truth; more

specifically give accuracy and authenticity to their stories. I consciously attempted to understand the perspectives of each participant interviewed. The audio recordings also contributed to the trustworthiness of the study. Participants received a copy of the text to validate that it was true, accurate, and reflect a perspective regarding the phenomenon that was studied. These interactions with the participants reinforced the dependability of the data.

Confirmability

To achieve confirmability, I used member checking and reanalysis of the data, thus ensuring that the themes identified were objective and would make sense to another reader (Carlson, 2010; Creswell, 2007). Measures were taken to ensure the quality of transcription by sending each participant a copy of the transcribed interview for their review and approval. Triangulation was achieved through open ended questions during a semi-structured, face-to-face interview with direct observation of the participant. I utilized ATLAS.ti coding extensively to ensure that the findings and interpretations were grounded in the participants actual statements and personal viewpoints, therefore establishing the evidence of confirmability by using reflexity (Carlson, 2010; Creswell, 2007). The entire data set that was collected for this study will remain available for review for a minimum of seven years as per the American Psychological Association ethical guidelines (APA, 2007).

Results

The following details the emergent themes from interviews with the eleven men and women who participated in this research. The five main themes are successful aging,

control over one's environment, access to services, existing support system, and barriers to aging in place. Themes emerged using the ATLAS.ti software. Once transcripts were uploaded into the ATLAS.ti program common occurrences among interviews were labeled according to the issue that it most represented. Statements and direct quotes are listed below exactly how the participant expressed them, without grammatical correction to ensure authenticity. Statements from participants are illustrated throughout Chapter 4 to reflect their experiences as it relates to each theme.

Research Questions

Three research questions were explored. What have the participants experienced in terms of aging in place? What are the barriers (physical or mental) that impede successful aging in place? and What are the identified services needed to age in place? There were 28 questions asked that related to research question 1 (R_1). Out of those 28 questions, 10 prevalent codes were identified. The most prevalent codes that were identified in these responses were (a) self-sufficiency, (b) autonomy, (c) connection to current residency, (d) daily routine, (e) family support, (f) social activities, (g) drives, (h) regular medical care, (i) entertainment, and (j) spirituality. The code for social activities had the highest prevalence in R_1, with 11 out of 11 participants expressing this code. All of the participants interviewed considered themselves socially active.

There were four questions asked regarding barriers to aging in place (R_2). The most prevalent codes that were identified in these responses were (a) financial factors, (b) home modifications, and (c) loss of independence. All of the participants stated they would prefer to age in place if possible. There were four questions asked regarding

services needed to age in place, research question 3 (R_3). The themes that were revealed for this question were (a) financial support, (b) transportation needs, and (c) domestic assistance. From the codes listed above, illustrations of those themes as shared by the 11 participants are described below.

Table 3

Most Frequent Codes per Research Question

R_1: What have the participants experienced in terms of aging in place? 1. Self-sufficiency 2. Autonomy 3. Connection to current residency 4. Daily routine 5. Family support 6. Social activities 7. Drives 8. Regular medical care 9. Entertainment 10. Spirituality
R_2: What are the barriers that impede successful aging in place? 1. Financial factors 2. Home modifications 3. Loss of independence
R_3: What are the identified services needed to age in place? 1. Financial support 2. Transportation needs 3. Domestic assistance

Successful Aging

For the purposes of this study, successful aging is defined as a person's positive perception of the following factors: life satisfaction, good health, self-esteem, positive social support, and activity/functional level. This is consistent with the participant's

answers to the 28 questions asked related to R_1. There is a common thread found in the participant's responses regarding active lifestyle, good health, positive social support, and feelings of independence. Participants who noted that an active lifestyle was important also noted it was important to have positive social support and good health. Participants who noted feelings of independence were critical to successful aging also stated that it was correlated to an active lifestyle and good health. Below are some of the responses of each of the participants as it relates to successful aging that are relevant to R_1 are presented here:

> P1 (Mrs. D.) I work out. I dance here at the senior center. I do Zumba also at Curves. I go to Curves…My hobby is wood carving…As a matter of fact I belong to the wood carving group here.
>
> P2 (Racehorse) (Friend) and I are close friends and we travel together. We've been to Spain. We've been to Italy. We've been to Germany, Pamana Canal. She's a world traveler. I'm just getting started. And we go to different social events and go to the Kravis Center to shows and stay in touch with all my kids. I have one family that lives back in Arkansas and I had two sons in coaching. One is still coaching and I have two grandsons still coaching.
>
> P3 (Mrs. S) I do my own housework…I do my groceries…I do my own cooking. I like to go out and eat with the girls. I like to shop. I think most women do….I love to work in the flower garden.
>
> P4 (Gramps) I like to play cards. I like to shoot pool. I go golfing…and I don't bowl anymore. That's about it.

P5 (Mr. K.) I use the fitness room. Sometimes I play pool…I belong to the Eagles club and I go to the VFW a lot and I probably have 200 supporters.

P6 (Po) I like swimming and dancing. I come here (referring to senior center) to dance. I spend time with my grandkids. Today is a gift, tomorrow is mystery. Take it how it comes.

P7 (Lucky 4 Guys) I'm a good cook…I do my own grocery shopping and I still drive. I love where I am. I love being who I am and what I do.

P8 (Francois) I like to exercise….I do work in my house. I do yard work all the time….My son and daughter spend time with me all the time.

P9 (J.J.) I like to exercise and watch T.V. I like to play dominoes….I stay with my daughter. She helps me with the cooking and cleaning.

P10 (Rocky) I'm a minister at my church…I drive. I ride bicycles. I ride a motorcycle. I do my own laundry, maintenance, and stuff like that.

P11 (Jack) I play pool and cards. I usually go to the inlet and hang out there for a couple of hours. Then we go to the backyard (a bar) and listen to music.

Control Over One's Environment

When speaking to the participants, questions were not asked specifically about control over their environment, however, it was interesting to see that all of the participant's spoke about either being able to drive or the importance of staying in their home versus relocating and how that played into their control over their own environment.

P1 (Mrs. D.) Yes, I had to take the driver's test here recently and I passed it…that's the thing that bothers me, is really when I can't drive. I think of the things that I would be giving up if I can't drive…that is what really bothers me about getting older.

P2 (Racehorse) Yeah. You know you can't drive you can't get nowhere. You can walk down the corner maybe. You could still walk or take a bus down there that goes…but…the bus don't go by the store.

P3 (Mrs. S) I would like to stay in my own home…I would leave if I couldn't take care of the house and also if I had a little problem with…well, driving would be one.

P4(Gramps) I would stay in my home unless I couldn't drive.

P5 (Mr. K) I'd rather stay in my home…my independence is very important to me. I love the outdoors and I enjoy nap time around 2pm.

P6 (Po) I'm independent. I am retired but I still have an active license (referring to real estate license). I do not need assistance.

P7 (Lucky 4 Guys) I wouldn't move if I couldn't drive. I would sell my car and use a bus or taxi….I am very particular…not about cleaning but about order. I hate clutter. There is never a wrinkle in my bed after I leave it. There are no dirty dishes in the sink. The stove clock and the microwave clock must be the same and so forth.

P8 (Francois) I am capable of doing things for myself. My family would help me but I like my independence.

P9 (J.J.) I can drive but I do not. I had a fall a long time ago.

P10 (Rocky) I have no reason to leave my home. I will stay until I take my last breath.

P11 (Jack) I'm going to stay in my home. I could leave but I wouldn't want to. I'm right on the intercoastal close to everything.

It is important to note that 9 out of 12 participants were concerned about not being able to drive in their older age. It is also important to note that it was also the number one reason for relocation if they had to leave their current residence.

Access to Services

During the interview process, participants were asked about access to services and how often they saw a primary physician. Most participants saw a primary physician regularly. Very few participants stated access to services was difficult with regards to gaining medical care. The average answer resembled the following:

P3 (Mrs. S). Well, my cardiologist now is maybe about twice a year. I haven't had a stress test in a long time but I'm due for one now in another week or two. And I see my dentist twice a year and my general practitioner every six months or so. And the dermatologist, I just finished with him so that's every four months probably.

There were questions asked regarding accessing in-home assistance such as housecleaning, cooking, etc. Most of the participants do all of their own housework, cooking, cleaning and are able to perform all of their ADL's themselves. There were 4 participants that utilize a housekeeper to clean their home every couple of weeks. The

important element to note here is that the participant's with lower incomes (less than $35,000 a year) struggle to meet the poverty guidelines in order to access services such as food stamps and other government assistance programs.

Existing Support System

The participants were asked about their current support system and to speak about their friends and family. One participant responded:

> P3 (Mrs. S.) I was married for 50 some years. I had four daughters. All wonderful. They live in Connecticut where I spent most of my married life. One in Texas. I see them every year, sometimes they come down, most of the time I go up. I have nine grandchildren. I've tried to stay very active because I'm 86 and I think that's important.

Another participant shared his illustration of how supportive his family is to one another:

> P7 (Lucky 4 Guys) I have 3 sons live here. I see them every week. On Monday, I have breakfast with son #4. And on Tuesday, son #1. And on Saturday, there are 4 generations of us. Me, my son, my grandson, and my great grandson. We all meet at John G's in Lake Worth…If I need help; probably the sons would be the first avenue.

In general, most of the participants had a positive support system. Two of the participants shared that financial constraints hinder them from visiting their family as often as they would like but for the most part family support appears to be a positive factor for the participants.

