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SGS SOUTHERN GERONTOLOGICAL SOCIETY

Journal of Applied Gerontology
1–9

DOI: 10.1177/0733464819879015
journals.sagepub.com/home/jag
SAGE

Moving to a Continuing Care Retirement Community or Staying in the Community? A Comparison Between American and Israeli Older Adults

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Abstract

Using the theory of diffusion of innovations, this study examined differences between American and Israeli older adults who decided to move to continuing care retirement communities (CCRC) and American and Israeli older adults who decided to stay at home. A total of 101 American participants (52 residents, 49 nonresidents) and 154 Israeli participants (104 residents, 50 nonresidents) completed measures of attitudes toward CCRCs, well-being, limitations in daily living, health status, proximity to services, and collectivism. Americans were more likely to relocate to CCRCs compared with staying at home when they reported positive attitudes toward CCRCs, higher well-being, and poorer subjective health. Among Israelis, positive attitudes toward CCRCs, better subjective health, and higher collectivism were associated with moving to CCRCs compared with staying at home. This study has implications for facilitating older adults' decision-making and CCRC policies, as findings point to potential sources of influence on older adults' decision to relocate.

Keywords

continuing care retirement communities, community, diffusion of innovation, United States, Israel, cross-national, long-term care

Introduction

Continuing care retirement communities (CCRC) represent a living arrangement designed to allow independent older adults to age in place in the event that they lose their independence and require more intensive care (Denham, 2018). This living arrangement is usually available to older adults who are independent in their activities of daily living (ADL), at least upon entering the CCRC (Denham, 2018). This long-term care setting is designed to allow older adults to experience maximum independence, while meeting increasing needs for assistance and support (Doron & Lightman, 2003) that commonly arise from deterioration of physical and cognitive functioning (Smith, Walter, Miao, Boscardin, & Covinsky, 2013). As such, many CCRCs have assisted living units and nursing care units available for older adults with physical and cognitive impairments. CCRCs offer 24-hr health care and security services, social and recreational activities, attractive dining options, housekeeping, and wellness and fitness programs to their residents (Shinan-Altman & Ayalon, 2018). In CCRCs, residents are required to pay a monthly fee, similar to a rental payment, that is based on the type of unit in which they live. In addition, residents pay an up-front fee, which is either structured as a deposit or as an entrance fee (Peterman & Sickelka, 2010).

In the United States, the number of CCRCs has increased from 700 in 1986, to approximately 1,900 in 2010 (Hermann, Brod, & Giradi, 2009), with a typical CCRC having fewer than 300 total units (Zarem, 2010). There are no official statistics regarding the percentage of the American population aged 65 or older who live in CCRCs. In Israel, between 1990 and 2013, the number of CCRCs increased by 160%, and the number of units more than tripled (Brodsky, Shnoor, & Be'er, 2017). About 2% of Israelis 65 years and older

Manuscript received: April 6, 2019; **final revision received:** August 31, 2019; **accepted:** September 4, 2019.

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reside in CCRCs (Kane, 2019). Hence, despite its growing popularity, the majority of older adults in both the United States and Israel still live in the community (Brodsky et al., 2017; Denham, 2018).

Choosing between staying at home or moving to a CCRC represents a complex decision for older adults. Overall, the characteristics of late-life moves depend on the life course event or events motivating relocation. For example, retirement may create the opportunity for an amenity-seeking move, whereas severe disability often motivates a movement into a long-term care institution (Bradley, 2011; Litwak & Longino, 1987). According to the person-environmental fit theory (Lawton, Lawton, Windley, & Byerts, 1982), the decision to relocate is associated with the extent to which older adults perceive their surroundings as appropriate for their needs. Indeed, different predictors of relocation to CCRCs have been identified in the literature. Concerns regarding current and future health status and anticipation of future care needs appear to be major determinants of CCRC relocation (Erickson & Krout, 2012). Other common reasons for moving are the desire to have social interactions, personal safety and security, availability of medical services, freedom from maintenance of one's residence, and a wish to reduce uncertainty concerning future care needs (Bowblis & McHone, 2013; Erickson & Krout, 2012; Hollinger-Smith, Brod, Brecht, & Leary, 2012; Marx, Burke, Gaines, Resnick, & Parrish, 2011). However, the main reasons older adults decide not to move to a CCRC include attachment to place, stigma associated with older adult-specific dwellings (Erickson & Krout, 2012), high costs, and the need to adjust to a smaller housing unit (Green & Ayalon, 2019). The source of information provided about the CCRC may play a significant role in the decision to relocate to a CCRC; for example, a recent study found that, when information provided about the CCRC was derived primarily from one's spouse or children, the odds of actually relocating were significantly higher than when the information about the CCRC came from friends or nonhuman sources, such as advertisements (Ayalon & Gum, 2019).

