Portrait of Our Members:

Results of the LeadingAge Member Survey 2019

June 2020

Acknowledgment

LeadingAge extends its sincere thanks to LeadingAge members who completed the 2019 Member Survey, and to the 38 LeadingAge State Partners that supported the survey initiative.

The 2019 LeadingAge Member Survey process was managed by the LeadingAge LTSS Center @UMass Boston, which convened an interdisciplinary working group representing teams from across the LeadingAge organization. The group was assisted by the State Executives Member Survey Task Force.

The LTSS Center analyzed data collected through the 2019 Member Survey and prepared this report. Please direct your questions about the survey to Natasha Bryant, managing director and senior research associate, at nbryant@leadingage.org.

Learn more about the LeadingAge LTSS Center @UMass Boston at www.ltsscenter.org.

Table of Contents

A Message for Members 3

About the LeadingAge 2019 Member Survey 4

Research and Report Information 5

An Overview of Key Findings 7

Profile of LeadingAge Members 9

Nursing Homes 10

Assisted Living 13

Affordable Housing 15

Market-Rate Independent Living 17

Home and Community-Based Services 19

Appendix: Definition of Services and Technologies 25

A Message for Members

The 2019 Member Survey produced a host of meaningful data about LeadingAge members and the important services they provide to residents and clients. Working closely with our members and state partners, LeadingAge was able to achieve a survey response rate of 37%, which gave us a solid data set from which to distill the findings contained in this report.

We now have important baseline information about the LeadingAge membership. Subsequent member surveys, conducted every two years beginning in 2021, will help LeadingAge build on this data infrastructure and will allow us to track national and state trends in the field of long-term services and supports (LTSS), conduct in-depth research to learn more about specific trends, and share information about those trends with you.

We present this report with deep gratitude to every LeadingAge member who completed the 2019 Membership Survey, and to state partners who promoted the survey among their members and played a vital role in the survey's success.

We hope we can count on your continued participation in future surveys as we strive to provide meaningful data that LeadingAge and its members can use to conduct data-driven planning and decision making.

Katie Smith Sloan
President & CEO, LeadingAge

Robyn I. Stone
Co-Director, LeadingAge LTSS Center @UMass Boston

About the LeadingAge 2019 Member Survey

LeadingAge conducted a survey among its provider members during 2019 to gather much-needed information about nonprofit providers of aging services, and to help LeadingAge and its state partners understand their members better so they could better serve their needs.

The 2019 Member Survey included questions focusing on five settings/service lines within LeadingAge organizations:

- **Nursing homes (NH)**
- **Assisted living (AL)**
- **Affordable housing (AH)**
- **Market-rate independent living (IL)**
- **Home and community-based services (HCBS),** including home health care (HHC), non-medical home care (HC), adult day (AD) service centers, and hospice.

Surveys were mailed electronically to an individual in each major setting who had been identified by organizational leaders as a knowledgeable "expert." This individual tended to be the person who oversaw the operations for the specified business line or setting.

The survey's overall response rate was 37%. The highest response rate (44%) was achieved by housing members (AH or IL), followed by assisted living (39%), nursing home (33%), and HCBS (24%) members.

Research and Report Information

Methodology

Providers completing the 2019 LeadingAge Member Survey were asked questions about their organization's characteristics, resident demographics, services, workforce, and technology use. Following is an explanation of specific data sets.

Nursing home data: Data for nursing homes (NH) with designated post-acute (PA) and long-stay (LS) beds are presented separately for PA and LS, and identified in charts as "Nursing Home—Designated Beds." The data for nursing homes without designated beds for PA and LS are identified in charts as "Nursing Home—No Designated Beds."

Survey respondents were asked to provide some information for the entire nursing home. Therefore, this report presents information about services, staffing, and technology for the entire nursing home, even when an organization had designated PA and LS beds.

Resident data: Data presented in this report for the average number of residents living in NHs and assisted living (AL) communities are based on the most recent daily census or a daily census that is not older than six months.

Data describing the average number of residents/clients living in affordable housing (AH) and market-rate independent living (IL), or receiving home health care (HHC), non-medical home care (HC), and hospice care, are based on the number of residents/clients at the time of the survey.

Data describing the average number of participants in adult day (AD) service center programs is based on the number of participants who were enrolled at the AD center at the time of the survey. The maximum number of AD participants is based on the allowable daily capacity.

Workforce data: The workforce data presented in this report include only employees hired directly, and issued a W-2 federal tax form, by NHs, AL communities, and agencies providing home and community-based services (HCBS). The staffing data in this report do not include staff hired through a contract with an outside agency.

Workforce data is presented only for:

- Registered nurses (RN).
- Licensed practical nurses/licensed vocational nurses (LPN/LVN).
- Aides.
- Social workers.
- Activities personnel (AL only).
- Therapeutic recreational specialists and therapy personnel (NH only).
- Bereavement staff (hospice only).
- Physicians (hospice only).
- Service coordinators (AH only).
- Wellness nurses (AH only).

If NH, AL, and HCBS staff members were shared with another service line on a campus, these staff were considered part-time.

