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home industry trends

Jane Straker*

Michelle Crepeau†

*Miami University, commons@lib.muohio.edu

†Miami University, commons@lib.muohio.edu

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**Jane Karnes Straker
Michelle R. Crepeau**

Scripps Gerontology Center
396 Upham Hall
Miami University
Oxford, Ohio 45056

email: scripps@muohio.edu

phone: 513-529-2914

fax: 513-529-1476

URL: <http://www.muohio.edu/scripps/>

**HIGHLIGHTS FROM THE SURVEY OF
NURSING HOME INDUSTRY TRENDS**

Jane Karnes Straker
Michelle R. Crepeau

Scripps Gerontology Center
Miami University
Oxford, OH 45056

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The Scripps Gerontology Center at Miami University has been studying long-term care in Ohio through a variety of approaches for the past several years. In order to better understand the nursing home industry in our state, we undertook a study to describe some of the trends that are occurring in this industry. Although state and federal data provide answers to some of our questions about the industry, many other questions could only be answered by collecting our own data. This brief report highlights some of the findings from that study. Future work will combine these data with other state and federal data sources to provide additional comparative and descriptive information about Ohio's nursing home industry.

METHODS

A survey was mailed to a random sample of 436 nursing facilities in August, 1996. Because our main interest is in certified facilities that serve older adults, we omitted rest homes and homes for the mentally retarded from our sample. Telephone follow-up calls were made to facilities that had not returned their completed questionnaires after one month. After phone calls were completed, a second round of surveys was mailed to all facilities that had not yet returned a completed questionnaire. After using these follow-up strategies, 177 facilities completed and returned questionnaires for a response rate of 40.6%.

Table 1 compares our survey sample and our final respondents with the population of Ohio nursing homes from the Ohio Department of Health Annual Survey for 1996. These comparisons suggest that our respondents are representative of the larger Ohio nursing home industry in many important ways.

Table 1
1995 Characteristics of Long-Term Care Facilities from
Population, Survey Sample, and Survey Respondents

	Ohio Long-Term Care Facilities ^a (Percent)	Industry Trends Survey Sample (Percent)	Industry Trends Survey Respondent (Percent)
Operating Organization			
For-Profit	72.8	72.1	70.6
Not-For-Profit	22.7	24.8	27.6
Govt.	4.5	3.1	1.8
License			
Nursing Home	89.9	92.3	91.2
Mental Nsg. Home	.3	.5	0.0
Home for the Aging	4.8	3.4	5.8
County Home	1.7	.2	0.0
Hosp. Based LTC Unit	3.3	3.4	2.9
Number of Beds			
0-49	17.0	12.9	11.8
50-99	26.5	21.1	24.7
100 and up	56.5	66.0	60.1
Location			
Rural	29.4	28.9	29.8
Urban ^b	70.6	71.1	70.2
N=	1,001	436	177

^a Excludes homes for the mentally retarded and rest homes.

^b Located in counties included in census-defined Primary Metropolitan Statistical Area.

FINDINGS

Waiting Lists

- Most (79.5%) facilities keep waiting lists, despite the fact that the majority (75%) feel that they are not at all accurate or are only somewhat accurate in reflecting the demand for beds in their facilities.
- Half of the facilities indicated that a person placing their name on the waiting list today could be admitted in six weeks or less. Half of the facilities reported a similar waiting time in 1995. On average, all facilities reported a waiting time that was three days longer in 1995 than in 1996.
- Half (51%) of the facilities reported that none of their new admissions in July 1996 came from their waiting lists. Only one-quarter of facilities took more than half of their new admissions from names on a waiting list.

Admissions

- Facility admission rates ranged from 8% of a facility's bed capacity to 2612% of capacity in 1995. Facilities with the highest rate of admissions are licensed as hospital-based long-term care units. All facilities with admission rates over 500% held this type of license. Fifty-seven percent of facilities with admission rates over 100% also provide sub-acute services, and 48.5% provide hospice services. Nearly half (45.5%) provide respite services.
- Hospitals provide the largest source of admissions (61%). Community referrals are next (19.7% of admissions), followed by inter-nursing facility shifts. Inter-facility shifts do not benefit all homes equally--61 percent of facilities got no new admissions from another facility.
- July 1996 admissions were multiplied by 12 to get 1996 estimated admissions. The change in total admissions from 1995 to 1996 was examined for each facility. The average change across all facilities was an increase of 11.5 admissions.