Financial Constraints

Financial difficulties were prominent in the participants in the lower income bracket (less than $35,000/year). One participant stated:

P11 (Jack) Yeah, I run out of money all the time.

Another participant described his difficult divorce and then shared the financial consequences of the split from his wife:

P10 (Rocky) Well, I'm behind on my taxes right now. I can pay the note on the house but I can't really afford the taxes.

In addition, he stated that there are things he would like to do but cannot due to limited finances.

Health/Access to Healthcare and Services

All of the participants except for two see a medical professional regularly, usually every three months. All of the participants have Medicare and most have Medicare Part D for prescriptions. The one participant that could benefit from physical therapy for an injury stated his concern over his insurance and the lack of appropriate coverage. He stated:

P11 (Jack) Yes, but it only pays 80% (referring to his Medicare insurance). I can't afford the other 20% to get services.

One participant pointed out how the senior center assists him in compensating for his inability to pay for services. He was discussing how he only has Medicare A and he needed to have Medicare B in order to see his primary.

> P10 (Rocky) I go to the doctor when I need to…I went to the doctor just the other day and they didn't inform me anything about….I told them I had Medicare A. They said they only accept Medicare B. So I had to turn around and walk out. I've been there 3 times and they never once mentioned it. Now they hit me with a $370 bill and a $90 payment for the doctor to see me. I said, "I don't have that kind of money. If you don't accept Medicare A, fine"…The general practitioner said to me that I should go every 3-4 months but at the facility here (referring to the senior center), like tomorrow they are having the free blood test and everything. So I go by the read out and then I can judge my medication by the read out of the blood test.

When I probed further to find out what he was referring to, he mentioned that after the stint was put in it gave him high blood pressure. P10 is prescribed 3 different kinds of hypertension medication however he stated he has cut back on his medication on his own, partly due to the way it was making him feel and partly due to cost. P10 also mentioned that at the senior center they will check his blood pressure for free every Wednesday. The membership to the senior center is free if you live within the city limits. It appears that P10 utilizes the senior center to its full capacity in order to compensate for his limited access to services.

P11 (Jack) was candid about his frustrations in accessing services. He stated that although he had insurance, it only covered a minimal amount of visits for physical therapy and it was not enough therapy to heal his injuries. He has had to adapt and

compensate for his injury in order to function during the day. I asked if his city had services available to him, would he utilize them. He responded:

> P11 (Jack): Yes but I can't get them. My friends have it but they said I make too much money. I only make $18,000…..I was getting food stamps and they took them away from me.

In addition, when I asked him about his injuries he stated when he broke his arm; he lost 50% of the movement. Medicare only pays for 4 sessions of physical therapy and it only pays 80% of the cost so he couldn't afford the 20% to continue receiving treatment. He stated that he cannot hold his arm up for long periods of time and that his range of movement is limited. According to the literature reviewed in Chapter 2, his ability to compensate for his loss in movement reinforces Atchley's Continuity Theory which states that as people get older they will adapt and compensate to remain in their environment. In the case of this participant, his adaptation is a necessity to continue to function independently at home.

Family/Limited Support System

There was only 1 participant that had a limited support system. This participant recently went through a divorce and his children all live out of state. He does have friends locally that he spends time with and his participation in the church is strong. When asked about what he enjoys most in his day, he stated:

> P10 (Rocky) Being alive. Church. Most people it's their cup of coffee in the morning…me it's my church.

One participant described his situation when his wife was ill before her passing:

> P2 (Racehorse) I can relate to that more when my wife was going through her struggles. I felt like…I see all these people wanting to donate money to Alzheimer's research and all this but here I am with her every day and nobody cares.

Caregiver support is difficult to acquire and in many cases expensive and out of reach for families to afford. In the case of P2, he was able to hire some assistance but his wife refused the help. He explained, "She was a stranger to my wife and my wife didn't want strangers in our home." Ultimately, he was able to enlist the help of a family friend to help watch her so that he could continue to go swimming in the mornings. P2 shared that this was very important in maintaining his mental wellbeing since taking care of his wife at home was very emotionally and physically draining.

Barriers to Aging in Place (AIP)

One of the questions asked during the interview was "As you continue to age, would you prefer to stay here in your own home or move to another setting?" All of the participants responded with wanting to stay in their current home setting. However, when the follow-up question was asked, "If you had to move from your home, what possible circumstances would most likely prompt such a move?" The answer to that question was much more surprising. Below are some of the responses given.

> P1 (Mrs. D.) I would (prefer to stay in my home) unless I can't drive. And I've got the friends who have hired someone one morning a week and they do their shopping. I just don't know. I figure like I'm too independent to really adapt well

to that. I want my independence. I would be concerned that my social life would go also if I can't drive.

P3 (Mrs. S.) Only if I couldn't take care of the house and also if I had a little problem with…well, driving would be one.

P4 (Gramps) If I can't drive, I would move.

P6 (Po) Why do I have to leave? I leave when I go to heaven.

P7 (Lucky 4 Guys) I wouldn't move. If I couldn't drive I would sell my car and use a bus or taxi.

P11 (Jack) I prefer to stay in my home. I could leave but I wouldn't want to. They can bury me there. I'm not leaving. I'm not going to a nursing home.

Most of the participants (7) made reference to their ability to drive. This was one response that was not expected however would be consistent with the literature on successful aging and the ability to remain independent. The literature on successful aging speaks specifically to remaining active, maintaining relationships, and having a strong support system. What the literature did not address and could be a point for further research and study is the person's ability to drive. None of the articles reviewed regarding successful aging touched on the subject of being able to drive and the importance of driving to adults as they age in place.

Financial Support

The results in this area were split between being financially stable and having some financial difficulties. Half of the participants felt they had enough money to pay their expenses and live well. The other half were either having difficulties making ends

meet or felt they had just enough to get by. There did appear to be a slight correlation between educational level and income. Expect for 1 outlier, the participants with higher incomes ($50,000+) fared better with regards to being able to pay their bills and have some discretionary money for travel and other leisurely activities.

Transportation Needs

The results in this area were overwhelming to the degree that almost all of the participants felt that their ability to drive was a necessity. There were two participants that were accepting of utilizing the bus or other form of transportation but it was obvious the participants were adamant that they needed to drive themselves versus use public transportation or transportation service. One of the responses was:

> P1 (Mrs. D.) I couldn't get to curves so that exercise is out. I'd have to walk. I can't get to another gym…I can't get to the church. Very much of my social life is there with that church. They keep me hopping…So that would be a big hole…And I think sometimes with people too if you're not used to using the bus then it's a come down in prestige….You are used to your car and then life comes to this.

P1 also shared an experience a close friend of hers had where her friend was moved out to the country by her children so they could take care of her. However, without a vehicle she is now dependent on her children to get her to where she wants to go. She is out in the country so there is not a bus stop nearby. P1 stated she watched her friend deteriorate. With time, her friend went into a depression and now has severe short

term memory loss. P1 stated, “I saw her suffering through it because of the lack of independence.”

Domestic Assistance

All of the participants, with the exception of 1 stated they did their own cooking, cleaning, and housework. However, a few stated they utilize a professional cleaning service a couple of times a month to assist with keeping the house clean. This topic was closely correlated to the topic of independence. When I asked the participants about how important having their independence was, most stated that it was very important or extremely important. When the follow-up questions were asked about needing assistance, some of the responses were:

P4 (Gramps) I don’t think I need help. Other people do but I don’t.

Additionally, the topic of home modifications was explored. None of the participants had made changes to their home unless it was to upgrade their appliances or because they wanted to improve the resale value of their home. Some of the participants stated they could afford to make modifications to their home but did not see the need until it was necessary. Others stated that financially it was not an option. P6 (Po) stated, “No because it’s too costly (referring to making home modifications).”

Summary

Three research questions were explored: What have the participants experienced in terms of aging in place? What are the barriers (physical or mental) that impede successful aging in place? What are the identified services needed to age in place?

To answer these questions, themes were explored that illustrated the thoughts and desires of the participants interviewed. The research highlighted common characteristics the participants shared. Specifically, five main categories were identified. The themes revealed that many of the participants enjoy their life and are doing exactly what they want. It appears that as they age, it is important to them to remain active, both mentally and physically. The results indicated that the participants value their independence and with that their ability to drive and not depend on others for their transportation needs. In addition, the findings suggest that the participants displayed active involvement in their retirement, in the respect that they are living their lives to the best of their ability and are adapting to health conditions and other physical limitation in order to age in place. There are some concerns about the few participants that are struggling financially and how they will continue to receive the services they need in order to age in place. Some recommendations are listed in Chapter 5 that address this topic.

Chapter 5 will provide a more in-depth analysis of the study's results, as well as discuss themes consistent with continuity theory. Chapter 5 will draw conclusions from the data and discuss implications for positive social change. Recommendations for areas of future research will be included. Further discussion about the findings, implications for social change, and recommendations for action and further study as a result of the research study are presented in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Overview of Study

Baby boomers are living longer, and, as they age, they will need more supportive services (housing, mobility, nutrition, personal care, health care, to name a few examples) to meet their growing needs. Current service delivery programs are insufficient to meet the demands of this population in order for them to maintain their independence and autonomy. The purpose of this study was to examine the relationship between people and their environment by collecting their perspectives and experiences on aging in place. The study explored the lived experiences of this demographic in the hopes of gaining an understanding of their needs as they age. The research contributed to the literature and to social change by providing information to baby boomers on how they can use the information to make informed choices. Additionally, providing policymakers and administrators with information to strengthen the argument that public health issues cannot be addressed without discussing the impact retiring baby boomers will have on the nation's long-term systems of care as well as the economy.