IL providers were not asked about staffing.

Full-time equivalents (FTE) were calculated by dividing the number of part-time employees by two and adding that figure to the number of full-time employees.

Services Data: This report's data on NH services describe services delivered in addition to standard services that are mandated by federal regulations for NHs. This report's data on HHC services describe services that are regulated but are not required unless they are aligned with the plan of care and services delivered in addition to standard services that are mandated by federal regulations for HHC agencies.

The survey assessed a broader range of services in AL, AH, IL, HC, and AD settings, because there are no federal regulations governing service provision in these settings. Regulations for these settings, if they exist, are set at the state level. Some states do not regulate any services delivered in these settings.

The hospice survey asked providers to report their federally regulated services, as well as the additional, non-regulated services they offered.

The following services were assessed for each setting:

- ***Nursing home:*** Respite, hospice, and non-hospice palliative care; bariatric therapy, and alternative therapy, such as pet therapy and music therapy; dementia care provided in a specialized unit; respiratory health, dialysis, and substance abuse treatment.
- ***Assisted living:*** Hospice, skilled nursing, and non-hospice palliative care; home health, social work, dental, and mental health services; physical therapy (PT), occupational therapy (OT), and speech therapy; pharmacy, podiatry, dietary/nutrition, and pastoral care services; transportation (medical/dental and social); and social and therapeutic recreational activities.
- ***Affordable housing:*** Social and recreational activities; congregate meals; onsite grocery/commodity delivery or pick-up programs; exercise/fitness and health education programs; education about medications and/or addressing medication complications; homemaker, personal care, mental health, dental, podiatry, transportation, and health screening/monitoring services; primary care services provided by a physician or other clinician.
- ***Market-rate independent living:*** Resident health clinic; physician care (primary and specialty); dental and pharmacy services; therapy (PT, OT, speech).
- ***Adult day:*** Dental, social work, mental health, pharmacy, podiatry, and dietary/nutrition services; transportation (medical/dental, social, and daily round-trip); skilled nursing, respite, and hospice care; therapy (PT, OT, and speech); congregate meals.
- ***Hospice:*** Physician, pharmacy, dietary/nutrition, pastoral care, and social work services; skilled nursing and respite care; therapy (PT, OT, and speech); alternative therapy, such as pet therapy and music therapy.
- ***Home health care:*** Continuous home care and non-hospice palliative care; pharmacy, podiatry, dietary/nutrition, and pastoral care services; respiratory therapy and infusion therapy; home-delivered meals.
- ***Non-medical home care:*** Personal care, continuous home care, and respite care; dietary/nutrition, homemaker, and pastoral care services; transportation (medical/dental and social); home-delivered meals.

Data Presentation

Responder data: Survey respondents were not required to answer every question before submitting the survey. As a result, the number of respondents varied by question and topic area. The number or range of people who responded to each question is included in the charts and represented by "n" or "range."

Defining Setting

Assisted living: Settings providing "assisted living" services have different names in different states. These settings can be referred to as personal care or adult care homes, facilities, or communities; adult family or board and care homes; adult foster care; or homes for the aged.

Affordable housing: "Affordable housing" is defined as a community for residents who have incomes below a specified level and whose housing costs are reduced through a rent or mortgage subsidy.

An Overview of Key Findings

The LeadingAge membership includes nonprofit nursing homes (NH); assisted living (AL), affordable housing (AH), and market-rate independent living (IL) communities; and providers of home and community-based services (HCBS). In 2019, LeadingAge conducted a survey of these members to collect information about their services, workforce, residents, and technology use. Key findings from the survey included:

Response Rate: The survey's overall response rate was 37%. Setting-specific response rates included 44% for housing providers (1,501 surveys completed), 39% for AL communities (831), 33% for NHs (1,007), and 24% for HCBS providers (649).

Organization Size: Settings managed by LeadingAge providers were classified by size, based on their number of units/beds. Approximately 75% of the AL settings were classified as large communities. Almost one-quarter of NHs were classified as small in size. Almost half of AH settings were classified as medium-sized communities; 29% were classified as small. IL settings were a mix of small, medium, large, and extra-large apartments.

Resident Profile: LeadingAge members generally served people who were white, women, and aged 75 and older. AH residents and adult day service center participants were younger and more racially and ethnically diverse than residents of other settings.

Services: Services available to residents/clients varied by setting. Settings also took different approaches to service delivery, either providing services directly and/or through arrangements with outside service providers or contractors.

- In NHs, the top services provided were hospice care, non-hospice palliative care, alternative therapy, respiratory health, and respite care. These services were most likely to be provided directly by NH employees, with the exception of hospice care.
- More than three-quarters of AL communities provided all of the services asked about in the survey. The services were provided directly and through arrangements with outside providers.
- More than 80% of AH communities offered recreational activities and health education to their residents. Most of the services were provided to residents through a contract or partnership and were not provided directly by AH staff. The services least likely to be provided to AH residents were personal care and primary care services.
- Therapy (physical, occupational, and speech) was the top service provided by IL providers, primarily through a contract or partnership. Less than half of IL communities provided physician or dental services.
- HC agencies were most likely to offer services directly by staff. HHC agencies were more likely to offer most of the services asked about in the survey through arrangements with outside providers than directly by staff. AD service centers and hospice agencies took a mix of approaches to the delivery of services, combining services provided directly by staff with services provided through arrangements with outside providers. AH and IL settings were more likely to offer services through a contractor or partnership.