- Three-quarters of facilities (74.4%) reported no admission delays in the previous three months due to level-of-care determinations. Six percent (5.8%) of facilities reported admission denials due to level-of-care determinations.
- Half of the facilities felt that the availability of PASSPORT and home and community-based services (HCBS) had no effect on the number of their admissions. About forty percent (38.2%) felt that PASSPORT and HCBS had decreased their admissions, and nearly half (48.2%) felt their residents were admitted more functionally impaired than two years ago.

Discharges

- Discharge rates in 1995 ranged from 1.37% to 2581% of a facility's adjusted bed capacity.
- Discharges to the community were the most prevalent. Over half (59.2%) of facilities discharged residents to the community, and as a proportion of all discharges, community discharges were 37.5%. Of these, 6% were connected to PASSPORT before leaving the facility. Over a third (37%) were connected with other HCBS before discharge. Of those with the highest proportions of community discharges (25% or more of their discharges), over half (55.8%) have managed care contracts, and a quarter (27.8%) are part of an integrated health delivery system. About one-quarter (26.2%) of all discharges were due to death. As a proportion of total discharges, about 9% of residents are discharged to another facility.
- Compared to calendar year 1995, 1996 estimated discharges show an increase in about 40% of facilities.
- Almost one third (29.8%) felt that PASSPORT and HCBS had increased the number of residents they discharged and allowed them to discharge residents more functionally impaired (30.0%) compared to two years ago.

Personnel

- Over half (54.9%) of the respondents reported that 10 percent or more of their direct care staff had been on the job less than three months. One quarter (25.4%) indicated that 20% or more of their staff had been at the facility less than three months. About three-quarters (74.1%) of facilities have 50% or more of their staff with one or more years tenure. On average, facilities in urban areas have had 61% of their staff for one year or longer; rural facilities have had 67% of their employees one year or longer.
- Three-quarters of facilities indicated that employee recruitment had been a problem in the last year. Of these, 82.9% reported nursing assistants as the position which caused recruiting problems. Over half of those with problems (53.3%) said that their major challenge was a lack of applicants. The most common strategy used by those with recruitment problems was to increase visibility in the community.
- About two-thirds (68%) of facilities reported retention problems in the past year. Of these, 83.5% mentioned nursing assistants as the position which caused the most retention problems. Strategies used by those with recruitment and retention problems include increasing wages, and providing longevity and attendance bonuses. There is no significant relationship between whether a facility is located in an urban or rural area and the extent to which they have recruitment or retention problems.
- Average starting salaries for nursing assistants ranges from \$4.75 to \$7.82 with an average of \$6.23 per hour. The range for facilities' most highly paid nursing assistants is \$5.29 to \$11.50, averaging \$8.65 per hour. Facilities with recruitment and retention problems pay salaries slightly above average, those without problems pay about \$.20 less per hour. Urban facilities pay about 35 cents more per hour as an average starting salary than do rural facilities. Rural facilities also pay about 75 cents less per hour to their highest paid nursing assistants than do urban facilities.
- The average number of benefits offered to nursing assistants is 5.7 out of 9 benefits we examined. Almost all facilities offer health insurance (94.9%), but only 10% offer employer paid insurance. Three-quarters (74.6%) offer paid sick leave, almost all (98.3%) offer paid vacations and holidays. Benefits are significantly related to recruitment problems--21.9% of facilities without recruitment problems offer 7 or more benefits. Only 8.3% of facilities with problems offer 7 or more benefits.

Managed Care

- About a third (39.6%) of facilities have some type of managed care contract. About one-fourth (26.7%) are part of an integrated health delivery system. The most common type of participation is as part of a preferred provider organization. Seventeen percent of all facilities participate in private and/or Medicare HMO's.