The few studies that compared CCRC residents with community dwellers indicate a higher rate of medical conditions and significant health care use for individuals living in CCRCs (Grabowski, Caudry, Dean, & Stevenson, 2015). Existing research also suggests that CCRC residents enjoy a wider array of social contacts and social activities than community residents (Ayalon, 2018; Cutchin, Marshall, & Aldrich, 2010). It was also found that personal relationships within the CCRC create opportunities for social support, which in turn may promote residents' well-being (Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014). Yet, a qualitative study of 29 CCRC residents and 19 adult children concluded that, although CCRCs help to alleviate the social loneliness (i.e., lack of social ties) experienced by older adults, they are less successful in alleviating emotional loneliness (i.e., lack of intimate relations) (Ayalon & Green, 2012). Although informative, these pioneering studies (Grabowski et al., 2015; Winstead et al., 2014) tended to focus primarily on individual-level factors associated with the decision to transition into a CCRC, such as perceived health status. Overall, most research has involved small-scale studies within single CCRCs that have not considered the social and cultural influences on decision-making as well as the individual influences. To fill this gap in the literature, there is a need to compare individuals across different residential settings (CCRC vs. community dwelling) and different cultures (e.g., United States vs. Israel). Therefore, the aim of the current study was to examine differences between American and Israeli older adults who decided to move to a CCRC and American and Israeli older adults who decided to stay in the community.

The present study relied on the diffusion of innovation theory to explore the relocation decision into CCRCs (Rogers, 1962). The theory of diffusion of innovations (DOI; Rogers, 1962) refers to the spread of abstract ideas and practices within a social system, in which the spread denotes flow or movement from a source to an adopter/actor (i.e., the deciding person), typically via communication and influence. Several different branches of DOI have been developed (Wejnert, 2002), although Rogers's theory (Rogers, 1962) remains one of the most influential. According to Rogers (1962), innovations spread in society through an S curve, as initially only a selected few adopt the innovation, the "early adopters," followed by a larger group of early majority, late majority, and laggards. DOI occurs over time in six stages: (a) awareness of the innovation, (b) knowledge of the innovation, (c) attitudes toward the innovation, (d) decision to adopt or reject, (e) implementation of the new idea, and (f) confirmation of the decision (Rogers, 2003). In the present study, we focus on the factors that correlate with a decision to adopt or reject the innovation.

Wejnert (2002) synthesized literature across multiple disciplines to identify three categories of characteristics that influence DOI. The first category includes characteristics of the adopter/actor such as socioeconomic status, well-being, and attitudes toward the innovation. For example, in the case of deciding whether to move to a CCRC, age, gender, education, health status, and functional status have been found to relate to the decision to move (Bekhet, Zauszniewski, & Nakhla, 2009). The second category includes characteristics of the innovation (i.e., the CCRC), such as proximity to services and amenities (e.g., health, leisure, financial, religious, food). The third set of characteristics includes the environmental context. For example, moving to a CCRC may be more likely for older adults whose culture (i.e., values, norms, family ties) is consistent with CCRCs.

Both Unites States and Israel are considered Western societies, but Israel is considered a more familistic society, characterized by strong and close family ties (Clarfield et al., 2018). When comparing countries on degree of collectivism versus individualism, evidence suggests that United States is one of the most individualistic countries

(Triandis, 2018), as Americans tend to prioritize individual goals and self-reliance over societal goals (Oyserman, Coon, & Kemmelmeier, 2002). Israel, however, has a strong tradition of social welfare and is characterized as more collectivist in nature (Clarfield et al., 2018), suggesting that Israelis tend to emphasize group interests and values that, in turn, influence individuals' decisions and behaviors (Lee & Wohn, 2012). Hence, the present study allows for evaluating the relationships of these sociocultural differences in relation to the decision to move to a CCRC.