Workforce: Aides were the most commonly employed full-time equivalent (FTE) in NHs, AL communities, home health agencies, home care agencies, and adult day service centers. Registered nurses were the most commonly employed FTE in hospice agencies.

- Of the positions reported, social workers were the least commonly employed FTE in AL (an average of .5), home health care agencies (.5), and home care agencies (.4).
- Licensed practical nurses and licensed vocational nurses were the least commonly employed FTE in adult day service centers (an average of .5) and hospice agencies (2.3).
- Just over half of AH communities reported having an onsite, full-time service coordinator. These communities differed in how the service coordinator position was funded.

Technology: LeadingAge members differed in their use of a variety of technologies and the providers with which they exchanged electronic health information.

- More than half of NHs used technologies to facilitate social connectedness.
- Less than half of all AL communities exchanged electronic health information with outside providers such as physicians, hospitals, and skilled nursing facilities. There was one exception: 59% of AL providers exchanged information with pharmacies.
- IL communities were not likely to use technology tools. Less than half of these communities used care management/care coordination, sensor technologies, and social connectedness and engagement tools.
- HCBS agencies were not likely to exchange health information with any type of provider. Less than 20% of HCBS agencies used telehealth/telemedicine or remote activity monitoring technologies.

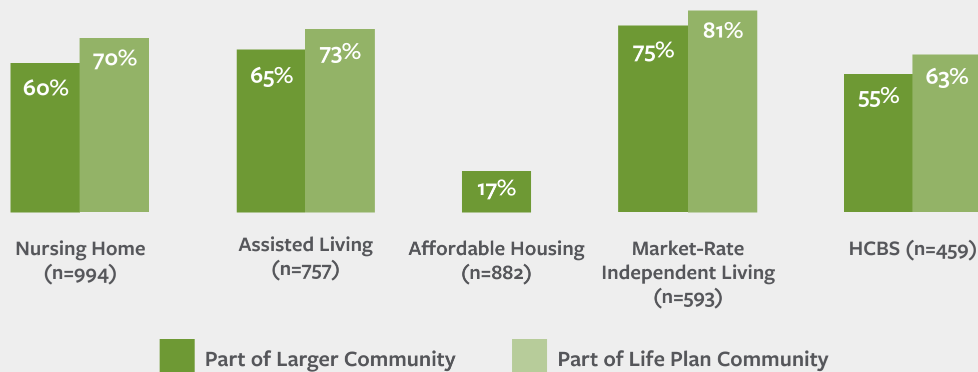
Profile of LeadingAge Members

LeadingAge received almost 4,000 surveys from member organizations representing nursing home, assisted living, affordable housing, market-rate independent living, and home and community-based services providers.

LeadingAge members are generally well-established organizations that have been operating, on average, for 15 to 46 years. Nursing homes have the longest history of operation, while home health care, home care, and hospice providers have been in operation for the fewest number of years.

The majority of LeadingAge settings reported being part of a larger community, most often a life plan community. The one exception was affordable housing: 83% of these communities reported that they were freestanding.

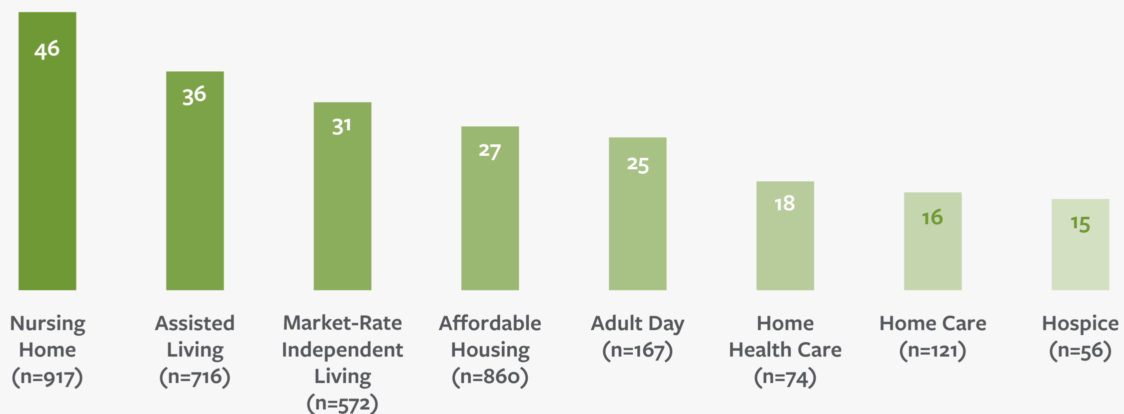
Percentages of Providers that are Part of Larger Community and Part of Life Plan Community*



*Respondents were first asked if they were a free-standing community or part of a larger community. Respondents who indicated they were "part of a larger community" were asked whether they were part of a life plan community.