Assisted Living

- About one-quarter (23.2%) of all respondents had also designated a portion of their facility as Assisted Living. Another 17.5% of facilities were exploring the possibility of adding Assisted Living.
- The most common feature of Assisted Living is personal furnishings owned by residents (90.2% of Assisted Living facilities). Over three-quarters offer individual dwelling units, community spaces for resident use (82.9%), and full baths that are accessible without exit to the corridor(80.5%). Over two-thirds offer lockable doors (68.3%) and individual unit temperature controls (70.7%). Food preparation spaces were the least common feature, offered by about a third (39.3%) of facilities. Since this study included only nursing homes, some of which also offer assisted living, the number of amenities offered may not be indicative of the entire assisted living industry.

Home and Community Based Services

- One-fourth (26.6%) of our respondents offer at least one home and community-based service. About one quarter offer five or more services; about half (47.8%) offer only one or two.
- The most common services are outpatient rehabilitation and respite care, offered by about half (45.7%) of these facilities. Home health services were offered in one-third of facilities. Transportation, home delivered meals, adult day care, educational programming for families, and personal care services are each offered by about one-quarter of these facilities.
- About one-third (35.8) began offering HCBS in the last three years. Another quarter (26.5%) have been offering at least one HCBS for 10 years or longer.

Special Care Services

- Eighteen percent of our respondents have sub-acute care units, and an additional 9.6% offer sub-acute services in their facilities. Three-quarters of these providers (76.7%) have added sub-acute care since 1992.
- Respite services are offered by three-quarters of the facilities (72.7%). One quarter (23.8%) added these services in 1995 or 1996.
- Almost a third (31.8%) offer services in a separate Alzheimer's unit.
- Hospice services were offered by 89.5% of facilities. About one-third (38.9%) began hospice care in 1995 or 1996.

Sub-Acute Care

Thirty out of the 42 facilities that reported having sub-acute services (72%) were followed up with a telephone interview. The section below summarizes the findings from these semi-structured telephone interviews.

- Half of our respondents defined sub-acute care as care that comes after a hospitalization. *"Transition from hospital to home..."*, *"whatever care Medicare pays for..."*. The other half of respondents defined sub-acute care in terms of the services provided. *"High acuity services that are normally above what is considered skilled care."* *"Higher than complex care, but done after acute care, or acute care done in our nursing home setting."*
- About one-third identified with a transitional medical model, and two-thirds saw themselves as providing specialized care for particular problems.
- Three-quarters of these facilities have a separate sub-acute unit, and about one-quarter have a separate outside entrance to the unit. One-third of facilities provide a different type of room, often with a TV and telephone, more specialized equipment, and more likely to be private.

- All sub-acute providers provide occupational and physical therapy, almost all (96%) provide IV Drug therapy, parenteral hydration, and a dispensing pharmacy (94%). Respiratory therapy and laboratory services are available in 86% of sub-acute providers. Peritoneal dialysis is provided by 67%.
- About one-third (37%) do not share sub-acute nursing staff with the rest of the facility. Half also have additional positions such as case managers, directors of nursing, and physicians that are exclusive to the sub-acute service and half provided specialized sub-acute staff training.
- Half (46%) of facilities reported average stays of 21 days or less. All but one reported an average stay of 55 days or less.
- Base daily costs ranged from \$95 to \$750. Facilities with managed care contracts reported that costs were different because of negotiated rates with different insurers. All respondents indicated that the majority of their payments come from Medicare.
- A third of our respondents thought that sub-acute services and reimbursement work quite well. The majority, however, thought a greater move towards managed care would help, along with some refinements in the managed care concept. Standardizing sub-acute definitions and terminology across the industry would help in setting appropriate payment and reimbursement levels.
- Challenges faced by sub-acute providers include *"competition for people coming out of the hospital..."*, *"constant staff turnover..."* short lengths of stay, *"you have to know the discharge plan before the person even comes in..."* and discharge problems, *"our long-term care beds stay filled so we have nowhere to discharge people when they don't need sub-acute care."*