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A Typology of Source of Information About the Continuing Care Retirement Community and Older Adults' Living Arrangement

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ABSTRACT

A continuing care retirement community (CCRC) represents a residential alternative for older adults. It offers a variety of social and health care services to meet older adults' needs and preferences. Using the theory of innovation as a theoretical basis, the overall goal of the study was to use the source of information about the CCRC as a potential predictor of the decision to move. In total, 76 older adults responded to a question about the source of information on the CCRC. Of these, 40 were CCRC residents and 36 were community dwellers, who expressed an interest in the CCRC but decided to remain in their community. Based on their responses, respondents were classified into one of five clusters (e.g., spouse, friends, children, nonhuman sources, mixed human and nonhuman sources). Those classified into the spouse or adult children as sources of information were more likely to live in a CCRC. Results show that information about the CCRC should be conveyed to additional members in the family, such as adult children, as they often take a major role in the decision to relocated. The findings have implications for administrators as they clearly point to potential sources of greater influence on older adults' decision to relocate.

Introduction

A continuing care retirement community (CCRC) is defined as a residential community for the remainder of one's life. The CCRC represents a residential alternative that is available to older adults who are independent in their activities of daily living (ADLs), at least upon entering the CCRC. The CCRC is privately funded and thus is usually available to more affluent older adults. Although this living arrangement is available to a select segment of the population, the number of CCRCs in the United States has increased from 700 in 1986 (Cohen, Tell, Batten, & Larson, 1988) to 1861 in 2010 (Hermann, Brod, & Giradi, 2009).

Relocation to the CCRC

Litwak and Longino (1987) identified three types of migration or relocation styles in old age. The first move occurs relatively early following retirement and is termed the "amenity migration." Movers are often married couples in good health with satisfactory financial means, who move in order to improve their lifestyle (Wiseman, 1980). A warmer climate, recreational amenities, rural qualities, and reduced cost of living have all been considered as facilitators of such a move. The second move usually occurs following impairments in instrumental activities of daily living in the absence of a spouse who could have otherwise compensated for this functional loss. This move is characterized by bringing parents and adult children geographically closer to one another (Longino, Jackson, Zimmerman, & Bradsher, 1991; Silverstein, 1995). This move usually takes place at an older age than the "amenity" migration. The third move is to a nursing home following the inability of the family to provide informal care (i.e., unpaid care provided by family and friends) (Wolinsky & Johnson, 1992).

Although informative, it is hard to place relocation to a CCRC within this framework. In some ways, relocation to a CCRC may be viewed within the amenity migration, as the CCRC offers a variety of recreational amenities to its residents and often attracts residents based on these amenities. A CCRC also might be viewed as representing the second type of move, as it offers assistance in instrumental activities of daily living, such as household maintenance and meal preparation. Finally, the move into a CCRC has some similarities with the third type of move, as the CCRC is an institution that offers easy access to long-term care services on an as-needed basis. According to Groger and Kinney (2007), moving into a CCRC is similar to making the first type of move with the anticipation of making the second and third moves in the future.

One detailed, qualitative study of 20 CCRC residents identified a preponderance of social concerns that led to choosing a CCRC: burdening family members if they remained at home, partner's health if they remained at home, and closer proximity to friends in CCRC or family nearby if they moved to a CCRC (Groger & Kinney, 2007). Nonetheless, these residents were concerned about the somewhat isolated location of the CCRC and that it might isolate them from interactions with younger people in the larger community (Groger & Kinney, 2007). Security and companionship also were mentioned as reasons for moving into a CCRC (Graham and Tuffin, 2004).

In general, research has shown that older adults with more social needs (i.e., smaller social networks, less social contact) outside the CCRC appear more likely to decide to enter a CCRC, compared to older adults with fewer social needs. Prior research has found that those who entered a CCRC were less likely to have informal social support and fewer

interactions with family members compared with those who expressed interest but remained on the waiting list (Sheehan & Karasik, 1995). Consistent with the qualitative study, other CCRC residents have reported not wanting to burden family members as an important reason for entering a CCRC (Krout, Moen, Holmes, Oggins, & Bowen, 2002).

