Resident Contact With Family and Friends Following Nursing Home Admission

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Purpose: This study explored factors that are related to the level of contact (number of visits and calls) between newly admitted nursing home residents and their family and friends. In addition to reexamining factors studied previously, several new factors were explored: contact level prior to nursing home placement, dementia status, and resident race. Design and Methods: Interviews were conducted with the significant others of 1,441 residents from a representative sample of nursing homes in Maryland. Results: Contact decreased by approximately half following admission, compared to reported preadmission contact. Rates of contact are positively related to nonuse of Medicaid, kinship closeness, support network proximity, nondemented status, and White race. After controlling for preadmission contact, postadmission contact is positively associated with kinship closeness, support network proximity, nondemented status, and White race. Implications: The study identifies factors that are useful to consider when designing interventions to increase family involvement with nursing home residents.

Key Words: Family involvement, Long-term care, Dementia, Caregiving

Understanding family caregiving to frail elders is a large and growing area within gerontology; however, the attention paid to caregivers has generally ended at the nursing home door. Consequently, little is known about family caregiving to the 1.5 million persons aged 65 and older currently residing in nursing homes in the United States (U.S. Department of Health and Human Services, 1999). This gap in understanding is unfortunate because family involvement has the potential to positively influence the nursing home setting through improved psychosocial well-being of residents (Greene & Monahan, 1982), reduced care burden of staff, and increased public involvement in the concerns of America’s enlarging elderly population. With better information about factors that inhibit or facilitate involvement, interventions may be feasible.

Part of the reason for the lapse in research focus may be the longstanding misconception that nursing home residents are abandoned by relatives. In fact, family members and friends stay in contact, retain close emotional ties, and continue to contribute to basic care needs of residents (see Naleppa, 1996, for a review). Most families live within 30 miles of their institutionalized relative and within a median traveling distance of 10 miles (Greene & Monahan, 1982; Hook, Sobal, & Oak, 1982; Montgomery, 1982). Findings regarding visitation frequency have been remarkably consistent, with at least weekly visitation for the majority (approximately 60%) of residents (Bitzan & Kruzich, 1990; Hook et al., 1982; National Center for Health Statistics, 1979). Nonetheless, large numbers of nursing home residents receive less frequent visits. In one study, 16% received no visits by family and 40% received no visits from friends (Bitzan & Kruzich, 1990).