The research questions explored were: (a) What have the participants experienced in terms of aging in place (i.e., the decision to remain in your home or community as you age instead of opting for relocation to long-term care, assisted living, and nursing home)? (b) What are the barriers (physical or mental) that impede successful aging in place? and (c) What are the identified services needed to age in place?

To address these questions, I used an exploratory approach to understanding the life experiences of the population being studied. Using face-to-face interviews, I

documented the lived experiences of the participants and gathered information that provided possible insight into their perceptions and realities which may lead to proactive decision making for their futures.

This chapter provides an interpretation of the findings, implications for social change, recommendations for action, and recommendations for further study. Data from the interviews show common themes about the feelings toward aging in place and the thought process leading up to the decision to age in place or relocate.

Interpretation of Findings

Many of the ways that the participants in this study experience aging in place is consistent with the continuity theory of aging (Atchley, 1989). Elements of the theory were found in every theme in this study; idea patterns, personal goals, lifestyle, and adaptive capacity.

Theme 1: Successful Aging.

There was a common thread found in the participant's responses regarding active lifestyle, good health, positive social support, and feelings of independence. These responses can be correlated to the concept of idea patterns in Continuity Theory. Idea patterns represent our internal framework (i.e., attitudes, beliefs, values, coping strategies, etc.), and when combined makes us whole and distinguishes us from another person (Atchley, 1999, p. 9). People are motivated to maintain their idea patterns when faced with life decisions and adapting to change (Atchley, 1999).

The participants were all actively engaged in their retirement and based on their idea patterns were making conscious efforts to live life fully. As an example, Mrs. D.

made comments that she was motivated to stay active because she felt it kept her mentally sharp. She is aware that as her health declines she will need to compensate in other ways to maintain a similar lifestyle to the one she has now. Her positive idea patterns allow her to make daily changes to adapt to changing situations. This is consistent with the literature review in Chapter 2 that conceptually addresses the factors associated with successful aging. Ferri, James, and Pruchno (2009) support the findings of good physical health, positive social support, and activity/functional ability in their research as well. Other researchers (Aldwin & Igarashi, 2015; Atchley, 1999; Baltes & Baltes, 1990; Baltes & Smith, 2003; Dahany et al, 2014; Freund & Baltes, 1998) also support successful aging to be attributed to those same factors.

Theme 2: Control Over One's Environment.

Atchley's (1989) continuity theory of aging presumes that individuals will adapt to their environment and/or circumstances based on their experiences. The theory assumes that as people age, they will strive to remain consistent in their behavior patterns (i.e., work schedule, leisure activities, etc.). Additionally, they will make adaptive choices in an effort to avoid disruption to these patterns of behavior (Atchley, 1999).

Many of the participants who had structured schedules before retirement were keeping a similar routine after retirement. Lucky 4 Guys for example, illustrated the importance of keeping a routine during retirement. He shared that some of his friends after retirement where not adjusting as well due to the lack of structure. Lucky 4 Guys not only keeps a consistent routine during the day but also makes it a point to have a strong support network. He meets regularly with friends and family. This is an example

of controlling one's environment to suit your needs. One condition that stood out from the rest was the ability to drive. Every participant who still drives made the same argument that losing the ability to drive was a significant loss of independence and a lack of control over one's environment. One consequence of not being able to drive was having to depend on others for transportation or even having to depend on the schedule of public transportation was a negative consequence to some of the participants.

Theme 3: Access to Services.

This theme was divided between those that could afford to access services and those who were limited on which services they could access. Continuity theory assumes that adults have personal goals for developmental growth. Adults use life experiences to make decisions about which aspects of their life they should focus their attention on, activities to engage in, careers to pursue and so on (Atchley, 1999, p. 11). Each of the participants had personal goals they wanted to focus on. Ninety percent wanted to remain active to ward off mental decompensation. Sixty percent wanted to exercise for health reasons and yet others (30%) were seeking services for medical concerns that had gone unaddressed. The issue was that some of the participants were able to access the services they needed because they could afford to pay for them out of pocket. However, those participants with lower incomes were not able to access services due to their income. Additionally, the participants with lower incomes (less than $30,000 a year) did not qualify for Medicaid or other similar benefits (i.e. food stamps) because their income did not meet the poverty guidelines. One can speculate that this segment of the population, whether old or young, will be at a significant disadvantage by being caught in the "in-

between" income guidelines of not earning enough money but still making too much to qualify for government assistance programs.

Out of all of the themes, access to services, or lack thereof will have the most powerful impact on Americans as they grow older. Medicare is the primary source of funding for older Americans to meet their medical needs however there continues to be a gap between services needed and the ability to pay for them (National Council on Aging, 2015). Although Medicare covers nearly all the costs associated with coverage (premiums and deductibles), many Americans are left with substantial out-of-pocket expenses (Johnson, 2013). One can infer that if measures are not taken to close the gap between access to services and the ability to pay for them, there will be a segment of the population with unmet medical needs. This may lead to taxpayers having to carry the burden in order to pay for older Americans who will seek medical care in emergency rooms to address their medical conditions. Furthermore, unmet medical needs could lead to premature institutionalization which will burden the already overstressed resources of the government.

Theme 4: Existing Support System.

The element of continuity theory that stood out was lifestyle. Lifestyle involves our external patterns or social roles, relationships, and living environments. Over time, our external patterns are what set people apart from each other. It is presumed that continuity of these roles, relationships and living environments can prevent or minimize the social, psychological, and physical losses that cultural concepts of aging might lead us to expect (Atchley, 1999, p. 11). One thing I would like to point out is that 84% of the

participants had a positive attitude about aging, a positive outlook on their future, and a genuine joy for their life. This positivity is linked to successful aging and longevity. Positive social support has also been linked to reducing the likelihood of depression and other mental heath issues (Skoog, 2011). People who report depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care resource utilization (Federal Interagency Forum on Aging-Related Statistics, 2012; Skoog, 2011). Furthermore, factors such as the loss of close relatives, social network, sensory functions and health that effect a person's mental health and ability to live on their own are associated with the aging process. It can be inferred that a positive social network can help reduce mental health issues and increase longevity. This is consistent with the successful aging studies (Aldwin & Igarashi, 2015; Atchley, 1999; Baltes & Baltes, 1990; Baltes & Smith, 2003; Dahany et. al, 2014; Freund & Baltes, 1998) which also reinforces this inference.

Theme 5: Barriers to Aging in Place.

In Atchley's (1989) continuity theory of aging, retirement is not seen as a stressful disruption but rather as an opportunity to maintain a certain lifestyle and social contacts. In the case of the participants in this study, they all reported being happy with their life and positive social interactions with others. The responses given by the participants in this study support the premise that individuals will find a way to compensate for any limitation in order to remain in their environment as outlined in the continuity theory of aging (Von Bonsdorff, Shultz, Leskinen, & Tansky, 2009). For those participants who are financially stable, they maintain routines, social networks, hobbies, and an overall

healthy lifestyle in order to age in place and live independently. For those participants who are not as financially stable, they also try to maintain routines and their social networks. They do not have the same resources as their counterparts to be able to travel or seek medical care as often however they try to minimize their barriers (physical and financial) so they may also age in place and retain their sense of independence. An example of this is when a person decides to work part-time after retirement. Employment after retirement offers an opportunity to maintain social contacts and daily routines (Von Bonsdorff, Shultz, Leskinen, & Tansky, 2009) which has been linked to successful aging (Minhat, Rahmah, & Khadijah, 2013; Shultz & Wang, 2011; Wang, 2007; Zhan, Wang, Liu, Shultz, 2009).

Only two of the participants are engaged in bridge employment, however it should be noted that they appear to be working for the enjoyment of interacting with others and not necessarily due to monetary need. In accordance with Continuity Theory, work is the main source of daily routines in the lives of older employees. Work enables employees to maintain not only their work identity but also a satisfying level of social contacts (Fugate, Kinicki, & Ashforth, 2004). Labor shortages could be alleviated by encouraging employees to engage in bridge employment. This is referred to as adaptive capacity and refers to the evolution of adults as they age and through these experiences they will adapt based on their internal and external patterns. Internal patterns refer to a person's constructs such as their personal goals, philosophy of life, and coping mechanisms. External patterns refer to a person's social role, activities, relationships, and living environment (Athley, 1999). Another example is Lucky 4 Guys. He has

consciously decided that he wants to be actively retired which means although he will not work anymore he would like to continue his social relationships with friends and his social role in society as a father, grandfather, and great-grandfather. He has a desire to continue driving and he understands that as he chooses to age in place he may need to adapt (i.e. give up driving at some point) his lifestyle in order to continue this personal goal. The results are complex since everyone is different with regards to their personal experiences. At the conclusion of this study, it became clear that driving for the participants gives them a sense of independence which is significantly important to them. Also, living in their own home was an important element for the participants since they equated living in their own home and maintaining their own schedules as freedom and a form of independence that was essential to them. The results of this study not only reinforce successful aging studies (Aldwin & Igarashi, 2015; Atchley, 1999; Baltes & Baltes, 1990; Baltes & Smith, 2003; Dahany et. al, 2014; Freund & Baltes, 1998) but also opens a window for further research surrounding aging in place and people's ability to drive. Further studies could be conducted specifically addressing the importance of driving for older adults which may lead to changes in transportation options and other alternatives for those people not able to drive.