Research has also found that advanced planning is a major determinant of relocations into a CCRC. Common reasons for moving were the anticipation of future needs due to deteriorating health status, the desire for continued care, availability of medical services, freedom from maintenance of residence, protection against rising costs, and the desire not to burden family members (Cheek, Ballantyne, Byers, & Quan, 2007; Krout et al., 2002; Maloney, Finn, Bloom, & Andresen, 1996). Indeed, the few studies that compared CCRC residents to community dwellers found that CCRC residents are more functionally impaired, have worse health and mobility, and enjoy fewer social support networks (McCormick & Chulis, 2003; Sheehan & Karasik, 1995).

Diffusion of innovations (DOI) and relocation to a CCRC

The overall goal of this study was to examine the source of information about the CCRC as a potential predictor of the decision to move. The present study relied on the diffusion of innovation (DOI) theory to explore the relocation decision into a CCRC. Diffusion of innovation "refers to the spread of abstract ideas and concepts, technical information, and actual practices within a social system, where the spread denotes flow or movement from a source to an adopter, typically via communication and influence" (Wejnert, 2002, p. 297). DOI research is concerned with the specific characteristics of the innovation, the individual, social context, and culture that are required for new ideas or practices to be adopted. DOI is focused on how, why, and at what rate new ideas spread through culture and society. To date, DOI has not been examined in relation to relocation into a CCRC.

Several different theories of DOI have been developed (Wejnert, 2002), although Rogers's theory (Rogers, 2003) 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 towards the innovation, (d) a decision to adopt or reject, (e) implementation of the new idea, and (f) confirmation of the decision (Rogers, 2003). In the present project,

we focus on the factors that correlate with a decision to adopt or reject the innovation.

Wejnert (2002) synthesized literature across a wide range of disciplines (sociology, economics, political science, etc.) to identify the range of characteristics that influence diffusion and adoption of innovations. These influences are divided into three components, characteristics of the (a) innovation itself, (b) "actor" deciding whether to adopt or not, and (c) context. In this study, we examine both "actor" characteristics and contextual characteristics as potentially responsible for the decision to relocated to the CCRC. Specifically, with regard to the characteristics of the actor, we examine age, gender, education, health status, marital status, and overall number of relationships. These variables are examined as they have shown to play a role in older adults' decisions as to whether or not to relocate to a CCRC (Bekhet, Zauszniewski, & Nakhla, 2009).

Unique to the present study is the examination of a contextual variable that has not received much attention in the past, namely, the source of information about the CCRC. CCRCs usually involve individuals or couples, and the adoption of these types of innovations likely depends on social ties (e.g., community ties, face-to-face interactions with sources familiar with the innovation). Based on DOI research in other fields (Wejnert, 2002), individuals may be more likely to move to CCRCs if they obtain information about CCRCs that is communicated through strong social ties. Taking this information into consideration, we expected that in addition to one's health status, marital status, and perceived availability of social support (i.e., the actor's characteristics), the source of the information about the CCRC would make a difference. More specifically, we expected older adults to be more likely to relocate into a CCRC when the information came from their spouse, children, or friends than when it came from nhuman sources, such as television shows or newsletters.

Methods

Participants and recruitment

Overall, 101 participants were recruited from 13 CCRCs located in multiple cities in the United States. In each CCRC, two employees were identified to serve as a primary and a secondary liaison. These liaisons were trained by the research team to recruit participants. They were instructed to recruit all English-speaking residents as soon as possible after moving into the CCRC (within 3 months). They were also instructed to recruit all English-speaking nonmovers (i.e., individuals who had visited the CCRC but decided not to move), at the point when they informed the liaison of their decision to not move. Exclusion criteria were non-English speakers, long-term residents in

the CCRC, and people who were cognitively impaired and were unable to participate in the study. We also excluded individuals with a hearing impairment, as interviews were conducted over the phone. Liaisons were instructed to use recruitment flyers and a script developed by the research team to obtain verbal consent to share the name and telephone number of potential participants with the research team.

Measures

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

Independent variable. Respondents were asked about the source who provided them with information about the CCRC. Response options were spouse, child, friend, or nonhuman (e.g., television, newspaper, mail ad). Respondents could specify more than one source of information.

Control variables. Participants self-reported gender, age, education (1 = less than high school to 6 = professional education), and marital status (married/partnered = 1 or not = 0). Subjective health was evaluated by the single question "How would you rate your health" (Brook et al., 1979). Answers ranged between 1 (*excellent*) and 5 (*very poor*). The subjective health score ranged between 2 and 5 in this study. Perceived availability of social contact was determined as the overall number of individuals that are significant in one's life (range 1–12 in this study).