A handful of factors have been examined in relation to the disparity in contact levels of nursing home residents. Contact is greater for residents whose care is funded by family resources (Geib, 1980). Contact also increases with proximity. As geographic distance of the nursing home to a family caregiver decreases, visitation increases (Bitzan & Kruzich, 1990). Those with children living within an hour’s drive receive more visits (Hook et al., 1982). Another study found that for each doubling of distance between the nearest direct relative and the nursing home, visitation declined by about half (Greene & Monahan, 1982). Kinship status also is important: more visits are received by persons who are married (Hook et al., 1982; National Center for Health Statistics, 1979). Residents with greater impairments in activities of daily living (ADLs) receive more visits.
This approach underestimates contact levels for resi-
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home. Nursing home contact is generally measured
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likely to remain so after placement. An early study
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looked but potentially important component of post-
ment care, and racial discrimination. Considering that
reduce contact. Cognitively impaired residents can lose the ability to
participate in certain forms of contact, such as phone
calls and written communication.
Race/ethnicity has been shown to be related to
 nursing home admission rates, with lower use of
institutional care by older African Americans, Hispanics,
and Asian Americans as compared to Caucasians
(Damron-Rodriguez, Wallace, & Kington, 1994;
Falcone & Broyles, 1994). The larger social support
networks available to elderly Blacks (Gibson, 1982;
Gibson & Jackson, 1987; Thornton, White-Means,
& Choi, 1993) may be providing care longer and
thus delaying or avoiding institutionalization. Other
possible explanations for the reduced use of formal
long-term care services among Blacks may include
socioeconomic disadvantage, decreased access to long-
term care, and racial discrimination. Considering that
nursing home admission rates differ by race, it may
be useful to examine nursing home contact levels by
race as well.
Preadmission contact is another largely over-
looked but potentially important component of post-
admission contact. Family and friends who are
highly involved prior to placement may be more
likely to remain so after placement. An early study
suggests that telephone contact prior to placement is
weakly but positively related to later nursing home
Methodological limitations are evident in the ex-
isting literature on family involvement in the nursing
home. Nursing home contact is generally measured
as the number of in-person visits received by a resi-
dent. However, more distant relatives may utilize
other forms of communication such as telephone
calls. Contact has also been traditionally measured
as the visitation of a single primary significant other.
This approach underestimates contact levels for resi-
dents whose social support is shared across a net-
work of family and friends. In one study, more than
three quarters of nursing home visits were by groups
of persons (Hook et al., 1982). A fuller understand-
ing of family involvement should encompass how
many persons maintain contact with a nursing home
resident via in-person visits or telephone calls.
The existing literature also has limited generaliz-
ability to today's nursing home populations. Most
studies relied on small and nonrepresentative sam-
les from rural areas, often selected from a limited
number and type of nursing homes. These studies ei-
ther include no information about participants' race
or indicate that the sample was essentially all-White.
Residents were sometimes excluded on the basis of
illness and impaired cognition. Moreover, most of
the studies were published more than 15 years ago.
Given the increasing age and acuity of today's nurs-
ing home residents, both the residents and their so-
cial networks may be different now.
The current study addressed these limitations in
several ways. Reports of in-person visits and tele-
phone calls were combined to create a more compre-
ensive measure of contact. Visits and phone calls
from spouses, siblings, children, other relatives, and
friends/neighbors were considered separately to ob-
tain a more complete picture of the contact patterns
of the resident's entire social network. The study uti-
ilized a large and representative sample. In addition
to reexamining several of the factors shown in previ-
ous studies to affect visitation rates, the current study
also examined preadmission contact levels and resi-
dent dementia status and race. Finally, we conducted
an analysis examining the relative contributions of
these factors to postadmission contact levels while
controlling for preadmission contact levels.
Based on previous research, we hypothesized the
following. Higher levels of postadmission contact
would be positively related to non-Medicaid pay-
ment status, closer kinship status, a greater number
of family and friends in geographic proximity to the
nursing home, and a higher number of ADL depend-
cencies. We expected that residents with dementia
would have less contact with family and friends. We
also hypothesized that Black nursing home residents
would receive higher contact levels than would
White residents. Finally, we expected contact levels
prior to admission to be positively correlated with
postadmission contact levels.

Methods
Participants and Procedure
Subjects were interviewed as part of the Maryland
Long-Term Care Project (LTCP), a program of re-
search dedicated to studying quality of life among
persons residing in long-term care settings (Mag-
izzer et al., 2000). Study participants were the signif-
icant others (as identified by staff) of nursing home
residents enrolled in the LTCP. Nursing homes were
identified and residents were enrolled as follows. All
221 licensed long-term care facilities in Maryland
were categorized by location and number of beds, and a stratified random sample of 64 homes was selected. Four (6%) homes did not participate and one had no eligible residents. The 59 homes providing data represented a 27% sample of all Maryland nursing facilities and included rural, urban, and suburban homes as well as a range of nursing home sizes. All residents newly admitted from September 1992 through March 1995 aged 65 years and older who had not resided in a nursing home in the previous year (for more than 8 days) were eligible. Seventy percent of the 3,851 eligible residents were enrolled, for a total of 2,285. Most residents were female (70.9%), the average age was 81.5 years, 80.5% (1,837) were White, 15.7% were Black, 0.9% were Hispanic, and 2.8% were described as “other.” These demographics are comparable to national figures (Magaziner et al., 2000; Strahan, 1997). Efforts were made to interview one significant other per resident over the telephone or in person; 2,112 were interviewed.