The CCRC industry is growing rapidly in the United States and Israel, although there are very few regulations in either country to ensure that older adults' rights are protected during the decision-making process. Past studies provide an important foundation, but have not included socio-cultural variables and comparisons across cultures. The current study addresses these research needs. By examining diffusion of innovation across cultures, we contribute to the growing body of research in the field. From a public policy point of view, by better understanding factors involved in the decision to move to a CCRC, we can ultimately help the growing older population across different countries and cultures make well-informed decisions to improve their satisfaction and well-being. This study also could inform policies that regulate CCRCs, such as requirements for information that should be provided to help older adults decide about moving and information about how services are delivered in CCRCs to optimize satisfaction and well-being in individualistic and collectivistic societies.

The Present Study

The aim of the current study was to examine differences between American and Israeli older adults who decided to move to a CCRC and American and Israeli older adults who decided to stay in the community. We used main variables that are theoretically related to decision-making according to DOI (Rogers, 1962). We focused on characteristics of the actor as variables associated with entrance into CCRC (attitudes toward the CCRC, well-being, limitations in ADL, instrumental activities of daily living [IADL], objective, and subjective health). Next, we examined the characteristics of the innovation (living arrangement), such as distance from shops and services. Finally, we examined the characteristics of the environment through cross-national comparison of the values of individualism versus collectivism in American and Israeli societies. Figure 1 demonstrates the conceptual model of the current study.

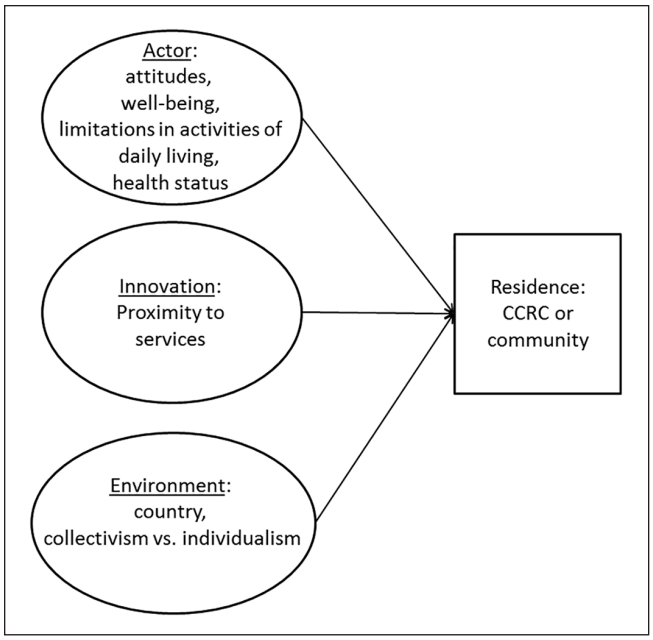

Figure 1. Conceptual model based on diffusion of innovations.
Note. CCRC = continuing care retirement communities.

Method

Recruitment

In both United States and Israel, we approached CCRCs of diverse sociodemographic characteristics (e.g., varied average monthly payment, age range of residents, etc.), in different geographical locations. These characteristics were deemed important based on past research (Ayalon, 2015).

For the American sample, 101 participants (52 residents, 49 nonresidents: those who considered moving into a CCRC but did not follow through) were recruited from 13 CCRCs in multiple cities. Two employees in each CCRC recruited participants, based on standard procedures and scripts. When individuals moved into the CCRC, the employees were trained to invite them to participate; CCRC residents were eligible to participate if they spoke English and had moved into the CCRC within 3 months or less. Staff also invited all individuals who visited the CCRC but chose not to move in to participate in the study; these individuals comprised the nonresident group. Potential participants gave the employees verbal permission to share their name and telephone number with the research team. The employees did not record information about individuals who were invited to participate but refused.