Procedures

Informed consent and all interviews were conducted by telephone with a trained research interviewer. The interviewer read an informed consent script, and participants provided verbal informed consent. The interviewer then completed the interview, reading items and response options in a consistent manner across participants. Participants were paid $20 by mail for their participation. All materials and procedures were approved by the University of South Florida Institutional Review Board.

Data analyses

Data were analyzed using SPSS v.23 for Windows. We first obtained descriptive data and a correlation matrix of study variables. Next, we obtained a typology of the source of information about the CCRC, using cluster analysis. Cluster analysis represents a convenient method for organizing heterogeneous data into more homogeneous groups, with no prior

hypotheses about the exact structure of the data (Everitt, Landau, Leese, & Stahl, 2011, p. 3). To establish a typology of the source of information about the CCRC, a two-step cluster procedure was used. In the first step, an algorithm creates preclusters based on a distance measure between the attributes of each individual. The algorithm then decides for each individual whether it should be merged with the previously formed precluster or whether a new precluster should be created. Once this process ends, all cases in the same precluster are treated as a single entity. In the second step, a standard hierarchical clustering algorithm is used in order to explore a range of solutions using different numbers of clusters, based on the Schwarz Bayesian information criterion (BIC) or the Akaike information criterion (AIC). In the present study, the BIC was used as it allows for comparisons of more than two models at the same time (Fraley & Raftery, 1998; Norušis, 2012). The algorithm in a two-step cluster analysis yields the optimal number of clusters. The silhouette coefficient is used as an indicator of the "goodness" of fit of the cluster solution. The silhouette measure ranges between −1 and +1, with a higher score indicating that the individuals within a cluster represent a cohesive group and the different clusters are distinguishable (Norušis, 2012).

We subsequently used chi-squared analyses to examine group differences in the outcome variable (living arrangement) by cluster. We also used chi-squared analyses for categorical variables and one-way analyses of variance (ANOVAs) for continuous variables in order to examine their distribution against the cluster profile identified. Next, we used a hierarchical regression analysis to examine the potential additive effects of the source of information typology to the dependent variable, living arrangement.

Results

Descriptive statistics and correlations between study variables

Overall, 25 respondents did not specify a source who provided them with information regarding the CCRC. These individuals were excluded from further analysis. Hence, the present analysis concerns 40 CCRC residents and 36 community dwellers. The average age of the sample was 77.5 years ($SD = 6.7$) and the majority were female (60.5%). The average level of education was 4.6 ($SD = 1.6$) on a 1–6 scale. The majority of respondents identified their friends as a source of information about the CCRC (57.9%). Nonhuman sources were the next common source of information (36.8%). The least common source of information was children (21.0%). There was a significant correlation between being less likely to have friends as a source of information about the CCRC and having nonhuman information about the CCRC. See Table 1 for details.

Table 1. Sample characteristics and correlation matrix of study variables ($N = 76$).

	Total	1	2	3	4	5	6	7	8	9
Respondent's characteristics										
1. Age (years)	77.5 (6.7)									
2. Women	46 (60.5%)	−.05								
3. Education (1–6)	4.6 (1.6)	−.18	−.40***							
4. Married	38 (50%)	−.03	−.38**	.33**						
5. Subjective health status (1–5)	1.9 (.7)	.12	.01	−.02	.17					
6. Overall number of significant relations (1–12)	5.8 (2.5)	−.09	.15	.02	−.07	.10				
Respondent's source of information about the CCRC										
7. Spouse	17 (22.4%)	.05	−.15	.02	.48***	.23*	.00			
8. Children	16 (21.1%)	.26*	.15	−.35***	−.19	.05	.09	−.05		
9. Friends	44 (57.9%)	−.02	.08	.23*	−.16	−.04	.03	−.12	−.21	
10. Nonhuman sources	28 (36.8%)	.06	.06	−.03	.06	.23*	−.15	−.21	−.13	−.29*

*$p < .05$, **$p < .01$, ***$p < .001$.

A typology of source of information about the CCRC

A two-step cluster analysis was conducted with spouse, children, friends, and nonhumans identified as sources of information, which serve as constituent variables to construct an overall typology. The supported model contained five clusters. The silhouette coefficient measure was 0.7, which is considered "good." The clusters differed from each other on all four constituent variables (see Table 2).