Only interviews with family members and friends (excluding guardians and paid helpers) 18 years or older that had taken place at least 2 weeks (14 days) after the resident’s admission to the nursing home (for at least a 15-day stay) were included in the current sample (N = 1,441). Guardians and paid helpers (n = 73) were excluded out of concern that they would be unfamiliar with the contact patterns of the resident’s family and friends. Of the significant others included in the present analyses, most were female (n = 979; 67.9%) and White (n = 1,211; 84%). They had a mean age of 57.4 years (range 25–98; SD = 12.6), 13.6 years of education (range 0–20; SD = 3.1), and were interviewed an average of 34.3 days following the resident’s admission (range 15–65; SD = 13.0). The significant others had known the patient an average of 51 years (range 2–90; SD = 14.2). The largest group was daughters (36.3%), followed by sons (20.9%), spouses (12.8%), nieces and daughters-in-law (5.5% and 5.3%, respectively), granddaughters and sisters (3.3% each), and friends and neighbors (3.2%). The remainder was made up of other family relationships. Resident characteristics for the final sample were very similar to the full sample: average age 81.7 years (range 65–99; SD = 7.6), 72.2% female, and 81% (n = 1,167) White. Of non-Whites in the sample, 15% (n = 216) were Black, 1.1% (n = 16) were Hispanic, and 2.9% (n = 42) were “other.” For this reason, only White versus Black comparisons were conducted in the regression analysis, excluding the Hispanic and “other” categories.

Variables

Network Proximity.—A count of the number of persons living within a one-hour drive of the nursing home was obtained for five categories of persons: spouse, siblings, children, other relatives, and friends/neighbors (postadmission network proximity). For example, for each category, respondents were asked, “How many (brothers/sisters) live within a one-hour drive of the nursing home?” Significant others were also asked how many miles the nursing home was from the resident’s nearest family member or friend (nearest loved one), how many miles the nursing home was from the home in which the resident lived prior to admission (geographic relocation), and how many relatives lived within a one-hour drive of the resident prior to admission, including those living with the resident (preadmission network proximity).

Contact.—Contact was defined as the number of days in a defined 2-week period that a resident was visited or telephoned by specific categories of persons. Preadmission contact was the total number of visits and calls by four categories of persons who did not live with the resident: siblings, children, other relatives, and friends/neighbors. Persons living in the same household with the resident were automatically assigned daily contact for visits. For postadmission contact, information was obtained regarding five categories of persons: spouse, siblings, children, other relatives, and friends/neighbors. Preadmission contact covered the 2 weeks before the resident was admitted to the nursing home. Postadmission contact referred to the 2 weeks preceding the interview with the significant other.

Medicaid Status.—Residents whose stay in the nursing home was funded in some part by Medicaid received a 1 for this variable, while all others received a 0. Data were obtained from the Minimum Data Set (MDS; Morris et al., 1990) upon admission.

Number of ADL Dependencies.—Current physical functioning was rated by nursing home staff with a modified version of the Katz Activities of Daily Living Scale (Katz, Ford, & Moskowitz, 1963). The scale was derived from 14 items in the Psychogeriatric Dependency Rating Scale (PGDRS; Wilkinson & Graham-White, 1980) on six domains: bathing, dressing, toileting, transferring, feeding, and continence. Each Katz domain was scored dichotomously as any dependency versus fully independent. A summary Katz score was created by adding the number of dependent domains; higher scores are indicative of more dependence.

Kinship Status.—Residents whose significant other was a first-degree family member (sibling, child, parent, or spouse) were assigned a 1 for Kinship status. Residents whose significant other was not a first-degree relative were assigned a 0.

Dementia Status.—Dementia status was determined in accordance with the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised (American Psychiatric Association, 1987) by an expert panel of geriatric psychiatrists, neurologists, and a geriatrician using information collected from
interviews with residents, nursing staff, significant others, and medical records. A detailed description of the dementia ascertainment methodology may be found elsewhere (Magaziner et al., 1996). For the present analyses, residents with dementia were assigned a 1, and those determined not to have dementia (or whose dementia status could not be determined conclusively) were assigned a 0.

Results

Descriptive Data for Primary Study Variables

Table 1 provides descriptive information about residents and significant others. On average, nursing home residents lived less than 15 miles from a significant other. Mean relocation following placement was less than 20 miles. The mean number of ADL skills in which the resident was dependent was less than 20 miles. The mean number of contacts decreased from 33 prior to placement to the mean number of contacts during the 2-week period prior to placement (37.8) compared to the mean number of contacts during the 2-week period preceding the significant other interview (19.9) decreased by approximately half. The median number of contacts decreased from 33 prior to placement to 17 following placement. The mean number of visits dropped by 45% following admission; the mean number of phone calls dropped by 45%

The primary significant other was a first-degree relative for 1,087 (75.4%) of the residents. A total of 315 (23.2%) of the residents utilized Medicaid at admission. Approximately half (53.9%, n = 776) of the residents had dementia.