Implications for Social Change

The literature review conducted in Chapter 2 depicts the gap in research studies addressing the needs of active adults in retirement. There are a group of older adults that have minimal physical limitations however are financially caught between poverty and

making ends meet. These people are unable to access services (i.e. respite, housecleaning, transportation, etc.) needed to continue to age in place.

The themes from the content analysis indicated that the participants were actively embracing the concept of aging in place and making the most of their limitations, whether it is financial, physical, or otherwise. At least half of the participants were financially stable enough that if they needed in-home care, although costly, they could afford to pay for it out of pocket. The remainder of the participants, however, fall in-between the federal poverty guidelines and middle class income. These individuals cannot afford to pay for services out of pocket but their income level is not low enough to qualify for many of the programs offered by Title III programs under the older Americans Act.

This study contributes to positive social change by providing policymakers and administrators information to strengthen the argument that our current social service delivery system is currently overburdened but also ineffective in reaching a very specific socio-economic demographic. Subsequently, this study raises awareness regarding the desire for older Americans to be able to drive and function independently.This study also raises questions regarding the gap between current social service programs and the identified needs of Older Americans. For example, if we make the argument that a disproportionate number of older Americans would like to continue to drive as they age in place, our current social service delivery system has no mechanism to make transit services more flexible and customer responsive. There is also no mechanism in place to improve roadway design and signage to make it easier for older adults to navigate the

roadways given that older adults are living longer and their eyesight will naturally deterioriate with older age.

Although the results of this study cannot be transferred to the general population, it did provide a glimpse into the experiences of people choosing to age in place in this geographic area. There appears to be a portion of the population who are financially stable and are able to live comfortably while they enjoy their retirement years. For those not as fortunate, their struggle to meet their physical and financial needs are real. We need to take into consideration people who need to continue to work to meet their financial obligations and who may prefer to drive to get to work or take care of personal appointments. Maintaining a vehicle (i.e., gas, repairs, insurance) is costly and for those individuals with limited financial resources, this may not be a viable option. However, public transportation may not be readily available in all areas should older adults decide to participate in alternate means of transportation. Furthermore, as indicated in this study, people are self-diagnosing, self-medicating, and self-administering medications in order to save money, avoid medical bills, and/or avoid seeing a physician. People should not have to make the choice between being able to feed themselves and receiving appropriate medical care. It is the hope that local governments will take into account the needs of this ever growing population when they are making funding decisions and deciding which programs to implement in the community.

Recommendations for Action

Several audiences may benefit from reviewing the results of this study. One is policymakers who make funding decisions may be interested in the type of services

needed by the participants. Policymakers could use the information to review existing programs and/or direct some funding allocated for other programs toward programs that focus on evidence based practices rather than having fragmented programs throughout the State. It is imperative that policymakers adopt programs and practices that will increase the likelihood of producing positive effects. The results of the study strongly suggest that there is a need to make the best use of already scarce resources. With impeding budget cuts for 2016, we continue to have fewer resources but a substantial need for increased programs and services (United States Senate, 2013).

Social workers could use the information on successful aging to assist them in their case management roles. Publishing in academic journals could help close the gap in the literature regarding successful aging and aging in place. Another avenue may be the development of lectures, seminars, and workshops for community workers to inform them of the phenomenon and what was discovered through this study.

Listed below are some recommendations based on the themes found in the study: Successful Aging.

1. Encourage flexible employment options for older works to ease the transition to retirement.
2. Create a person-centered approach to services versus a system centered approach.
3. Continue to utilize senior centers but utilize them as a central hub for accessing services. Have a case manager available that can assist members in applying for Medicaid and other services.

Access to Services.

1. Lower drug costs for Medicare beneficiaries.
2. Improve Self-Sufficiency Nutritional Access Program (SNAP) access for elderly individuals and lower the income requirements to obtain food stamps.
3. Support family caregivers. Family caregivers are a major part of the equation for providing the majority of care to their loved ones.

Transportation.

1. Make transit services more flexible and customer responsive.
2. Improve roadway design and signage (i.e. larger, well-placed directional signs, dedicated left-turn signals).

Financial.

1. Offer financial classes at the senior center to assist members with budgets and paying bills.
2. Offer financial advisors at a lower rate to assist members with their retirement needs.

Recommendations for Further Study

A limitation of the study was the interview instrument. Questions were created based on what the literature revealed as being important. However, when participants were asked about making home modifications, for example, all the participants stated that if they made any modifications it would only be to assist in the resale of the property. None of the participants felt that making home modifications prior to an incident (i.e.

injury) would be beneficial. One recommendation for further study would be to conduct a similar study but remove the questions regarding home modifications and further probe the questions regarding independence and the importance of driving. If older adults are going to be driving well into their 80s and 90s it will be a topic that will need to be addressed further since our roadways are not currently equipped with signage that is user friendly to someone with failing eyesight or someone with slower reflexes (Federal Interagency Forum on Aging Related Statistics, 2012).

Another recommendation for further study would be to take a closer look at the population accessing services and try to gauge how many people are not able to access needed services due to their financial class. The results of the study suggest that there appears to be a gap in the service continuum when someone reaches a certain income level. When I started this project, I did not think I had any significant biases. I quickly learned that I did not expect so many older adults in their 80s and 90s to be so active in their retirement. I heard stories of participants changing the dosage on their medication (due to inability to pay) to failing to see a physician for current medical conditions for fear of an invoice. The literature is clear that as people begin to retire, there are simply not enough workers in the work force to care for a population that is growing exponentially (Johnson, 2013; MetLife Market Institute, 2012; United States Senate, 2013). As a society, we are failing our older adults and if the situation continues to be ignored, the importance of being proactive in extending their longevity, the nation will suffer greatly. Not only will the government spend more money in long-term treatment but cases of elder abuse and neglect will increase significantly if proper controls are not

put in place. People age 65 and older will outnumber all other age brackets within the next 30 years (U.S. Census Bureau, 2010). It would be in our best interest as a nation to adapt to them instead of us trying to get them to fit into a society structured for a younger generation.

References

Aberg, A. C., Sidenvall, B., Hepworth, M., O'Reilly, K., & Lithell, H. (2005). On loss of activity and independence, adaptation improves life satisfaction in old age: A qualitative study of patient's perceptions. *Quality of Life Research, 14*(4), 1111-1125. doi:10.1007/s11136-004-2579-8

Administration on Aging. (2014). *Historical evolution of programs for older Americans*. Retrieved March 2, 2014, from http://www.aoa.gov/AoARoot/AoA_programs/OAA/resources/History.aspx

Aldwin, C. M., & Igarashi, H. (2015). Successful, optimal, and resilient aging: A psychosocial perspective. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. L. Wetherell (Eds.), *APA handbook of clinical geropsychology: Vol. 1. History and status of the field and perspectives on aging* (pp. 331-359). doi:10.1037/14458-014

Angus, J., & Reeve, P. (2006). Ageism: A threat to "aging well" in the 21st Century. *Journal of Applied Gerontology, 25*(2), 137-152. doi:10.1177/0733464805285745

Atchley, R. C. (1999). *Continuity and adaptation in aging*. Baltimore, MD: The Johns Hopkins University Press.

Babbie, E. (2007). *The practice of social research* (11th ed.). Belmont, CA: Thomson Wadsworth.

Baltes, M. M., & Lang, F. R. (1997). Everyday functioning and successful aging: The impact of resources. *Psychology and Aging, 12*(3), 433-443.

Baltes, P. B., & Baltes, M. M. (Eds.). (1990). *Successful aging: Perspectives from the*

behavioral sciences. New York, NY: Cambridge University Press.

Baltes, P. B., & Smith, J. (2003). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology, 49*, 123-135. doi:10.1159/000067946

Bertaux, D. (1981). From the life-history approach to the transformation of sociological practice. In D. Bertaux (Ed.), *Biography and society: The life history approach in the social sciences* (pp. 29-45). London, England: Sage.