All respondents classified to a *spouse as the main source of information* ($n = 12$) specified their spouse as a source of information, and 41.7% of them also identified friends as a source of information. Those classified into a *mixed source* ($n = 14$) primarily identified nonhuman sources, supplemented by a mix of other information sources. Those classified into *children as a source of information* ($n = 12$) specified their children as a source of information. However, to a varied degree, they also specified their friends and spouse as a source of information. Those classified into *friends as a source of information* ($n = 24$) identified friends as a source of information about the CCRC. Finally, *nonhuman source of information* ($n = 14$) consisted of those respondents who identified nonhuman sources of information about the CCRC. This group did not identify any human sources of information.

The five clusters varied by age, education, and marital status. Those classified into the *child as a source of information* cluster were the oldest. This cluster also had the lowest levels of education. Married people were most likely to be classified into the spouse as a source of information. Those who were classified as *child or spouse as sources of information* were more likely to live in the CCRC. See Table 2 for details.

Table 2. A typology of source of information about the continuing care retirement community (N = 76).

	Spouse (n = 12)	Mixed (n = 14)	Child (n = 12)	Friend (n = 24)	Nonhuman (n = 14)	F(df), p/χ² (df)
Information source typology indicators						
Spouse	12 (100%)	3 (21.4%)	2 (16.7%)	0	0	52.8(4), p < .001
Children	0	4 (28.6%)	12 (100%)	0	0	58.8(4), p < .001
Friends	5 (41.7%)	11 (78.6%)	4 (33.3%)	24 (100%)	0	43.4(4), p < .001
Nonhuman sources	0	14 (100%)	0	0	14 (100%)	76.0(4), p < .001
Respondent's characteristics						
Age (years)	76.1 (6.6)	79.4 (5.2)	81.9 (5.2)	75.4 (7.5)	76.7 (6.3)	2.5(70,4), p = .05
Women	5 (41.7%)	10 (71.4%)	9 (75.0%)	14 (58.3%)	8 (57.1%)	3.65(4), p = .45
Education (1–7)	5.3 (1.7)	4.6 (1.8)	3.3 (1.6)	5.0 (1.5)	4.4 (1.5)	2.8(70,4), p = .03
Married	12 (100%)	6 (43%)	4 (33.3%)	7 (29.2%)	9 (64.3%)	18.9(4), p < .001
Subjective health status (1–5)	2.1 (.7)	2.2 (1.1)	1.9 (.3)	1.6 (.6)	2.1 (.6)	2.2(71,4), p = .09
Overall number of significant relations (1-12)	5.8 (2.4)	5.4 (2.2)	5.8 (1.7)	6.3 (2.3)	5.1 (3.4)	.5(71,4), p = .72
Respondent's living arrangement (CCRC)	9 (75.0%)	3 (21.4%)	11 (91.7%)	12 (50.0%)	5 (35.7%)	16.8(4), p < .01

Table 3. A logistic regression with living arrangement as the outcome variable.

	Step 1	Step II
Control variables		
Age		.96 (.88–1.05), $p = .41$
Gender		.66 (.17–2.63), $p = .56$
Education		1.53 (1.00–2.35), $p < .05$
Marital status		1.62 (.75–3.51), $p = .22$
Subjective health		.28 (.10–.80), $p = .02$
Number of significant relations		.92 (.72–1.17), $p = .48$
Source of information typology (nonhuman reference group)		
Spouse	.19 (.03–1.01), $p = .05$	.11 (.01–.85), $p = .04$
Mixed	2.03 (.38–10.93), $p = .40$	4.51 (.47–43.46), $p = .19$
Child	.05 (.01–.51), $p = .01$	.06 (.01–.72), $p = .03$
Friend	.56 (.14–2.15), $p = .39$	.21 (.03–1.28), $p = .09$
−2 Log likelihood	86.4	67.9

Predictors of living arrangement as a function of source of information typology

Table 3 presents the results of the logistic regression. In step 1, only cluster membership was entered into the model. Those classified into *spouse or a child as a source of information* clusters had greater odds of living in a CCRC. Once control variables were included in the model, these findings remained consistent. In addition, higher levels of education and poorer subjective health were associated with having greater odds of living in the community.