Relationship to Postadmission Contact

Hypotheses regarding the relationships between contact and the primary study variables were examined via correlations for continuous variables and t tests for categorical variables. Table 2 shows the correlations. Contrary to prediction, the number of ADL dependencies was not significantly correlated with postadmission contact. As predicted, preadmission contact was significantly positively correlated with postadmission contact (t = .35, p < .001), indicating that residents whose social networks offered high levels of contact prior to admission received more visits and phone calls than residents whose social networks provided lower contact prior to admission. Postadmission network proximity was also positively correlated with post-admission contact (t = .35, p < .001); residents with a larger number of relatives and friends living within a one-hour drive of the nursing home had higher levels of contact.

Also as predicted, t tests indicated that residents whose stay was paid at least in part by Medicaid received less contact (M = 16.8, SD = 13.4) than those who were not covered by Medicaid (M = 20.7, SD = 14.8), t(1350) = 4.14, p < .001; residents whose primary visitor was a first-degree relative had higher contact levels (M = 21.2, SD = 15.2) than those whose primary visitor was not a first-degree relative (M = 15.9, SD = 12.1), t(1430) = −6.01, p < .001; and residents with dementia had less contact (M = 17.3, SD = 12.5) than those not meeting criteria for dementia (M = 22.9, SD = 16.4), t(1430) = −7.30, p < .001. Finally, and contrary to expectations, White residents had more contact (M = 20.5, SD = 14.3) than did Black residents (M = 16.2, SD = 14.9), t(1372) = 4.04, p < .001.

Dementia Status and Race

In an effort to better understand differences in contact levels by dementia status and race, we examined relationships between these variables and the remaining primary study variables.

Dementia Status.—Residents with dementia were different from those without dementia in several ways. Chi-square tests showed that demented residents were significantly more likely to have some part of their care paid for by Medicaid (p < .001; 17.4% for those without dementia and 28% for those with dementia). A series of t tests showed that demented residents were more dependent in ADLs (M = 4.3, SD = 1.7) than nondemented residents (M = 3.3, SD = 2.0), t(1236) = 9.29, p < .001; had fewer relatives and friends living within a one-hour drive of their home (M = 10.3, SD = 14.4) than nondemented residents (M = 12.0, SD = 17.6), t(1438) = −2.00, p < .05; and had fewer relatives and friends living within a one-hour drive of the nursing home (M = 10.2, SD = 13.7) than nondemented residents.
(M = 11.9, SD = 17.1), t(1436) = −2.06, p < .05. Residents with and without dementia did not differ statistically in terms of kinship status or amount of contact prior to nursing home admission.

**Race.**—Black and White residents also differed from each other in important ways. First, 51.1% (n = 596) of White residents and 68.5% (n = 148) of Black residents met criteria for dementia (p < .001). Second, whereas 77.8% (n = 908) of significant others of White residents were a direct relative, this was the case for 60.2% (n = 130) of Black residents (p < .001). Third, whereas 18% (n = 197) of White residents utilized Medicaid to finance some part of their nursing home care, 49.3% (n = 103) of Black residents did so (p < .001). A t test also demonstrated that Blacks had more ADL dependencies (M = 4.3, SD = 1.8) than Whites (M = 3.8, SD = 1.9), t(1191) = 3.46, p < .01. However, Blacks had a greater number of persons living within an hour of their home before admission (M = 14.2, SD = 25.9) than did Whites (M = 10.5, SD = 13.6), t(1380) = 3.06, p < .01; a greater number of persons living within an hour of the nursing home (M = 14.1, SD = 24.7) than did Whites (M = 10.4, SD = 13.2), t(1378) = 3.20, p < .01; and a greater amount of contact prior to nursing home admission (M = 42.6, SD = 28.1) than did Whites (M = 36.7, SD = 22.5), t(1375) = 3.35, p < .01.