Birkeland, A., & Natvig, G. K. (2009). Coping with ageing and failing health: A qualitative study among elderly living alone. *International Journal of Nursing Practice, 15*(4), 257-264. doi:10.1111/j.1440-172X.2009.01754.x

Boldy, D., Grenade, L., Lewin, G., Karol, E., & Burton, E. (2011). Older people's decisions regarding "ageing in place": A Western Australian case study. *Australasian Journal on Ageing, 30*(3), 136-142. doi:10.1111/j.1741-6612.2010.00469.x

Bookman, A. (2008). Innovative models of aging in place: Transforming our communities for an aging population. *Community, Work & Family, 11*(4), 419-438. doi:10.1080/13668800802362334

Brandon, B., & Flury, E. (2009). Aging with choice: Coping with a changing marketplace: The inexorable pressure to keep seniors home can present opportunities, not just threats. *Long-Term Living: For the Continuing Care Professional, 58*(1), 14-18. Retrieved from http://www.ltlmagazine.com/article/aging-choice-coping-changing-marketplace

Carlson, J. A. (2010). Avoiding traps in member checking. *Qualitative Report, 15*(5), 1102-1113. Retrieved from http://www.nova.edu/ssss/QR/QR15-5/carlson.pdf

Carpenter, B. D., Edwards, D. F., Pickard, J. G., Palmer, J. L., Stark, S., Neufeld, P. S.,Morrow-Howell, N., Perkinson, M. A., & Morris, J.C. (2007). Anticipating relocation: Concerns about moving among NORC residents. *Journal of Gerontological Social Work, 49*(1-2), 165-184. doi:10.1300/J083v49n01_10

Casado, B. L., Van Vulpen, K. S., & Davis, S. L. (2011). Unmet needs for home and community-based services among frail older Americans and their caregivers. *Journal of Aging and Health, 23*(3), 529-553. doi:10.1177/0898264310387132

Chen, Y., & Thompson, E. A. (2010). Understanding factors that influence success of home and community based services in keeping older adults in community settings. *Journal of Aging and Health, 22*(3), 267-291. doi:10.1177/0898264309356593

CNN Library. (2013). *Baby boomer generation fast facts*. Retrieved November 6, 2013, from http://www.cnn.com/2013/11/06/us/baby-boomer-generation-fast-facts/index.html?iref=allsearch

Cohen, C. S., Mulroy, E., Tull, T., Bloom, C. C., & Karnas, F. (2007). Integrating services for older adults in housing settings. *Journal of Gerontological Social Work, 49*(1), 145-164. doi:10.1300/J083v49n01_09

Colello, K. J. (2006). *Older Americans Act: Funding formulas*. Retrieved from Congressional Research Service website: http://research.policyarchive.org/4400.pdf

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Dahany, M. M., Drame, M., Mahmoudi, R., Novella, J. L., Ciocan, D., Kanagaratnam, L., . . . Blanchard, F. (2014). Factors associated with successful aging in persons aged 65 to 75 years. *European Geriatric Medicine, 5*, 365-370. Retrieved from http://dx.doi.org/10.1016/j.eurger.2014.09.005

Daly, K. J. (2007). Qualitative methods for family studies and human development. Thousand Oaks, CA: Sage .

Danziger, S., & Chaudhury, H. (2009). Older adults' use of adaptable design features in housing units: An exploratory study. *Journal of Housing for the Elderly, 23*, 134-148. doi:10.1080/02763890903035498

Denton, M., Ploeg, J., Tindale, J., Hutchison, B., Brazil, K., Akhtar-Danesh, N., . . . Plenderleith, J. M. (2009). Would older adults turn to community support services for help to maintain their independence? *Journal of Applied Gerontology, 29*, 554-578. doi:10.1177/0733464809345495

Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods*. New York, NY: McGraw-Hill.

Department of Justice. (2010). *2010 ADA standards for accessible design*. Retrieved from http://www.ada.gov

Dewey, J., & Denslow, D. (2012). *Baby boom retirees and Florida's job structure*. Retrieved from http://www.aabri.com/manuscripts/FSC-12-5.pdf

Edwards, J. R., Cable, D. M., Williamson, I. O., Lambert, L. S., & Shipp, A. J. (2006).

The phenomenology of fit: Linking the person and environment to the subjective experience of person-environment fit. *Journal of Applied Psychology, 91*(4), 802-827. doi:10.1037/0021-9010.91.4.802

Erkal, S. (2010). Home safety, safe behaviors of elderly people, and fall accidents at home. *Educational Gerontology, 36*, 1051-1064. doi:10.1080/03601277.2010.482482

Farber, N., Shinkle, D., Lynott, J., Fox-Grage, W., & Harrell, R. (2011). *Aging in place: A state survey of livability policies and practices*. Retrieved from National Conference of State Legislatures and AARP Public Policy Institute website: http://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf

Federal Interagency Forum on Aging-Related Statistics. (2012). *Older Americans 2012: Key indicators of well-being*. Retrieved from The Federal Interagency Forum on Aging-Related Statistics website: http://agingstats.gov/agingstatsdotnet/Main_Site/Data/Data_2012.aspx

Feldman, D. C., & Beehr, T. A. (2011). A three-phase model of retirement decision making. *American Psychologist, 66*(3), 193-203. doi:10.1037/a0022153

Ferri, C., James, I., & Pruchno, R. (2009). Successful aging: Definitions & subjective assessment according to older adults. *Clinical Gerontologist, 32*(4), 379-388. doi:10.1080/07317110802677302

Fields, N. L., Anderson, K. A., & Dabelko-Schoeny, H. (2011). Ready or not: Transitioning from institutional care to community care. *Journal of Housing for the Elderly, 25*, 3-17. doi:10.1080/02763893.2011.545330

Fisher, J. D., Johnson, D. S., Marchand, J. T., Smeeding, T. M., & Torrey, B. B. (2007). No place like home: Older adults and their housing. *The Journals of Gerontology, 62B*(2), S120-S128. doi:10.1093/geronb/62.2.S120

Fox-Grage, W., Ujvari, K., & AARP Public Policy Institute (Eds.). (2014). *Insight on the Issues*, (92). Retrieved from http://www.aarp.org/health/health-care-reform/info-2014/the-older-americans-act-AARP-ppi-health.html

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health, 25*(10), 1229-1245. doi:10.1080/08870440903194015

Freund, A. M., & Baltes, P. B. (1998). Selection, optimization, and compensation as strategies of life management: Correlations with subjective indicators of successful aging. *Psychology and Aging, 13*(4), 531-543. Retrieved from http://psycnet.apa.org/journals/pag/13/4/

Freund, A. M., & Baltes, P. B. (2002). Life-Management strategies of selection, optimization, and compensation: Measurement by self-report and construct validity. *Journal of Personality and Social Psychology, 82*(4), 642-662. doi:10.1037/0022-3514.82.4.642

Friese, S. (2012). *Qualitative data analysis with ATLAS.ti*. Thousand Oaks, CA.: Sage.

Fugate, M., Kinicki, A. J., & Ashforth, B. E. (2004). Employability: A psychosocial construct, its dimensions, and applicaitons. *Journal of Vocational Behavior, 65*(1), 14-38. doi:10.1016/j.jvb.2003.10.005

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology, 28*(2), 235-260. doi:10.1163/156916297X00103

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA.: Duquesne University Press.

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology, 43*(1), 3-12. doi:10.1163/156916212X632934

Giorgi, B. (2005). Reflections on therapeutic practice guided by a Husserlian perspective. *Journal of Phenomenological Psychology, 36*(2), 141-194. doi:10.1163/156916205774651069

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing Company.

Golant, S. M. (2008a). Commentary: Irrational exuberance for the aging in place of vulnerable low-income older homeowners. *Journal of Aging & Social Policy, 20*(4), 379-397. doi:10.1080/08959420802131437

Golant, S. M. (2008b). Low-income elderly homeowners in very old dwelling: The need for public policy debate. *Journal of Aging & Social Policy, 20*(1), 1-28. doi:10.1300/J031v20n01_01

Golant, S. M. (2011). The changing residential environments of older people. In R. H. Binstock & L. K. George (Eds.), *Handbook of aging and the social sciences* (7th ed., pp. 207-220). Gainesville, FL.: University of Florida. doi:10.1016/B978-0-12-380880-6.00015-0

Gustman, A. L., Steinmeier, T. L., & Tabatabai, N. (2009). *What the stock market decline means for the financial security and retirement choices of the near-retirement population* (Working Paper No. 15435). Cambridge, MA.: National Bureau of Economic Research.

Hallberg, L. (2008). Some thoughts about interviewing.... [Editorial]. *International Journal of Qualitative Studies on Health and Well-being, 3*, 130-131. doi:10.1080/17482620802303111

Hallrup, L. B., Albertsson, D., Tops, A. B., Dahlberg, K., & Grahn, B. (2009). Elderly women's experiences of living with fall risk in a fragile body: A reflective lifeworld approach. *Health and Social Care in the Community, 17*(4), 379-387. doi:10.1111/j.1365-2524.2008.00836.x

Helman, R., Mathew Greenwald & Associates, Adams, N., Copeland, C., & VanDerhei, J. (Eds.). (2013). *The 2013 retirement confidence survey: Perceived savings needs outpace reality for many*, (384). Retrieved from http://www.pacificlife.com/crp/public/chart_your_course/retirement_planning/EBRI_IB_0313No384RCS1.pdf

Hendrick, C., Wells, K. S., & Faletti, M. V. (1982). Social and emotional effects of geographical relocation on elderly retirees. *Journal of Personality & Social Psychology, 42*(5), 951-962. doi:10.1037/0022-3514.42.5.951

Howden, L. M., & Meyer, J. A. (2011). *Age and sex composition: 2010* (2010 Census Briefs No. C2010BR-03). Retrieved from United States Census Bureau website: http://2010.census.gov/2010census/data

Hurd, M. D., & Rohwedder, S. (2010). *Effects of the financial crisis and great recession on American households* (Working Paper No. 16407). Cambridge, MA: National Bureau of Economic Research.

Johansson, K., Josephsson, S., & Lilja, M. (2009). Creating possiblities for action in the presence of environmental barriers in the process of ageing in place. *Aging & Society, 29*(1), 49-70. doi:10.1017/S0144686X08007538

Johansson, K., Lilja, M., Petersson, I., & Borell, L. (2007). Performance of activities of daily living in a sample of applicants for home modification services. *Scandinavian Journal of Occupational Therapy, 14*, 44-53. doi:10.1080/11038120601094997

Johnson, R. W. (2013). *Retirement income challenges in the twenty-first century*. Retrieved from The Urban Institute website: http://www.urban.org/UploadedPDF/904604-Retirement-Income-Challenges-in-the-Twenty-First-Century.pdf

Karamcheva, N. (2013). *Is household debt growing for older Americans?* [Fact Sheet]. Retrieved January 26, 2014, from Urban Institute website: http://www.urban.org/publications/412742.html

Kaup, M. M. (2009). Life-span housing for aging in place: Addressing the home as an integrated part of the solution to long-term care in America. *Seniors Housing & Care Journal, 17*(1), 101-113.