For the Israeli sample, 154 participants (104 residents, 50 nonresidents) were recruited from 19 CCRCs. CCRCs provided information about new residents who moved into the setting within the past 3 months. These individuals were contacted by research assistants and were invited to participate in the study. CCRCs also provided the research team with lists of individuals who were interested in the setting, but did not relocate. These individuals also were contacted by the research team and were invited to participate in the study at a time and place of their choosing.

For both American and Israeli samples, informed consent was administered, and interviews were conducted by telephone with social science students who were trained by the

lead researchers to conduct the interviews. The interviewers read an informed consent script, and participants provided verbal consent. The interviewer then completed the interview, reading items and response options in a consistent manner across participants.

All materials and procedures were approved by the University of South Florida Institutional Review Board for the American sample and by the Ethics Committee of the School of Social Work of Bar Ilan University for the Israeli sample.

Measures

All measures have been used extensively with older adults.

Dependent variable. *Living arrangement* (CCRC = 1 vs. the community = 2) was determined based on the reports of the staff members of the CCRC at the time of the interview.

Independent variables

Actor characteristics. *Attitudes toward CCRC* were assessed by a measure that was designed by the researchers based on past studies (Ayalon, 2015; Ayalon & Green, 2012). This measure included a series of nine positive and negative statements regarding CCRCs (e.g., "Continuing care retirement communities are too expensive for most individuals"; "There is no sense of privacy in continuing care retirement communities"). For each statement, participants were asked to indicate whether they agreed (1 = true) or disagreed (0 = false). After reversing three of the items, a sum was calculated. The range of scores was between 0 and 9, with higher scores indicating more positive attitudes toward CCRCs. The internal consistency of the index was low (Cronbach's $\alpha = .56$).

Well-being was assessed by the General Health Questionnaire (GHQ)—a 12-item measure of psychological well-being (Goldberg & Williams, 2000). It included questions about ability to concentrate, amount of strain, and ability to engage in enjoyable activities. Participants were asked to indicate their response on a 4-point Likert-type scale (1 = "much less than usual" to 4 = "much more than usual"). In line with past research (Donath, 2001), an overall index was calculated by averaging all items, with higher scores indicating better well-being. This questionnaire has demonstrated adequate reliability and validity (Goldberg & Williams, 2000). The internal consistency of the index was good (Cronbach's $\alpha = .85$).

Limitations in ADL and IADL. Participants were asked if they can perform six ADLs (showering, dressing, using the restroom, moving from place to place, bladder control, eating) and five IADLs (cooking, cleaning, laundering, shopping, going to the post office or bank) without any assistance (yes = 1/no = 0). The questions were adopted from Katz's (1970) ADL index and Lawton and Brody's (1969) IADL index. The outcome variable was a count of all the ADL and IADL impairments, ranging from 0 to 11 limitations.

Objective health was measured by a list of seven common medical conditions diagnosed by a physician (dementia, arthritis, cancer, diabetes, heart attack, high blood pressure, stroke), which are common in both the United States and Israel (Fisher, Faul, Weir, & Wallace, 2005). For each participant, the number of medical conditions was calculated. The objective health score ranged from 0 to 7, with a higher score indicating more medical conditions (i.e., lower objective health status).

Subjective current health was evaluated by the question, "How would you rate your health?" (Brook et al., 1979). Participants were asked to indicate their level of current subjective health on a 5-point Likert-type scale ranging from 1 ("excellent") to 5 ("very poor"). A higher score reflects poorer subjective health.

Subjective future health was evaluated by the question, "How do you expect your health to be 5 years from now?" This question was based on the original measure of subjective current health (Brook et al., 1979); however, we changed the temporal aspect to the future. Participants were asked to rate their expectations on a 5-point Likert-type scale ranging from 1 ("excellent") to 5 ("very poor"). A higher score indicates poorer future health.

Sociodemographic variables included self-reported gender, age, living status (alone or with a partner), and annual household income.

Innovation characteristic. *Proximity to services and amenities* of the CCRC/home resident was evaluated based on self-report. Participants were asked regarding proximity to 12 services, such as health, leisure, financial, religious, and food, according to difficulty in accessing, ranging from 1 ("very easy") to 5 ("very difficult"). An overall index was calculated by averaging all items, with higher scores representing greater difficulty in access to the services.