Discussion

To our knowledge, this is the first study to rely on the DOI theory to explain the transition to a CCRC. The CCRC is a residential option that has become increasingly popular in recent years (Campbell, 2015). Past research has identified a variety of push and pull factors responsible for the transition (Krout et al., 2002). However, this is the first study to explore a possible association between the source of information about the CCRC and older adults' decision to relocate to a CCRC, using the DOI theory as a guide. Our findings demonstrate that when the information provided about the CCRC is derived primarily from one's spouse or children, the odds of actually relocating are significantly higher than when the information about the CCRC comes from friends or nonhuman sources. Hence, this study provides some support to the theory, which stresses the importance of the source of information in shaping one's attitudes and behaviors.

When partnered, the decision to move to a CCRC has to be mutual, a decision of two people. This is because usually both partners relocate together. This potentially explains the fact that one's spouse as a source of information plays a crucial role in the decision to relocate. This finding

adds to past research that has shown that one's spouse's deteriorated health is a major push factor (Bekhet et al., 2009). Our findings add by demonstrating that prior discussion about the topic between partners is a major factor that contributes to the move.

The finding that older adults are more likely to relocate when their children provide them with information about the CCRC is of importance to health care professionals and administrators. We show that an exclusive focus on older adults is likely inadequate. Instead, it is probably better to target both older adults and their children, as children seem to play a major role in the decision to transition to the CCRC (Ayalon, 2016a). As past research has shown that the decision to relocate is often fueled by a wish not to burden one's children (Ayalon, 2016a; Groger & Kinney, 2007), it is possible that when the information about the CCRC comes from one's children, older adults feel more motivated to move. Relying on the DOI theory, these findings point to the significance of family relations in instigating a decision to relocate.

The finding that poorer subjective health was associated with community dwelling is somewhat unexpected. This is because past research has shown that concerns about losing functional ability are a main push factor for older adults to relocate into a CCRC (Bekhet et al., 2009; Krout et al., 2002). Although informative, it is important to keep in mind the fact that CCRCs are open to older adults who are functionally independent upon admittance. Moreover, when residents require substantial assistance with activities of daily living, they often are transferred to nursing care (Ayalon, 2016b; Shippee, 2009). Hence, it is possible that those older adults who reported poorer subjective health status were already at a worse condition, which prevented them from relocating to the CCRC.

Given the substantial cost associated with enrolling in a CCRC, it is expected that those individuals of higher socioeconomic status are more likely to relocate into a CCRC. In the present study, we used level of education as a proxy of socioeconomic status. In contrast to expectation, our findings show that those individuals of higher levels of education are more likely to stay in the community, rather than move to a CCRC. Possibly, level of education is only a crude proxy of socioeconomic status. Alternatively, given the fact that both CCRC users and community dwellers who expressed an interest in the CCRC, but decided not to relocate, are of high enough socioeconomic status to consider a relocation to a CCRC, the difference between the two groups could potentially reflect the fact that even more opportunities are available to those who could potentially afford a relocation yet decided not to relocate.

Despite its strength, this study has several limitations. First, we relied on a nonrepresentative small sample, and our findings may not be

generalizable. Second, given the small sample size, we were unable to examine other factors that would potentially impact the decision to transition to a CCRC, as predicted by the DOI theory, such as similarity to the source or trust of the source. Finally, our cross-sectional design does not allow us to determine cause and effect. Nonetheless, this is the first study to examine the decision to relocate to the CCRC from a DOI perspective. Using the DOI theory, this study points to the important role of family members as a source of information about the CCRC in determining the decision to relocate. Our findings suggest that relying on one's children or spouse as the main sources of information about the CCRC is more likely to result in relocating to the CCRC. The findings have implications for administrators as they clearly point to potential sources of greater influence on older adults' decision to relocate. The findings also have implications for CCRC administrators and health care professionals as they potentially identify different clusters of individuals who are motivated to relocate to the CCRC by different reasons. Future research should identify whether the source of information about the CCRC is associated with actual satisfaction with one's living arrangement.

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References

Ayalon, L. (2016a). Intergenerational perspectives on autonomy following a transition to a continuing care retirement community. *Research on Aging 38*(2), 127—149.

Ayalon, L. (2016b). Do not hear, see, or speak: Views of older residents and their adult children about the nursing unit in the continuing care retirement community. *International Psychogeriatrics*, *28*(11), 1867–1877.