Keenan, T. A. (2010). *Home and community preferences of the 45+ population*. Retrieved from AARP website: http://assets.aarp.org/rgcenter/general/home-

community-services-10.pdf

Kemper, P., Weaver, F., Short, P. F., Shea, D., & Kang, H. (2008). Meeting the need for personal care among the elderly: Does medicaid home care spending matter? *Health Research and Educational Trust, 43*(1), 344-362. doi:10.1111/j.1475-6773.2007.00762.x

Kerz, M., Teufel, J., & Dinman, M. (2013). OASIS: A community-based model for successful aging. *Ageing International, 38*(2), 122-136. doi:10.1007/s12126-012-9170-3

Klumb, P. L., & Baltes, M. M. (2004). Adverse life events in late life: Their manifestation and management in daily life. *International Journal of Stress Management, 11*(1), 3-20. doi:10.1037/1072-5245.11.1.3

Kolb, P. J. (2004). Theories of aging and social work practice with sensitivity to diversity: Are there useful theories? *Journal of Human Behavior in the Social Environment, 9*(4), 2-24. doi:10.1300/J137v09n04_01

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural factors influencing the mental health of Asian Amiercans. *Western Journal of Medicine, 176*(4), 227-231. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071736/

Kruse, R. L., Moore, C. M., Tofle, R. B., LeMaster, J. W., Aud, M., Hicks, L. L., . . . Mehr, D. R. (2010). Older adults' attitudes toward home modifications for fall prevention. *Journal of Housing for the Elderly, 24*, 110-129. doi:10.1080/02763891003757031

Lawton, M. P. (1980). *Environment and aging*. CA.: Brooks/Cole Publishing Company.

Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), *Psychology of adult development and aging* (pp. 619-674). Washington D.C.: American Psychological Association. doi:10.1037/10044-020

Li, K. Z., Lindenberger, U., Freund, A. M., & Baltes, P. B. (2001). Walking while memorizing: Age-related differences in compensatory behavior. *American Psychological Society, 12*(3), 230-237.

Li, S., Aggen, S. H., Nesselroade, J. R., & Baltes, P. B. (2001). Short-term fluctuations in elderly people's sensorimotor functioning predict text and spatial memory performance: The MacArthur successful aging studies. *Gerontology, 47*, 100-116. doi:10.1159/000052782

Love, J. (2010). *Approaching 65: A survey of baby boomers turning 65 years old*. Retrieved from AARP website: http://assets.aarp.org/rgcenter/general/approaching-65.pdf

Mace, R. (2008). *About UD* [Definition of universal design]. Retrieved from The Center for Universal Design, College of Design, North Carolina State University website: http://www.ncsu.edu

Maisel, J. L., Smith, E., & Steinfeld, E. (2008). *Increasing home access: Designing for visitability*. Retrieved from AARP Public Policy Institute website: http://assets.aarp.org/rgcenter/il/2008_14_access.pdf

Malonebeach, E. E., & Langeland, K. L. (2011). Boomers' prospective needs for senior centers and related services: A survey of persons 50-59. *Journal of Gerontological Social Work, 54*, 116-130. doi:10.1080/01634372.2010.524283

Mason, M. (2010). Same size and saturation in PhD studies using qualitative interviews. *Qualitative Social Research, 11*(3), 1-19.

Mathison, S. (1988). Why triangulate? *Educational Researcher, 17*(2), 13-17. doi:10.3102/0013189X017002013

Meschede, T., Cronin, M., Sullivan, L., & Shapiro, T. (Eds.). (2011). *Rising Economic Insecurity Among Senior Single Women*. Retrieved from http://iasp.brandeis.edu/pdfs/2011/LLOL6.pdf

Meschede, T., Sullivan, L., & Shapiro, T. (Eds.). (2011). *From Bad to Worse: Senior Economic Insecurity on the Rise*. Retrieved from http://iasp.brandeis.edu/pdfs/2011/LLOL4.pdf

MetLife Mature Market Institute. (2012). *Transitioning into retirement*. Retrieved from https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-transitioning-retirement.pdf

Mihailidis, A., Cockburn, A., Longley, C., & Boger, J. (2008). The acceptability of home monitoring technology among community-dwelling older adults and baby boomers. *Assistive Technology, 20*(1), 1-12. doi:10.1080/10400435.2008.10131927

Miller, C., Olson, M. A., & Garner, S. G. (2007). Attitudes of interior design students: Concepts associated with aging in place. *Journal of Family and Consumer Sciences, 99*(3), 49-54.

Minhat, H. S., Rahmah, M. A., & Khadijah, S. S. (2013). Continuity theory of ageing and leisure participation among elderly attending selected health clinics in Selangor.

International Medical Journal Malaysia, 12(2), 51-58.

Mohamed, M. (2012). Ergonomics of bridge employment. *Work: A Journal of Prevention, Assessment, and Rehabilitation, 41*, 307-312. doi:10.3233/WOR-2012-0174-307

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5. doi:10.1177/104973200129118183

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA.: Sage.

Neal, A. (2007). Elder care: Aging in place. *Saturday Evening Post, 279*(4), 56-60.

Nimrod, G., & Kleiber, D. A. (2007). Reconsidering change and continuity in later life: Toward an innovation theory of successful aging. *The International Journal of Aging and Human Development, 65*(1), 1-22. doi:10.2190/Q4G5-7176-51Q2-3754

Nunn, T. L., Sweaney, A. L., Cude, B. J., & Hathcote, J. M. (2009). Consumer receptiveness to universal design features. *International Journal of Consumer Studies, 33*, 11-19. doi:10.1111/j.1470-6431.2008.00723.x

Nygren, C., Oswald, F., Iwarsson, S., Fange, A., Sixsmith, J., Schilling, O., . . . Wahl, H. W. (2007). Relationships between objective and perceived housing in very old age. *The Gerontologist, 47*(1), 85-95. doi:10.1093/geront/47.1.85

Oldman, J. (2008). Future housing plans and funding for the care of older people. *British Journal of Community Nursing, 13*(6), 280-283.

Onolemhemhen, D. N. (2009). Meeting the challenges of urban aging: Narratives of poor elderly women of Detroit, Michigan. *Journal of Gerontological Social Work, 52*,

729-743. doi:10.1080/01634370902914794

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. *Forum: Qualitative Social Research, 7*(4). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/175

O'Shaughnessy, C. V. (2008). *The aging services network: Accomplishments and challenges in serving a growing elderly population*. Retrieved from National Health Policy Forum website: http://www.nhpf.org/library/details.cfm/2625

O'Shaughnessy, C. V. (2010). *Aging and disability resource centers (ADRCs): Federal and state efforts to guide consumers through the long-term services and supports maze* (Background Paper No. 81). Retrieved from National Health Policy Forum website: http://www.nhpf.org/library/background-papers/BP81_ADRCs_11-19-10.pdf

O'Shaughnessy, C. V. (2011). *The ages services network: Serving a vulnerable and growing elderly population in tough economic times* (Background Paper No. 83). Retrieved from National Health Policy Forum website: http://www.nhpf.org/library/background-papers/BP83_AgingServices_12-13-11.pdf

O'Shaughnessy, C. V. (2014). Serving seniors through the Older Americans Act of 1965. In *Testimony* (pp. 1-6). Retrieved from http://edworkforce.house.gov/calendar/eventsingle.aspx?EventID=369501

Oswald, F., Wahl, H. W., Schilling, O., & Iwarsson, S. (2007). Housing-related control beliefs and independence in activities of daily living in very old age.

Scandinavian Journal of Occupational Therapy, 14, 33-43. doi:10.1080/11038120601151615

Pande, A., Laditka, S. B., Laditka, J. N., & Davis, D. R. (2007). Aging in place? Evidence that a state medicaid waiver program helps frail older persons avoid institutionalization. *Home Health Care Services Quarterly, 26*(3), 39-60. doi:10.1300/J027v26n03_03

Pappas, J., Sink, V., & Jamison, D. (2014). *Survey shows older Americans' health engagement, outlook on life improve* [News Brief]. Retrieved from National Council on Aging website: http://www.ncoa.org/press-room/press-release/older-americans-report-better-health-engagement-outlook.html

Peterson, C. L., & Murphy, G. (2010). Transition from the labor market: Older workers and retirement. *International Journal of Health Services, 40*(4), 609-627. doi:10.2190/HS.40.4.c

Petersson, I., Kottorp, A., Bergstrom, J., & Lilja, M. (2009). Longitudinal changes in everyday life after home modifications for people aging with disabilities. *Scandinavian Journal of Occupational Therapy, 16*, 78-87. doi:10.1080/11038120802409747

Pope, N. D., & Kang, B. (2010). Residential relocation in later life: A comparison of proactive and reactive moves. *Journal of Housing for the Elderly, 24*, 193-207. doi:10.1080/02763891003757122

Potter, J. F. (2010). Aging in America: essential considerations in shaping senior care policy. *Aging Health, 6*(3), 289-299. doi:10.2217/AHE.10.25

Poulos, S., & Nightingdale, D. S. (1997). *The aging baby boom: Implications for employment and training programs*. Retrieved from Urban Institute website: http://wdr.doleta.gov/research/FullText_Documents/97-aging.pdf

Powell, L. H., & Cassidy, D. (2007). *Family life education: Working with families across the life span* (2nd ed.). Long Grove, IL.: Waveland Press. (Original work published 2001)

Pynoos, J. (1993). Strategies for home modification and repair. In J. Callahan (Ed.), *Aging in place* (pp. 29-38). Amityville, NY: Baywood.