Environment context. *Individualism/collectivism* was assessed by the Horizontal and Vertical Individualism and Collectivism Scale (Singelis, Triandis, Bhawuk, & Gelfand, 1995). Participants rated 16 items (e.g., "I like my privacy," and "I am a unique individual") on a 5-point Likert-type scale ranging from 1 ("does not describe me at all") to 5 ("describes me very well"). An overall index was calculated by averaging all items, with higher scores indicating higher collectivism. The internal consistency of the index was low (Cronbach's $\alpha = .41$). This scale has demonstrated adequate reliability and validity in past research (Cozma, 2011).

Statistical Analyses

Descriptive statistics were used to describe participants' characteristics as well as the research variables. To assess differences between American residents, Israeli resident, American nonresidents, and Israeli nonresidents, chi-square analyses were conducted for categorical variables and *F* tests

were conducted for continuous variables. In addition, interaction effects between type of residence (CCRC vs. community) and country (United States vs. Israel) were performed. Finally, two separate logistic regressions analyses were conducted (for the U.S. sample and for the Israeli sample), with living arrangement as the outcome variable. When a significant effect was found, the magnitude of the effect size was estimated using criteria suggested by previous researchers (Chen, Cohen, & Chen, 2010). Essentially, Exp(*B*) with a value between 0 and 1.68 was considered very small, 1.68 and 3.47 was considered small, 3.47 and 6.71 was considered medium, and above 6.71 was considered large.

Results

Participants Characteristics

The characteristics of the four groups of participants (American CCRC residents, Israeli CCRC residents, American nonresidents, Israeli nonresidents) are shown in Table 1. Overall, most of the participants were women, married, or widowed, with CCRC residents being older than nonresidents. In addition, most participants had a high school education or more, and American participants were somewhat more educated than Israeli participants. Most participants described their financial situation as comfortable or better.

Compared with nonresidents, CCRC residents reported better attitudes toward the CCRC, better well-being, more ADL limitations, better subjective future health, easier proximity to services and amenities, and more collectivism.

A cross-country comparison showed differences for every scale, with American participants reporting better attitudes toward the CCRC, better well-being, more ADL limitations, worse objective health, better subjective health, easier proximity to services and amenities, and more individualism.

Interactions between type of residence (CCRC vs. community) and country (United States vs. Israel) were also significant for several variables: American CCRC residents had the highest well-being; Israeli CCRC residents had worse subjective current health and the highest collectivism; Israeli nonresidents had the lowest ADL limitations, the worst subjective future health, and lower proximity to services and amenities. In addition, Israeli CCRC residents reported better subjective future health, whereas Israeli non residents reported worse subjective future health, compared with the American samples.

Logistic Regression Predicting Living Arrangement

Table 2 summarizes the logistic regression results. The American sample was more likely to relocate to a CCRC compared with staying in the community when they reported positive attitudes toward the CCRC, higher well-being, and poorer subjective future health. Among the Israeli sample, positive attitudes toward the CCRC, better subjective future health, and higher collectivism were associated with moving to a CCRC compared with staying in the community.

Discussion

Older adults have much at stake when making a decision to move to a CCRC. Therefore, it is important to understand the factors associated with the decision to move to a CCRC, considering individual as well as sociocultural factors that may influence this last period of life decision. The purpose of the present study was to examine differences between American and Israeli older adults who decided to move to a CCRC and American and Israeli older adults who decided to stay in the community. The present study relied on the DOI theory to explore this relocation decision (Wejnert, 2002). The findings are important because they broaden our theoretical and practical understanding of migration in later adulthood among two different cultures.

In general, movers and non-movers from the United States and Israel were similar to each other, which is not surprising because both groups considered the same housing option, a CCRC. However, we did find that CCRC residents were older than non-CCRC residents, suggesting that older adults postpone the decision to move to a CCRC to advanced age. It might be that the older people get, the more they are concerned about their future needs, leading them to move to a more supportive environment, such as a CCRC.