**Predictors of Postadmission Contact Controlling for Preadmission Contact**

Regression models were used to explore the relative contributions of resident and significant other characteristics to postadmission contact levels. In the first model, preadmission contact was regressed onto postadmission contact. In the second model, variables previously found to be related to postadmission contact were entered: Medicaid status, kinship status, postadmission network proximity, and the number of the resident’s ADL dependencies. In the final model, two new variables examined in this study were entered, namely, dementia status and race (White vs Black). Results of the regression modeling are shown in Table 3.

In the first model, preadmission contact accounted for a substantial proportion of variance in postadmission contact. In the second model, after controlling for preadmission contact, variables shown in previous studies to be related to contact also contributed significantly to the prediction of postadmission contact. Both Medicaid status and ADL dependencies were significant contributors, with Medicaid status and greater ADL dependency predicting reduced contact. Kinship status and postadmission network proximity were also significant predictors of postadmission contact. Specifically, residents whose significant other was a first-degree relative and residents with a larger social network living within an hour’s drive of the nursing home experienced more postadmission contact. In the third and final step, two of the new variables examined in this study, dementia status and race, also contributed significantly to the prediction of postadmission contact. Results of the regression model were virtually identical when the MDS cognitive score was utilized in place of the dichotomous dementia status variable: adjusted $R^2$ = .13 for Step 1; $\Delta$ adjusted $R^2$ = .06 for Step 2 (p < .001); $\Delta$ adjusted $R^2$ = .03 for Step 3 (p < .001). Both being demented and being Black were associated with less postadmission contact. Moreover, after including dementia status and race in the model, neither Medicaid status nor greater ADL impairment

### Table 3. Regression Models Assessing the Effect of the Primary Study Variables on Postadmission Contact

<table>
<thead>
<tr>
<th>Variable</th>
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<th>Beta</th>
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<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Preadmission contact</td>
<td>0.21</td>
<td>0.02</td>
<td>0.35***</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission contact</td>
<td>0.19</td>
<td>0.02</td>
<td>0.32***</td>
</tr>
<tr>
<td>Medicaid status (Medicaid)</td>
<td>−3.3</td>
<td>0.94</td>
<td>−0.10**</td>
</tr>
<tr>
<td>Kinship status (first degree)</td>
<td>4.5</td>
<td>0.93</td>
<td>0.13***</td>
</tr>
<tr>
<td>Postadmission network proximity</td>
<td>0.13</td>
<td>0.02</td>
<td>0.15***</td>
</tr>
<tr>
<td>ADL dependencies</td>
<td>−0.68</td>
<td>0.21</td>
<td>−0.09***</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission contact</td>
<td>0.19</td>
<td>0.02</td>
<td>0.32***</td>
</tr>
<tr>
<td>Medicaid status (Medicaid)</td>
<td>−1.9</td>
<td>0.97</td>
<td>−0.06</td>
</tr>
<tr>
<td>Kinship status (first degree)</td>
<td>3.9</td>
<td>0.93</td>
<td>0.12***</td>
</tr>
<tr>
<td>Postadmission network proximity</td>
<td>0.13</td>
<td>0.02</td>
<td>0.14***</td>
</tr>
<tr>
<td>ADL dependencies</td>
<td>−0.33</td>
<td>0.21</td>
<td>−0.04</td>
</tr>
<tr>
<td>Dementia status (Demented)</td>
<td>−4.3</td>
<td>0.84</td>
<td>−0.15***</td>
</tr>
<tr>
<td>Race (Black)</td>
<td>−3.8</td>
<td>1.1</td>
<td>−0.10**</td>
</tr>
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</table>

Note: Adjusted $R^2$ = .12 for Step 1; $\Delta$ Adjusted $R^2$ = .05 for Step 2 (p < .001); $\Delta$ Adjusted $R^2$ = .03 for Step 3 (p < .001). **p < .01; ***p < .001.
was significant, although Medicaid status approached significance. In terms of their relative contributions to the prediction of postadmission contact in the final regression equation, postadmission network proximity and dementia status followed preadmission contact in importance, followed by kinship status and race. The total amount of variance in postadmission contact accounted for by the final model was modest at 21%.