*Affordable housing communities were not asked if they were part of a life plan community.

Average Years in Operation



Nursing Homes

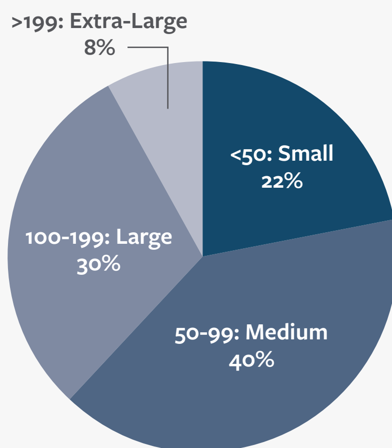
Forty percent of the 1,007 nursing homes (NH) responding to the survey indicated that they had designated post-acute (PA) and long-stay (LS) beds within their care settings. The remaining 60% of NHs did not have separately designated beds for PA and LS.

Size: Most (70%) of nursing homes surveyed were classified as either medium (40%) or large (30%) in size, based on the number of beds across the NH setting. Medium-sized NHs reported having 50-99 beds, while large-sized NHs reported having 100-199 beds. Most NH beds were Medicare- and Medicaid-certified.

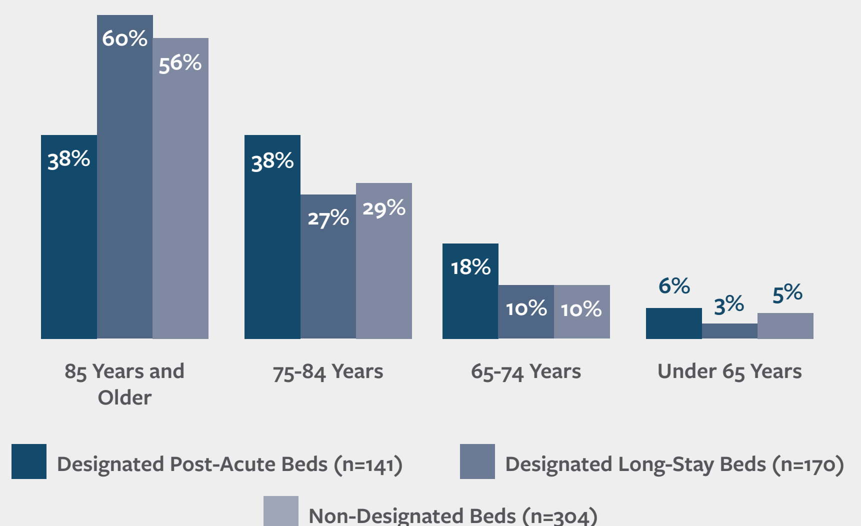
Residents: The average annual occupancy rate across NH settings was about 85%. Long-stay NH settings reported the highest average number of residents (85 residents), based on daily census, compared to an average of 32 residents in post-acute NHs and 66 residents in NHs without designated beds.

Across all NH settings, the majority of residents were women (65%-74%) and white (90%-93%). More than half of residents in long-stay NHs (60%) and NHs without designated beds (56%) were aged 85 and older, and less than one-third were between the ages of 75 and 84. Post-acute NH settings served more residents between the ages of 75 and 84, but fewer residents aged 85 and older, compared to long-stay NHs and NHs without designated beds.

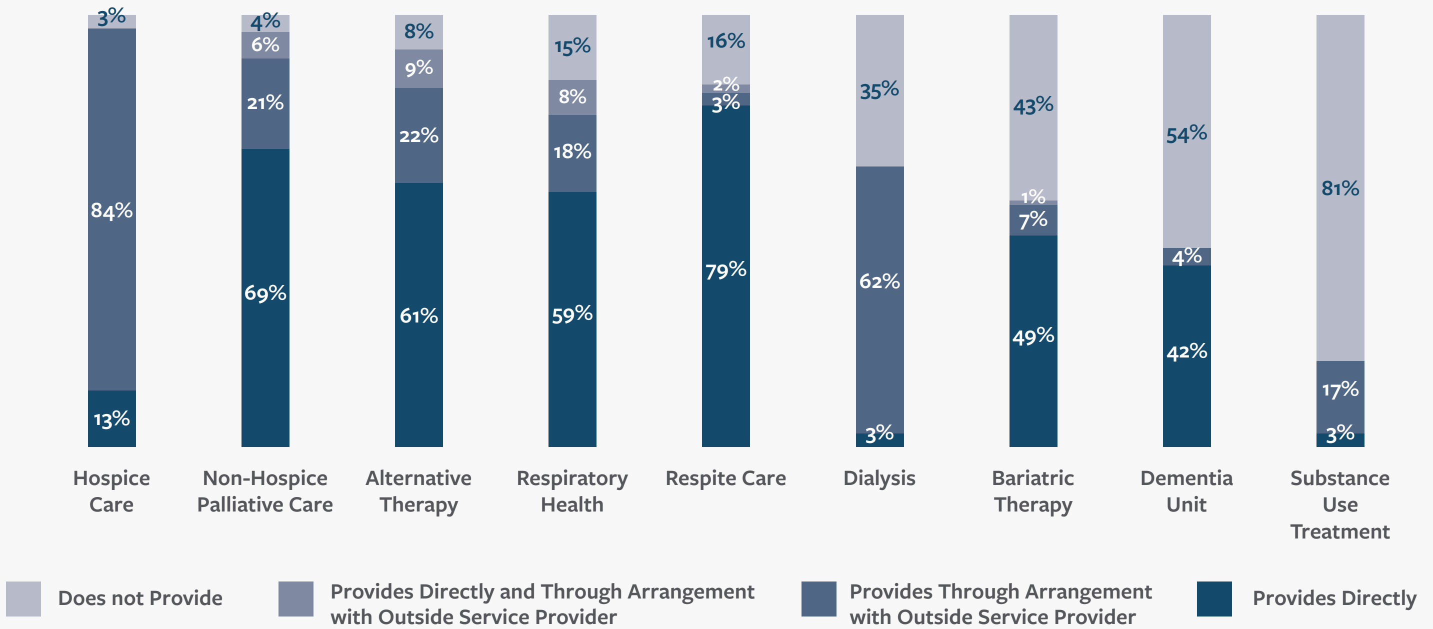
NH Size by Number of Beds (n=909)