Pynoos, J., Caraviello, R., & Cicero, C. (2009). Lifelong housing: The anchor in aging-friendly communities. *Journal of the American Society on Aging, 33*(2), 26-32. Retrieved from www.cinahl.com/cgi-bin/refsvc?jid=729&accno=2010463008

Quinn, J. (2002). Changing retirement trends and their impact on elderly entitlement program. In S. Altman & D. Schactman (Eds.), *Policies of an aging society* (p. 295). Baltimore, MD: The John Hopkins University Press.

Regnier, V., & Denton, A. (2009). Ten new and emerging trends in residential group living environments. *NeuroRehabilitation, 25*, 169-188. doi:10.3233/NRE-2009-0514

Reno, V. P., & Veghte, B. (2011). Economic status of the aged in the U.S. In R. H. Binstock & L. K. George (Eds.), *Handbook of aging and the social services* (7th ed., pp. 175-191). Washington, D.C.: National Academy of Social Insurance. doi:10.1016/B978-0-12-380880-6.00013-7

Rioux, L., & Werner, C. (2011). Residential satisfaction among aging people living in

place. *Journal of Environmental Psychology, 31*(2), 158-169. doi:10.1016/j.jenvp.2010.12.001

Rosenberg, E., Jullamate, P., & Azeredo, Z. (2009). Informal caregiving: Cross-cultural applicability of the person-environment model. *Health Sociology Review, 18*(4), 399-411. Retrieved from http://www.cinahl.com/cgi-bin/refsvc?jid=2671&accno=2010601456

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *Gerontologist, 37*(4), 433-440. doi:10.1093/geront/37.4.433

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). doi:10.4135/9781452226651

Saldana, J. (2012). *The coding manual for qualitative researchers*. Thousand Oaks, CA.: Sage. (Original work published 2009)

Schuman, H., & Scott, J. (1989). Generations and collective memories. *American Sociological Review, 54*(3), 359-381. doi:10.2307/2095611

Shah, S. K., & Corley, K. G. (2006). Building better theory by bridging the quantitative-qualitative divide. *Journal of Management Studies, 43*(8), 1821-1835. doi:10.1111/j.1467-6486.2006.00662.x

Shapiro, M. D. (2010). *The effects of the financial crisis on the well-being of older Americans: Evidence from the cognitive economics study* (Working Paper No. WP 2010-228). Ann Arbor, MI: University of Michigan, Retirement Research Center.

Shultz, K. S., & Wang, M. (2011). Psychological perspectives on the changing nature of

retirement. *American Psychologist, 66*(3), 170-179. doi:10.1037/a0022411

Singer, T., Verhaeghen, P., Ghisletta, P., Lindenberger, U., & Baltes, P. B. (2003). The fate of cognition in very old age: Six-year longitudinal findings in the Berlin aging study (BASE). *Psychology and Aging, 18*(2), 318-331. doi:10.1037/0882-7974.18.2.318

Skoog, I. (2011). Psychiatric disorders in the elderly. *The Canadian Journal of Psychiatry, 56*(7), 387-397.

Smith, C., Tingle, H., & Twiss, J. (2010). Aging populations. *Public Management, 92*(4), 14-19. Retrieved from http://webapps.icma.org/pm/9204/public/feature1.cfm?author=Henry%20Tingle%20and%20Clare%20Smith%20and%20Joan%20Twiss&title=Aging%20Populations&subtitle=

Stafford, P. B. (2009). *Elderburbia*. Santa Barbara, CA.: ABC-CLIO.

Stark, S., Landsbaum, A., Palmer, J. L., Somerville, E. K., & Morris, J. C. (2009). Client-centred home modifications improve daily activity performance of older adults. *Canadian Journal of Occupational Therapy, 76*, 235-245.

Stineman, M. G., Xie, D., Pan, Q., Kurichi, J. E., Saliba, D., & Streim, J. (2011). Activity of daily living staging, chronic health conditions, and perceived lack of home accessibility features for elderly people living in the community. *Journal of the American Geriatrics Society, 59*(3), 454-462. doi:10.1111/j.1532-5415.2010.03287x

Tang, F., & Lee, Y. (2010). Home and community-based services utilization and aging in

place. *Home Health Care Services Quarterly, 29*(3), 138 - 154. doi:10.1080/01621424.2010.511518

Tanner, B., Tilse, C., & Jonge, D. D. (2008). Restoring and sustaining home: The impact of home modifications on the meaning of home for older people. *Journal of Housing for the Elderly, 22*(3), 195-215. doi:10.1080/02763890802232048

Taylor, P., Morin, R., Parker, K., Cohn, D., & Wang, W. (2009). *Growing old in America: Expectations vs. reality*. Retrieved from Pew Research Center website: http://www.pewsocialtrends.org/2009/06/29/growing-old-in-america-expectations-vs-reality/

Tenenbaum, L. (2010). *Aging in place 2.0*. Retrieved from MetLife Mature Market Institute website: http://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-aging-place-study.pdf

The Florida Department of Elder Affairs. (2009). *Chapter 4: Title III and Title VII of the older Americans act*. Retrieved from http://www.agingflorida.net/resources/Program%20Documents/2009%20DOEA%20Program%20Handbook/Chapter%204%20-%20Title%20III%20and%20Title%20VII%20of%20the%20Older%20Americans%20Act%20(OAA).pdf

The Florida Department of Elder Affairs. (2012). *State plan on aging 2013-2016*. Retrieved from http://elderaffairs.state.fl.us/doea/StatePlan/2013_2016StatePlan.pdf

The Florida Department of Elder Affairs. (2013). *Assessing the needs of elder Floridians*. Retrieved from http://elderaffairs.state.fl.us/doea/pubs/pubs/Assessing_the_Needs_of_Elder_Floridians.pdf

The MetLife Mature Market Institute, & National Association of Home Builders. (2011). *Housing trends update for the 55+ market: New insights from the American housing survey*. Retrieved from http://www.metlife.com/mmi/research/55-housing-trends-update.html?SCOPE=Metlife#findings

Thurmond, V. A. (2001). The point of triangulation. *Journal of Nursing Scholarship, 33*(3), 253-258. doi:10.1111/j.1547-5069.2001.00253.x

Tinker, A., Wright, F., Hanson, J., Mayagoitia, R., Wojgani, H., & Holmans, A. (2008). Remodeling to extra care housing: Some implications for policy and practice. *Quality in Ageing, 9*(1), 4-12. doi:10.1108/14717794200800002

Urban Institute. (2009). *It's not easy being gray: The new rules of retirement* [Brief Series]. Retrieved February 11, 2014, from http://www.urban.org/UploadedPDF/411840_rules_of_retirement.pdf

United States Senate, S. Rep. No. 113-Commission on Long-Term Care Report to the Congress, at 1-138 (2013), http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf.

U.S. Census Bureau. (2010). *2008-2012 American community survey* [Fact Sheet]. Retrieved from

http://factfinder2.census.gov/rest/dnldController/deliver?_ts=407611701753

U.S. Department of Health and Human Services. (2011). *Profile of older Americans: 2010*. Retrieved from Administration on Aging website: http://www.aoa.gov/aoaroot/aging_statistics/Profile/2010/docs/2010profile.pdf

Vasunilashorn, S., Steinman, B. A., Liebig, P. S., & Pynoos, J. (2012). Aging in place: Evolution of a research topic whose time has come. *Journal of Aging Research*, 1-6. doi:10.1155/2012/120952

Vincent, G. K., & Velkoff, V. A. (2010). *The older population in the United States: 2010 to 2050*. Retrieved from United States Census Bureau website: http://www.census.gov/prod/2010pubs/p25-1138.pdf

Von Bonsdorff, M. E., Shultz, K. S., Leskinen, E., & Tansky, J. (2009). The choice between retirement and bridge employment: A continuity theory and life course perspective. *International Journal of Aging & Human Development, 69*(2), 79-100. doi:10.2190/AG.69.2.a

Wang, M. (2007). Profiling retirees in the retirement transition and adjustment process: Examining the longitudinal change patterns of retirees' psychological well-being. *Journal of Applied Psychology, 92*(2), 455-474. doi:10.1037/0021-9010.92.2.455

Wardrip, K. (2010). *Strategies to meet the housing needs of older adults*. Retrieved from AARP Public Policy Institute website: http://assets.aarp.org/rgcenter/ppi/liv-com/i38-strategies.pdf

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177. doi:10.1037/0022-

0167.52.2.167

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of "aging in place" to older people. *The Gerontologist, 52*(3), 357-366. doi:10.1093/geront/gnr098

Young, H. M., Sikma, S. K., Johnson Trippett, L. S., Shannon, J., & Blachly, B. (2006). Linking theory and gerontological nursing practice in senior housing. *Geriatric Nursing, 27*(6), 346-354. doi:10.1016/j.gerinurse.2006.08.014

Zayac, H. M., & Salmon, J. R. (2007). *West central Florida area agency on aging population characteristics and projections for an aging society: 2000-2030*. Retrieved from University of South Florida website: http://www.agingflorida.net/resources/Demographics%20&%20Surveys/[01]%20WCFAAA%20Population%20Characteristics%20&%20Projections%202000-2030.pdf

Zhan, Y., Wang, M., Liu, S., & Shultz, K. S. (2009). Bridge employment and retirees' health: A longitudinal investigation. *Journal of Occupational Health Psychology, 14*(4), 374-389. doi:10.1037/a0015285

Appendix A: Fact Sheet for Senior's Group

In 2010, the population age 65 years and older reached 40.3 million people.