Discussion

This study examined factors related to the level of contact between nursing home residents and their family and friends. In addition to reexamining variables previously shown to be related to contact, three new variables were examined, and the relative contributions of the study variables in predicting postadmission contact while controlling for preadmission contact were analyzed. The study is unique with regard to the size and representativeness of the sample, the expanded definition of contact, and the inclusion of the resident’s larger social network.

With one exception, our results confirmed previous findings. Residents receiving Medicaid assistance had less contact with family and friends. Greater monetary resources may facilitate contact in several ways; for example, family members of higher socioeconomic status may experience fewer practical barriers to visitation and phone calls. Residents whose primary significant other was a first-degree relative also had higher contact levels. Stronger emotional bonds and/or greater sense of familial duty likely exist between closely related family members as opposed to those more distantly related, or those related only by marriage.

The number of family and friends living in close proximity to the nursing home was also related to more contact. Although network proximity is a measure of access to family and friends, it is also an estimate of the social network size of the resident. Most likely both the nearness and sheer number of family and friends relate positively to contact levels. Studies that specifically measure the impact of social network size on contact levels would be informative in this regard.

One finding from previous research was not borne out in our study; ADL dependencies were not correlated with postadmission contact. In the regression analysis, ADL dependencies lost significance when dementia status and race were considered. This finding is perhaps not surprising considering that ADL dependencies are higher among demented elders than among the nondemented, and being nondemented was a strong predictor of postadmission contact.

Dementia status has not previously been studied in relation to family contact patterns, despite its obvious relevance to nursing home populations. This study found that residents with dementia receive less attention from family and friends. Demented residents were also more likely to utilize Medicaid and to have fewer family and friends living nearby. Their frequency of contact prior to admission and their likelihood of having a first-degree relative as a primary significant other did not differ from nondemented residents, however. These results suggest that residents with dementia begin with a smaller available social network than that of the nondemented and also suffer greater decreases in contact, perhaps related to financial barriers.

Interpersonal issues, though not examined here, may also lead to decreased contact for residents with dementia. The study by York and Caslyn (1977) found enjoyment of visits decreased as resident self-care ability, cognitive functioning, and personal appearance declined. Moreover, families reported greater difficulty coping with mental deterioration (37%) than with physical disabilities (15%). Resident cognitive impairment was also shown to be related to poorer nursing care and reduced staff awareness of medical problems (Fleishman, Rosin, Tomer, & Schwartz, 1987). This disturbing finding may relate to the resident’s reduced ability to direct his or her care, but may also reflect a lack of involved family members to advocate on the resident’s behalf. Research is needed on the reactions of family and friends to the illness and impairment of nursing home residents and how this relates to contact levels.

Another variable examined in the current study for the first time is race. Black residents were hypothesized to have greater contact from family and friends than Whites, but this was not the case. Black residents did have greater contact than Whites prior to admission and, as seen in other studies, Black family networks were larger in size and more diverse in terms of kinship than those of Whites (Burton et al., 1995; Gibson, 1982; Gibson & Jackson, 1987; Thornton et al., 1993). The finding of reduced contact following admission therefore suggests that barriers to the continuation of contact may be greater for Blacks than for Whites. One barrier may be lower family resources, as Black residents were significantly more likely to utilize Medicaid than were White residents. Lower socioeconomic status may translate into greater work obligations that diminish opportunities to visit during facility visiting hours, difficulty paying for transportation and telephone costs, and many other practical barriers. Black residents were also more dependent in ADLs and more likely to have dementia than White residents, both of which have been documented previously among nursing home residents (Engle & Graney, 1995). This suggests that the residents may have been cared for in the community for a longer time and only brought to a nursing home when the family’s ability to continue care had diminished. Finally, Black residents were less likely to have a first-degree relative as a primary significant other. Burton and colleagues (1995), noting racial differences in support systems for elders, point out that little is known about the stability of more diverse family systems over time. Variables not examined in the current study, but which might also pertain to Black elders and their families, include the overall health of the social net-
work, additional filial duties, and cultural differences such as level of comfort in visiting a nursing home. Research focused on barriers to visitation that differentially affect Black families is needed.