Bekhet, A. K., Zauszniewski, J. A., & Nakhla, W. E. (2009). Reasons for relocation to retirement communities: A qualitative study. *Western Journal of Nursing Research*, *31*(4), 462–479. doi:0193945909332009

Campbell, N. (2015). Designing for social needs to support aging in place within continuing care retirement communities. *Journal of Housing and the Built Environment*, *30*(4), 645–665. doi:10.1007/s10901-015-9437-6

Cheek, J., Ballantyne, A., Byers, L., & Quan, J. (2007). From retirement village to residential aged care: What older people and their families say. *Health & Social Care in the Community*, *15*(1), 8–17. doi:10.1111/j.1365-2524.2006.00646.x

Cohen, M. A., Tell, E. J., Batten, H. L., & Larson, M. J. (1988). Attitudes toward joining continuing care retirement communities. *Gerontologist*, *28*(5), 637–643. doi:10.1093/ger-ont/28.5.637

Everitt, B., Landau, S., Leese, M., & Stahl, D. (2011). *Cluster analysis*. New York, NY: John Wiley & Sons. Ltd.

Fraley, C., & Raftery, A. E. (1998). How many clusters? Which clustering method? Answers via model-based cluster analysis. *The Computer Journal*, *41*(8), 578–588. doi:10.1093/comjnl/41.8.578

Graham, V., & Tuffin, K. (2004). Retirement villages: Companionship, privacy and security. *Australasian Journal on Ageing*, *23*(4), 184–188. doi:10.1111/j.1741-6612.2004.00047.x

Groger, L., & Kinney, J. (2007). CCRC here we come! Reasons for moving to a continuing care retirement community. *Journal of Housing for the Elderly*, *20*(4), 79–101. doi:10.1300/J081v20n04_06

Hermann, D., Brod, K., & Giradi, J. (2009). *Ziegler national CCRC listing and profile*. Chicago, IL: Ziegel Capital Markets-Senior leaving research.

Krout, J. A., Moen, P., Holmes, H. H., Oggins, J., & Bowen, N. (2002). Reasons for relocation to a continuing care retirement community. *Journal of Applied Gerontology*, *21*(2), 236–256. doi:10.1177/07364802021002007

Litwak, E., & Longino, C. F. Jr. (1987). Migration patterns among the elderly: A developmental perspective. *Gerontologist*, *27*(3), 266–272. doi:10.1093/geront/27.3.266

Longino, C. F., Jr., Jackson, D. J., Zimmerman, R. S., & Bradsher, J. E. (1991). The second move: Health and geographic mobility. *Journal of Gerontology*, *46*(4), S218–S224.

Maloney, S. K., Finn, J., Bloom, D. L., & Andresen, J. (1996). Personal decisionmaking styles and long-term care choices. *Health Care Financing Review*, *18*(1), 141–155.

McCormick, J. C., & Chulis, G. S. (2003). Growth in residential alternatives to nursing homes: 2001. *Health Care Financing Review*, *24*(4), 143–150.

Norušis, M. J. (2012). *IBM SPSS statistics 19 statistical procedures companion*. Upper Saddle River, NJ: Prentice Hall.

Rogers, E. M. (1962). *Diffusion of innovations*. New York, NY: Free Press of Glencoe, Macmillan Company.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York, NY: Free Press.

Sheehan, N. W., & Karasik, R. J. (1995). Decision to move to a continuing care retirement community. *Journal of Housing for the Elderly*, *11*(2), 107–122. doi:10.1300/J081V11N02_07

Shippee, T. P. (2009). "But I am not moving": Residents' perspectives on transitions within a continuing care retirement community. *Gerontologist*, *49*(3), 418–427. doi:10.1093/ger-ont/gnp030

Silverstein, M. (1995). Stability and change in temporal distance between the elderly and their children. *Demography*, *32*(1), 29–45. doi:10.2307/2061895

Wejnert, B. (2002). Integrating models of diffusion of innovation: A conceptual framework. *Annual Review of Sociology*, *28*(1), 297–326. doi:10.1146/annurev.soc.28.110601.141051

Wiseman, R. F. (1980). Why older people move: Theoretical issues. *Research on Aging*, *2*(2), 141–154. doi:10.1177/016402758022003

Wolinsky, F. D., & Johnson, R. J. (1992). Widowhood, health status, and the use of health services by older adults: A cross-sectional and prospective approach. *Journal of Gerontology*, *47*(1), S8–S16. doi:10.1093/geronj/47.1.S8