By 2030, all of the baby boomers will have moved into the ranks of the older population. The baby boomer generation represents the largest single population growth in U.S. history at over 76 million people and have had an enormous impact on every institution in the country.

In 2010, the percentage of adults 65 years of age and older was 13 %. In Florida, the percentage was 17.8% and it is projected to rise to 24.7 by 2025.

People 65 and older represent 21.6% of the population in Palm Beach County. The city of Boynton Beach alone consists of 68,217 residents. Out of the 68,217 residents, 21.4% are 65 and older, 17.9% of the households are owned by people age 65 and older, 36.3% of the households have at least one member age 65 and older, and 36.2% of residents age 65 and older have a disability (U.S. Census Bureau, 2010).

What does this mean to you?

My presentation will address why this information should be important to you and how you can impact change for the future.

What am I trying to accomplish?

I am working on my research for my Ph.D and would like to share the information I have with your group and hopefully recruit 6-12 volunteers who would be interested in participating in my research project. The only requirement is that you have to be 65 years of age or older and live in Boynton Beach and live with in your own home or with family.

Appendix B: Invitation to Participate/Informed Consent Form

You are invited to take part in a research study pertaining to people's "lived experiences" with regards to "aging in place" (living in one's home versus moving to an institution). The researcher is inviting men and women ages 65 and older who live in Boynton Beach, FL. to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Magaly "Maggie" Dante, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to examine the relationship between people and their environment by collecting their perspectives and experiences. The intent is to determine if there is a relationship between a person's perceptions and their current living situation and how it impacts their decision making. The information provided by participants will help educate them on the concept of aging in place but more importantly increase their knowledge so they may make informed decisions about their future.

Procedures:

If you agree to be in this study, you will be asked to:

- Go over information about the study and sign this informed consent form.
- Complete a screening questionnaire (Not all people who complete the screening questionnaire may be interviewed. You will be contacted within 5 business days of submitting it and told whether or not you have been selected for interviewing.
- Complete an in-depth interview of 60-90 minutes that will be audio-recorded.
- Review the interview transcript to check for accuracy.
- Review the study report to verify the findings and interpretations.
- Provide your feedback on the research process via interview.

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. If you feel stressed during the study you may stop at any time. You may skip any questions you feel are too personal. If you decide to join the study now, you can still change your mind later.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as emotional stress. Being in this study would not pose risk to your safety or wellbeing.

Benefits that participants may receive include the opportunity to learn more about the concept of aging in place which may lead to making more effective informed decisions regarding their futures.

Payment:

There will be no fianancial compensation for participation in this project.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by a password-protected computer database file that only Maggie will have access to. A pseudonym will be used in place of your real name in the final report. No one will have access to your information except for Maggie, and nothing that could identify you will be included in the report of the study. You will be able to see the report before it is submitted. Data will be kept for a period of at least 5 years (on a password protected flash drive), as required by the university.

If a transcriber is hired, he/she signs a form agreeing to strict confidentiality. Only I, and the transcriber, have access to tapes and transcripts.

Contacts and Questions:

You may ask any questions you have now. If you have questions later, you may contact the researcher via cell phone. Walden University's approval number for this study is **09-12-14-0039992** and it expires on **September 11, 2015**.

The researcher will give you a copy of this form to keep (for face-to-face research).

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix C: Demographics Survey

1) Gender Female Male

2) Age (in years) _____

3) Marital Status

Married or living with partner
Separated
Divorced
Single/Never Married
Other (explain) _____

4) Ethnic background

White, non-Hispanic
Asian
Latino/Hispanic
American Indian
Black or African American
Native Hawaiian or other Pacific Islander
Other (explain _____)

5) What is the highest degree or level or schooling you have completed

8th grade or less
Some high school (no diploma or GED)
High school graduate or equivalent (GED)
Some college (no degree)
Associate degree
Bachelor's degree
Master's degree
Professional degree (e.g., MD, DDS, JD)
Doctorate degree

6) Which best describes your current employment status

Employed for pay, full-time
Employed for pay, part-time

Volunteer work full or part-time
Retired
Homemaker
Unemployed
Other _____

7) Please choose the one that best describes your current household composition/family structure

Living alone
Single parent
Married or partnered living with children
Married or partnered living with no children
Multi-generational (more than two generations living under the roof)
Other _____

8) What is your before-tax yearly household income (including all sources)?

Under $15,000
$15,000 to $25,000
$25,001 to $35,000
$35,001 to $50,000
$50,001 to $75,000
$75,001 to $125,000
$125,001 or more

Appendix D: Interview Guide

Interview: Part 1 – Study Goals and Background

The goals of the first part of the interview are threefold: to establish a researcher/participant relationship, to clarify research goals, and to gather information about the individual's history, and aspects of their physical and social environments. The researcher will introduce herself and explain the goals of the research. Time will be allowed for questions and answers. Interviewees will be asked to state their name, address, age, and date of birth.

Interview: Part 2 –

The goals of the second part of the interview are to obtain additional personal information. They will be asked to describe their current home in terms of size, number of rooms, and need for modifications. They will be asked to provide more information about health status, how they receive assistance if they need it, and whether their needs are being met. People will be asked about their plans for the future: If they plan to stay in their current residences, or move somewhere else? What are the reasons why they would stay? What are the reasons they would move? What are the factors that will influence their decision to stay or move? What helps them stay? What hinders them froms staying? Do they still feel as if they belong? If yes, why? If no, why not?

Closure and Thank you:

The researcher will assess the participant's interest in this project.

Would you like to be kept informed about the progress of and learning from the study?

What would be the best way to do this?

The researcher will acknowledge the participant's contribution, offering thanks and appreciation.

Appendix E: Interview Format

Building rapport questions

1. I would like to get to know you better. Tell me a little about yourself and your family.
2. Are you working, volunteering, retired?
3. What kinds of social activities have you done recently? What do you enjoy doing leisurely?
4. What is your routine during the day? Tell me about what you do around the house. Start with the morning.

General health, sensory, & communication section

1. How would you rate your overall health at this time?
2. How often are there things you want to do but cannot because of physical problems? (R_2)
3. Do you have concerns of falling in your home? Have you ever experienced a fall before?
4. When you need medical care, how often do you get it?
5. Do you drive a car or other motor vehicle?
6. How often do finances/insurance allow you to obtain health care and medications when you need them? (R_2)
7. Are you usually able to climb two or three stair steps?
8. Has a doctor told you that you currently have vision problems?
9. Has a doctor told you that you currently have hearing problems?

Continuity theory questions

1. Tell me about your childhood and where you grew up?
2. Did you grow up in a home similar to your current house?
3. Tell me about your home.
4. Do you anticipate any problems that may inhibit your ability to remain in your home? (R_2)
5. Has your home been an important place for you over the years? If so, can you share examples?
6. As you continue to age, would you prefer to stay here in your own home or move to another setting?
7. If you end up having to move from your home, what possible circumstances would most likely prompt such a move? (R_2)
8. What would you miss most about your home?
9. What would you miss least about your home?
10. What do you enjoy the most in your day?

11. What you do dislike the most in your day?
12. What hobbies and interests do you have now?
13. Do you have someone or multiple people that check on you or help you on a regular basis? If yes, how do you feel about needing their help?
14. Is this paid help or unpaid help?
15. What types of things do they help with?
16. Do you think it would be easier to hire help rather than utilize family?
17. Do you feel dependent on others to this point in your life?
18. If you could have any type of help, what would that look like for you?
19. What are the qualities that make you feel comfortable in or attached to your home?
20. Since you have been in your home, have you made any modifications to your home? If so, what were they? And were any of them to make your home easier or more comfortable to live in? (R_3)
21. I have a list of some common modifications. Let me know if you have considered adding any of these modifications to your home or if you have made some of these modifications. Please explain why the modifications were made, if any. (R_3)

    a. Ramps
    b. Handrails
    c. Bath Bars
    d. A call device or emergency response system
    e. Wheelchair access
    f. Widened doorways
    g. Added brighter lighting
    h. Removed throw rugs
    i. Changed/added level faucets in the place of knobs
    j. Replaced door knobs with levers
    k. Changed kitchen cabinet hardware
    l. Enlarged identification icons on things such as a stove or telephone
    m. Installed non-slip surfaces
    n. Purchased a shower seat, hand held shower or a raised toilet seat
    o. Remodeled a bath or kitchen
    p. Others
22. If you could redesign your home to accommodate your current needs and desires, how would you do that? (R_3)

Exit Interview

1. What are you looking forward to in the future? (R_3)
2. Would you like to be kept informed about the progress of and learning from the study?
3. What would be the best way to do this?