CCRC residents reported more ADL limitations, better subjective future health, and easier proximity to services and amenities, compared with nonresidents. These findings suggest that, despite their functional limitations, CCRC residents are optimistic about their future health. In other words, CCRC residents may have confidence that the CCRC will address their future health needs. Relying on DOI (Rogers, 1962), these findings point to the significance of assessing individuals' health perceptions. Given that the main reasons for moving to CCRC are future health concerns (Erickson & Krout, 2012), it seems that CCRCs provide a solution for this concern, as CCRC residents feel more confident about their future health needs being met.

The findings indicated that the American sample was more likely to relocate to a CCRC compared with staying in the community when they reported positive attitudes toward CCRC, higher well-being, and poorer subjective future health. The effect sizes for attitudes toward CCRC and well-being were large (Chen et al., 2010), whereas the effect size for subjective future health was medium (Chen et al., 2010). Beyond positive attitudes toward the CCRC and higher well-being, subjective future health, such as concerns about losing physical abilities, is an important factor in the decision to relocate into a CCRC, though potentially of a lesser magnitude (Bekhet et al., 2009; Cutchin et al., 2010). Given that CCRCs allow independent older adults to age in place in the event that they lose their independence and require more intensive levels of care (Denham, 2018), it seems that

Table 1. Characteristics of U.S. Residents, Israeli Resident, U.S. Nonresidents, and Israeli Nonresident ($N = 255$).

Variable	Residents ($N = 156$)		Nonresidents ($N = 99$)				
	USA ($N = 52$)	Israel ($N = 104$)	USA ($N = 49$)	Israel ($N = 50$)	Living arrangement main effect *F* value	Country main effect *F* value	Chi-square values/ interaction effect *F* value
Women[a]	33 (63.5)	75 (72.1)	28 (57.1)	39 (78)			$\chi 2(1) = 6.61$*
Age	79.24 (6.49)	80.73 (6.33)	77.00 (6.93)	79.10 (5.71)	$F(1, 249) = 5.26$*	$F(1, 249) = 4.56$*	$F(1, 249) = 0.13$
Marital status[a]							$\chi^2(3) = 3.57$
Married/Living with partner	30 (57.7)	32 (31.1)	23 (46.9)	18 (36)			
Widow	16 (30.8)	59 (57.3)	15 (30.6)	24 (48)			
Divorced/Separated/Single	6 (11.5)	12 (11.7)	11 (22.4)	8 (16)			
Education level[a]							$\chi^2(4) = 13.81$**
Less than high school	0	30 (29.4)	0	9 (18)			
High school	11 (21.6)	23 (22.5)	1 (2)	14 (28)			
Some college/Trade school	9 (17.6)	2 (2)	11 (22.4)	3 (6)			
Associates degree/Professional degree	9 (17.6)	23 (22.5)	5 (10.2)	10 (20)			
Bachelors degree/Masters degree	22 (43.1)	24 (23.5)	32 (65.3)	13 (26)			$\chi^2(3) = 0.59$
Financial Situation[a]							
Can't make ends meet	0	3 (2.9)	0	2 (4)			
Have just enough to get along	5 (9.6)	11 (10.8)	4 (8.2)	7 (14)			
Comfortable/	31 (59.6)	84 (82.4)	35 (71.4)	35 (70)			
Excellent	16 (30.8)	4 (3.9)	10 (20.4)	6 (12)			
Attitudes toward CCRC (0-9)	6.63 (1.20)	5.92 (1.18)	4.67 (2.11)	3.84 (1.80)	$F(1, 250) = 99.74$**	$F(1, 250) = 14.58$**	$F(1, 250) = 0.09$
Well-being (1-4)	1.78 (0.38)	1.45 (0.29)	1.53 (0.30)	1.37 (0.26)	$F(1, 249) = 18.37$**	$F(1, 249) = 37.39$**	$F(1, 249) = 4.13$*
Limitations in daily activities (0-11)	10.56 (0.98)	9.88 (2.19)	10.94 (0.24)	8.04 (3.85)	$F(1, 251) = 6.09$*	$F(1, 251) = 36.29$**	$F(1, 251) = 14.09$**
Objective health (1-7)	2.10 (1.24)	1.54 (1.09)	1.88 (1.23)	1.78 (1.09)	$F(1, 251) = 0.00$	$F(1, 251) = 4.66$*	$F(1, 251) = 2.29$
Subjective current health (1-5)	2.12 (0.64)	2.64 (0.71)	1.84 (0.75)	1.84 (0.75)	$F(1, 250) = 0.41$	$F(1, 250) = 84.41$**	$F(1, 250) = 12.98$**
Subjective future health (1-5)	2.58 (0.78)	2.26 (0.68)	2.29 (0.74)	3.75 (0.84)	$F(1, 215) = 11.64$**	$F(1, 215) = 63.13$**	$F(1, 215) = 38.11$**
Proximity to services and amenities (1-5)	1.39 (0.44)	1.58 (0.55)	1.37 (0.36)	2.29 (1.31)	$F(1, 236) = 13.69$**	$F(1, 236) = 33.91$**	$F(1, 236) = 14.73$**
Individualism/collectivism (1-5)	2.61 (0.27)	2.91 (0.32)	2.57 (0.42)	2.67 (0.38)	$F(1, 249) = 9.75$**	$F(1, 249) = 19.83$**	$F(1, 249) = 4.98$**