Age Categories of NH Residents by NH Setting



Service in the NHs (Range of Ns: 693-718)



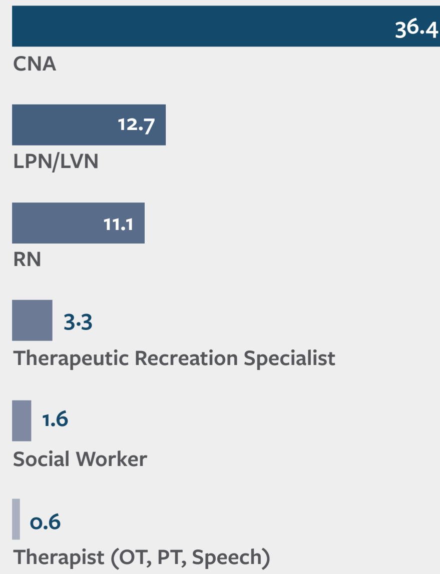
Services: Most of the services asked about in the survey were provided by at least half of the nursing homes. The top services provided only through arrangements with outside service providers were hospice care (84%) and dialysis (62%). Services most often provided directly by nursing home employees included respite care (79%), non-hospice palliative care (69%), alternative therapy (61%), and respiratory health treatment (59%). Substance use treatment was the service least frequently provided in NHs, either directly or through an arrangement with an outside provider: 81% of NHs did not provide the service. About half of the NHs (46%) reported having specialized dementia units.

Workforce: Certified nursing assistants (CNA) were the most frequently employed staff across NH settings, with an average of 36 full-time equivalents. The least frequently employed profession at NHs was therapy staff, including occupational therapists, physical therapists, and speech therapists.

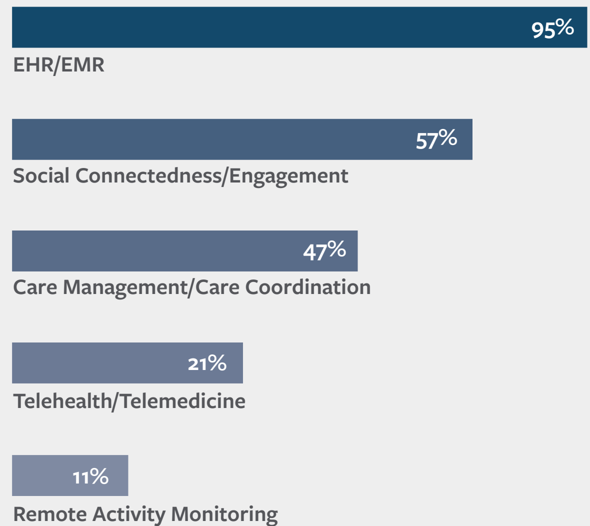
Nursing homes reported that, on average, CNAs spent more than three staff hours per resident per day. This was the highest average staff hours per resident per day reported for NHs. Licensed practical nurses/licensed vocational nurses spent an average of 1.2 hours per resident per day, followed by registered nurses (1.1 hours), and therapeutic recreation specialists (.35 hours or 21 minutes). Social workers (.15 hours or nine minutes) and therapy staff (.03 hours or two minutes) spent the fewest staff hours per resident per day.

Technology Use: The most frequently used technology tools in NHs were electronic health records or electronic medical records, which were used by 95% of respondents. External providers participating in electronic health information exchange with NHs included pharmacies (76%), physicians (63%), hospitals (52%), behavioral health specialists (23%), and other long-term care providers (19%). More than half of nursing homes (57%) reported using technologies that facilitate social connectedness and engagement among residents.