Perhaps the most striking finding of the present study is that, although families tend to live quite close to their loved one in a nursing home, contact via in-person visits and telephone calls dropped by approximately half within the first few weeks and months of placement. Although this does not indicate that families are no longer involved in care (residents received visits or calls from 20 persons per 2-week period on average), the decline is striking. Some drop in contact would be expected as persons who lived in the same household with the resident prior to admission (and were automatically coded as having a daily visitation contact rate) must now go to the home to visit. However, drops in contact are similar for visits and phone calls. Postadmission contact was not related to the distance the resident moved when admitted to a nursing home; however, residents generally moved very short distances from home. To our knowledge, this study is the first to closely examine change in the amount of family involvement from pre- to postadmission.

This study also provides one of the most complete explorations to date of how previous family habits and demographic, health, and socioeconomic factors relate to contact after admission. Preadmission contact accounted for the largest portion of variance in explaining postadmission contact, with higher preadmission contact positively related to postadmission contact. The longstanding contact patterns of an individual’s social network are clearly important to keep in mind when evaluating patterns of contact after admission. Other variables of importance are the proximity of family and friends, kinship status of the primary significant other, dementia status, and race. Nevertheless, the overall variance accounted for by the regression equation is modest (approximately 21%), indicating that much more has yet to be learned about families and nursing home contact. Other variables to consider include (a) the health of the resident’s social network, (b) the extent of additional time constraints such as employment and other caregiving obligations, (c) transportation and other practical barriers, (d) the quality of the personal relationship between the resident and his or her support system, (e) the quality of the personal relationships between members of the resident’s support system, and (f) characteristics that make the nursing home facility a welcoming setting for maintaining involvement.

Although addressing many shortcomings of the existing literature, the current study also has limitations, most importantly the short length of nursing home stay, the use of newly admitted residents only, and the use of reports of contact frequency from significant others. Length of stay has not been conclusively found to be associated with a decrease in contact, but longitudinal studies are needed to assess change over longer time periods. Because our study included only newly admitted residents, we must be cautious in interpreting the results. Contact patterns may change to a greater degree at times of transition, such as just prior to and just after nursing home admission. On the other hand, the use of new admissions was valuable in that it facilitated more accurate recollections of preadmission contact levels. Given the social expectation that contact levels be high, it is possible that the reports from significant others used here were inflated. Unfortunately, no clearly superior alternative exists for measuring contact levels. Staff reports also entail biases and inaccuracies, and direct observation to count all of the visits and phone calls received by a resident would be logistically very difficult. Because there is no reason to suppose that some population groups would be more likely than others to inflate contact rates, biases that exist would tend toward the null.

Study results have implications for the design of interventions to improve family involvement in the nursing home. Preadmission contact would clearly be difficult to alter. Likewise, neither increasing the number of persons within a resident’s support network nor increasing the likelihood that a primary significant other is a first-degree relative are feasible. While one can recommend that elders be placed in nursing homes that are near to their support networks, it appears from this study that this goal is already being accomplished. An approach with more potential for improvement may be to target residents with dementia. Loved ones may need more information about dementia in order to increase their comfort level while visiting a cognitively impaired resident. Such an intervention could also emphasize the critical need for family and friends to advocate on behalf of a person with dementia as his or her own ability to do so lessens. Socioeconomic factors may also be amenable to intervention. For example, transportation barriers may be ameliorated through volunteer ride systems; less flexible work schedules may be accommodated through longer visiting hours, and addressing the psychiatric and health needs of significant others may improve their ability to be involved in the nursing home. There is currently insufficient information regarding the salience of these barriers or what steps would be effective in reducing their negative effect on contact levels.

References
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Received December 20, 2000
Accepted June 4, 2001
Decision Editor: Laurence G. Branch, PhD

Special Issue Announcement

In October, The Journals of Gerontology Series A: Biological Sciences and Medical Sciences will publish a special issue on nutrition, physical activity, and quality of life. The papers were commissioned by the International Life Sciences Institute Center for Health Promotion. David R. Thomas, MD, is the guest editor for this issue.

All GSA members will receive this special issue as a membership benefit. Subscribers to The Journals of Gerontology Series A will also receive the special issue as part of their subscription. The issue will mail in late October.