Note. Numbers represent mean and standard deviation (*M, SD*) unless otherwise noted. Higher numbers indicate a better score, except for objective health, subjective current health and subjective future health (for which a higher number indicates poorer subjective/objective/future health), limitations in daily activities limitations (for which a higher number indicates more limitations in ADLs), and proximity to services (for which a higher number indicates greater difficulty accessing services). CCRC = continuing care retirement communities; ADL = activities of daily living; NS = not significant.
[a]Number and percent, *N*(%).
*$p < .05$. **$p < .01$.

Table 2. Predictors of Living Arrangement.

Country	Variable	*B* (*SE*)	Wald	Significance	Exp(*B*)
USA ($N = 101$)	Attitudes toward CCRC	−8.59 (2.06)	17.35	<0.001	0.00
	Well-being	−3.77 (1.10)	11.68	<0.001	0.02
	Limitations in daily activities	1.27 (0.72)	3.12	0.07	3.58
	Objective health	0.05 (0.29)	0.28	0.86	1.05
	Subjective current health	−0.05 (0.62)	0.00	0.92	0.94
	Subjective future health	−1.24 (0.61)	4.08	0.04	0.28
	Proximity to services and amenities	−0.78 (0.73)	1.14	0.28	0.45
	Individualism/collectivism	0.53 (0.83)	0.41	0.52	1.71
Model: –2Log likelihood = 75.84; Nagelkerke $R^2 = 0.62$					
Israel ($N = 154$)	Attitudes toward CCRC	−6.88 (1.97)	12.11	<0.001	0.00
	Well-being	0.20 (1.09)	0.03	0.85	1.22
	Limitations in daily activities	−0.09 (0.10)	0.75	0.38	0.91
	Objective health	−0.18 (0.33)	0.30	0.58	0.83
	Subjective current health	−0.33 (0.62)	0.29	0.58	0.71
	Subjective future health	2.03 (0.68)	8.86	<0.001	7.64
	Proximity to services and amenities	0.26 (0.50)	0.26	0.60	1.30
	Individualism/collectivism	−2.19 (1.05)	4.35	0.03	0.11
Model: –2Log likelihood = 68.20; Nagelkerke $R^2 = 0.64$					

Note. CCRC = continuing care retirement communitie.

American older adults feel more secure with the support of CCRC if they think their health is going to deteriorate. Furthermore, in a society that stresses individualism, it might be that American older adults who anticipate poorer subjective health choose a CCRC to release their families from providing care, thus retaining the value of independence.

The findings indicated that the Israeli sample was more likely to relocate to a CCRC rather than stay in the community when they reported positive attitudes toward the CCRC, better subjective future health, and higher collectivism, with large effect sizes for all three factors (Chen et al., 2010), indicating that each factor may play a comparable, significant role in the decision to move to a CCRC.