Average FTE Employees in NHs (Hired Directly) (Range of Ns: 386-484)



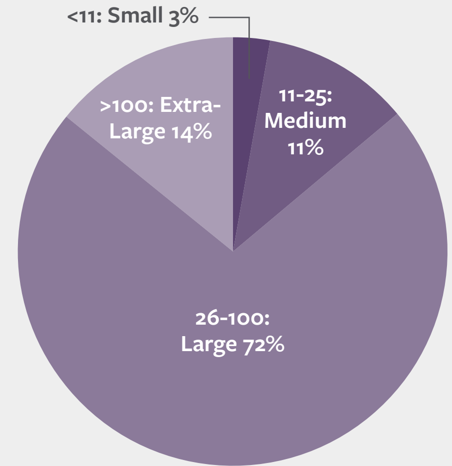
Technology Used by NHs (n=1,007)

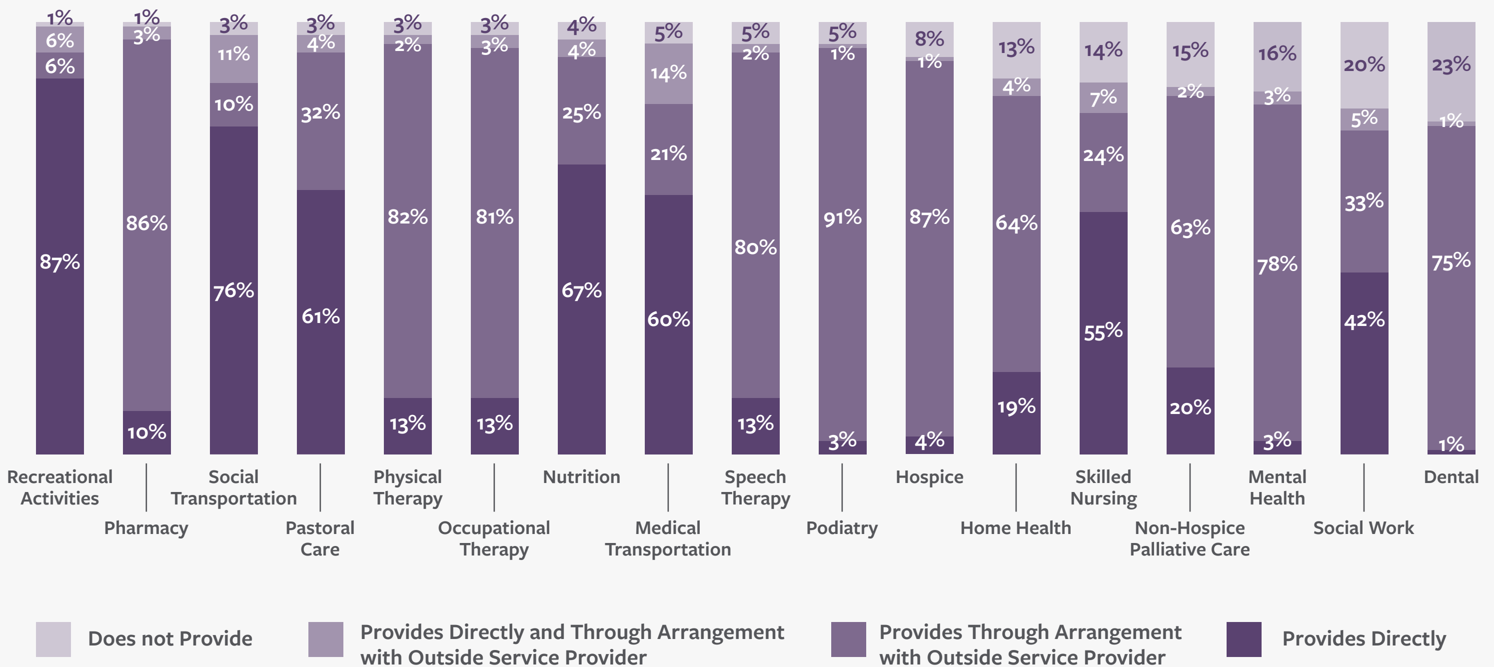


Assisted Living

Size: Most (86%) assisted living (AL) communities reported having more than 25 beds, while AL communities participating in the survey reported an average of 63 beds. Three-quarters (72%) of AL communities were classified as large settings (26-100 beds) while 14% were classified as extra-large because they had more than 100 beds.

Residents: An average of 54 residents lived in the AL communities surveyed. Resident census across AL survey respondents ranged from four to 215 residents. Roughly three-quarters of AL residents (74%) in the surveyed communities were women and over half (62%) were 85 and older. Nearly all AL residents (96%) were white. Survey respondents reported small populations of residents identifying as Black (1%), Hispanic (1%), or another race/ethnicity (2%).





Services: AL communities reported providing most of their services either directly or through arrangements with outside service providers. The top five services were recreational activities, pharmacy, social transportation, pastoral care, and therapy (physical or occupational). Assisted living communities were most likely to provide five services directly to residents: recreational activities, dietary/nutrition, social and medical transportation, pastoral, and skilled nursing. Over 75% of the AL communities made arrangements with outside service providers to deliver dental, hospice, mental health, podiatry, therapy, and pharmacy services to residents.

Dementia Care: Few assisted living communities (14%) served only adults with Alzheimer's disease or other dementias. Of those AL communities serving a mixed population, 41% reported having a distinct unit, wing, or floor designated as a dementia, Alzheimer's, or memory care unit. These units contained an average of 24 licensed beds.

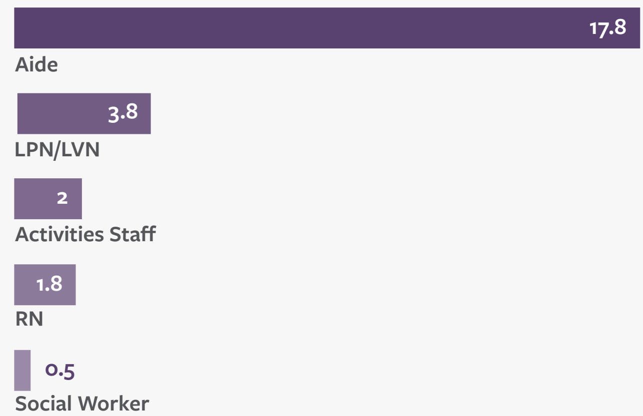
Workforce: Aides were the most commonly reported staff employed at assisted living communities, with an average of 18 full-time equivalent aides employed. Those aides spent more time with residents—an average of two hours per resident per day—than any other AL employee, including activity professionals (.24 hours or 14 minutes), social workers (.12 hours or seven minutes), licensed practical nurses/licensed vocational nurses (.4 hours or 24 minutes), and registered nurses (.2 hours or 12 minutes).

Social workers were least likely to be employed by assisted living communities. On average, AL communities reported an average of .5 FTE social workers.

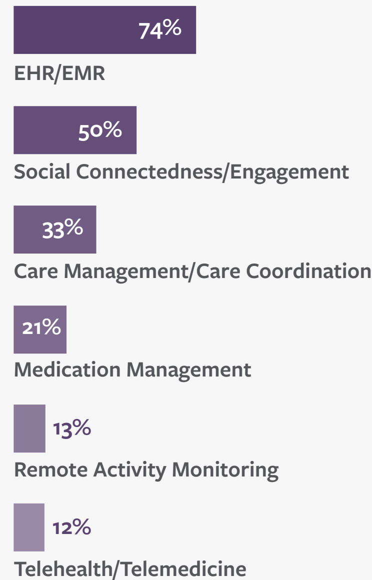
Technology Use: Electronic health records or electronic medical records were the most commonly reported technology used by assisted living communities (74%). Half of the surveyed communities also reported using technologies that facilitate social connectedness and engagement among residents. Assisted living communities were least likely to use telehealth/telemedicine (12%) and remote activity monitoring (13%).

Roughly half of AL communities used a computerized system to support electronic health exchange with pharmacies (59%), followed by skilled nursing facilities (47%), physicians (44%), hospitals (32%), and other long-term care providers (10%).

Average FTE Employees in AL Communities (Hired Directly) (Range of Ns: 418-485)



Technology Used by AL Organizations (Range of Ns: 635-645)



Affordable Housing

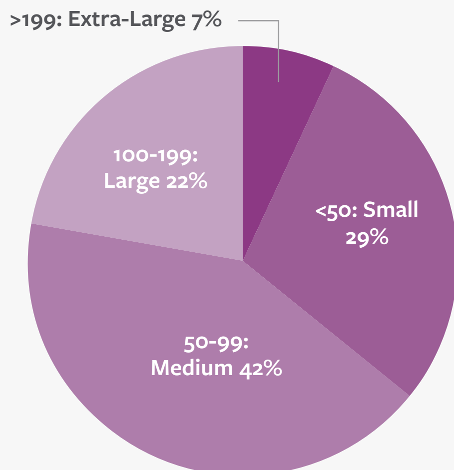
Size: Less than half of affordable housing (AH) communities (42%) responding to the survey reported having 50-99 units. The average number of units reported by surveyed communities was 90 units, with the number of units across all survey respondents ranging from two to 1,093 units. Some affordable housing communities—147 of the 890 communities completing the survey—reported that they also offered market-rate units.