It was somewhat unexpected to find that older Israelis were more likely to move to a CCRC rather than stay in the community if they expected better subjective future health. This is because previous studies have shown that concerns regarding current and future health status and anticipation of future care needs appear to be major determinants of CCRC relocation (Erickson & Krout, 2012). Perhaps those older adults who reported better subjective future health believed that, to benefit from the various activities and services offered by the CCRC, it would be better to move when their health condition is good.

In addition, among the Israeli sample, higher collectivism was associated with living in a CCRC compared with staying in the community. This finding is in line with the DOI theory (Rogers, 1962) which stresses the importance of environmental context in shaping one's attitudes and behaviors. Thus, the environmental context of Israel, as a society between traditional values of family relations and support and modern values of individualization and separation (Clarfield et al., 2018), provides a context for this finding. It seems that Israeli older adults are seeking social contacts and social activities that reflect the value of collectivism (Arpino & de Valk, 2018). Indeed, it was found that many Israeli residents and their adult children were quite enthusiastic about the opportunity for residents to reengage in social relations and activities, arguing that the CCRC fulfills their expectations for social interaction (Ayalon & Green, 2013). Furthermore, studies that compared individualistic and collectivistic cultures generally indicated that residents of collectivistic societies are more likely to feel lonely than those in individualistic societies in spite of the fact that individuals across both types of cultures are more likely to live alone in old age (Rokach, 2018). Accordingly, it might be that Israeli older adults' decision to move to a CCRC serves as a means to dispel loneliness and to live in an environment that allows for a continuation of collective life.

Four main limitations regarding the current study should be noted. First, personnel at the CCRCs recruited participants with the research team's guidance, but no records were provided concerning who was invited to participate and who refused, resulting in potential selection biases. It should be noted that we encouraged personnel to invite all new CCRC residents and all of those who had visited and declined to move, but we cannot determine how closely they followed this guidance. It is possible that personnel chose participants whom they thought would report more favorable attitudes about CCRCs. Therefore, it is suggested that future studies collect background information regarding potential participants who refuse to participate to reduce selection biases. Second, older adults who moved to the CCRC were interviewed approximately 3 months after moving. Thus, we have no information regarding their state just before the move, which could have been different than their state after

moving. In addition, we did not assess participants' former living situation. Future research will benefit from interviewing participants prior to enrollment in the CCRC and over time after relocation. Third, our quantitative cross-sectional design does not allow us to determine cause and effect. Future studies would benefit from investigating this topic by the use of qualitative longitudinal studies with in-depth interviews as these may allow to better explore push and pull factors that shape the decision to move to a CCRC and to examine changes in these factors over time. Finally, internal consistency was low in this sample for individualism/collectivism (Cronbach $\alpha = .41$) and attitudes toward the CCRC (Cronbach $\alpha = .56$). Therefore, the current study's results should be viewed with caution given the low reliability of these measures. Furthermore, additional use and testing of these measures' psychometric properties is recommended.

Despite these limitations, our study is the first to examine differences between American and Israeli older adults who decided to move to a CCRC and American and Israeli older adults who decided to stay in the community, using the theory of DOI. In the current study we used variables that theoretically are related to decision-making. The study's findings expand the limited body of knowledge regarding factors associated with the decision to move or not to move into a CCRC, comparing individuals across different residential settings (CCRC vs. community dwelling) and cultures (the United States vs. Israel).

Practically, by better understanding the characteristics of CCRC residents and nonresidents and the factors associated with their decision to move or not to move to CCRCs, we can assist the growing older population make well-informed decisions that will improve their satisfaction with their residential setting. This research also could inform policies that regulate CCRCs in terms of requirements for information provided to facilitate decision-making. For example, older Americans may be more concerned with information about how a CCRC will help them in the event of a future decline in health status, whereas older Israelis may be more concerned with the social supports of the CCRC. The findings also have implications for CCRC administrators and health care professionals as they identify different clusters of individuals who are motivated to relocate to a CCRC by different reasons such as positive attitudes toward CCRCs and poorer subjective health.

Ethical Considerations

All materials and procedures for the American sample were approved by the University of South Florida Institutional Review Board.

All materials and procedures for the Israeli sample were approved by the Ethics Committee of the School of Social Work of Bar Ilan University.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Data collection for the U.S. sample was funded by a grant from the Institute for Optimal Aging.

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