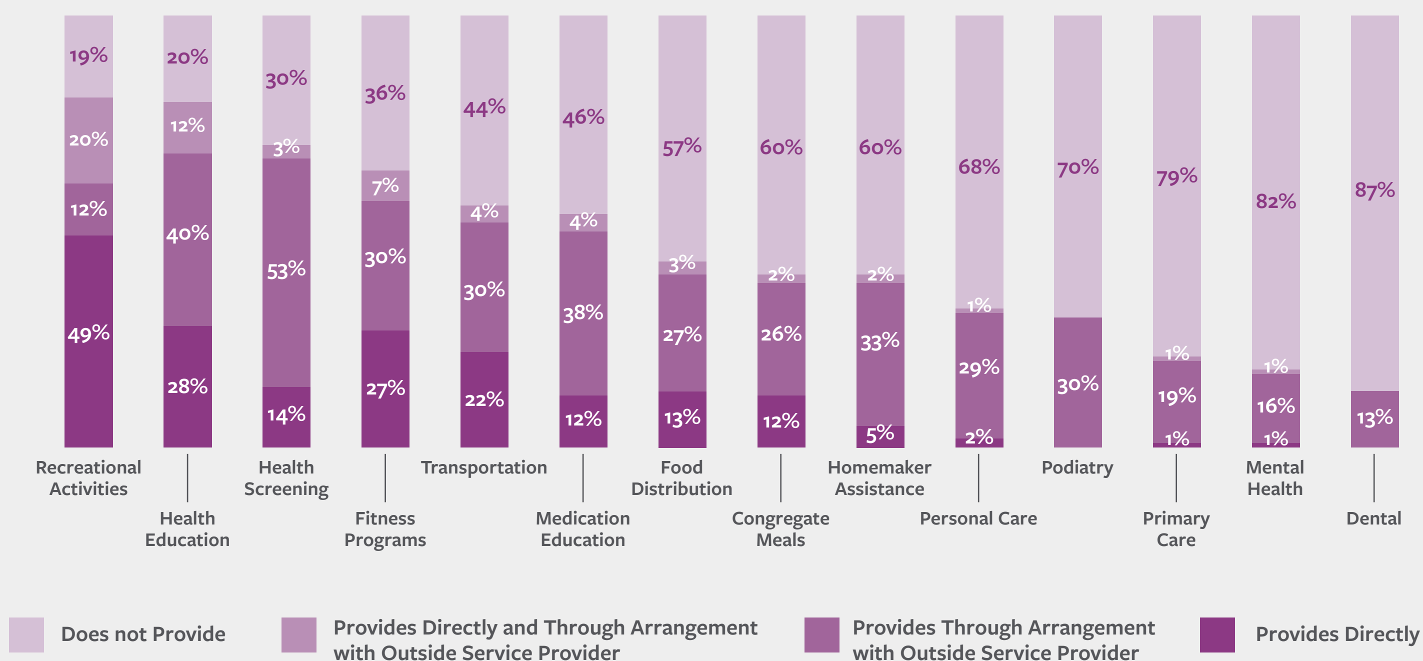
Occupancy: Most (88%) of AH communities reported an average annual occupancy rate of 98% or higher, and nearly all (94%) had a wait list. Of those housing communities with a wait list, the average wait time was 25 months.

Residents: The average number of residents in AH communities was 95 at the time of the survey, and the median number of current residents was 74 at that time. Roughly three-quarters of affordable housing residents (72%) were women. Affordable housing communities reflected the most resident diversity of all settings in the survey. When asked about resident ethnicity, AH communities reported that 12% of residents were Hispanic. Survey data about race showed that 70% of residents were white, 17% were Black, and 12% were Asian.

Most AH residents (73%) were aged 65 to 84, with equal portions of residents between the ages of 65 and 74 (37%) and between the ages of 75 and 84 (36%). Sixteen percent of residents were 85 years and older.

AH Community Size by Number of Units (n=884)





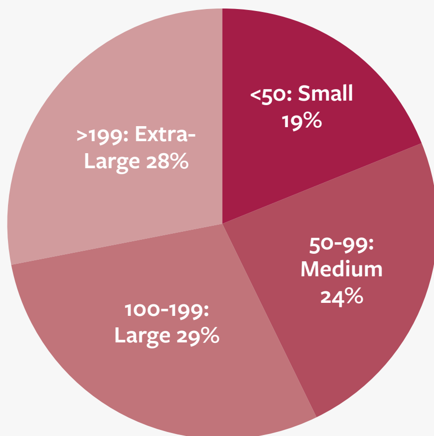
Services: More than half of AH communities offered the following services either directly by a staff member or through a contractor: recreational activities, health and education programs, fitness programs, transportation, medication education, and health screening and monitoring. Less than one-third of AH communities provided personal care, primary care, mental health, podiatry, or dental care either directly by AH staff or through a contractor or partnership. With the exception of recreational activities, less than half of AH communities provided services or programs directly.

Workforce: Most (90%) of the affordable housing communities participating in the survey reported having a service coordinator, and 54% of service coordinators were employed full-time. Most AH communities (87%) employed service coordinators directly through the property owner or management agent. The U.S. Department of Housing and Urban Development funded salaries for 66% of service coordinators working in affordable housing communities. Most of the AH communities (92%) did not have a wellness nurse on staff. Among the AH properties with a wellness nurse, 42% employed the nurse directly and 37% used the services of a wellness nurse provided by another organization.

Technology Use: Nearly half of the affordable housing communities surveyed (49%) reported using a web-based software for resident documentation and outcomes. A third (34%) of AH communities also reported using technologies that facilitate social connectedness and engagement among residents.

Market-Rate Independent Living

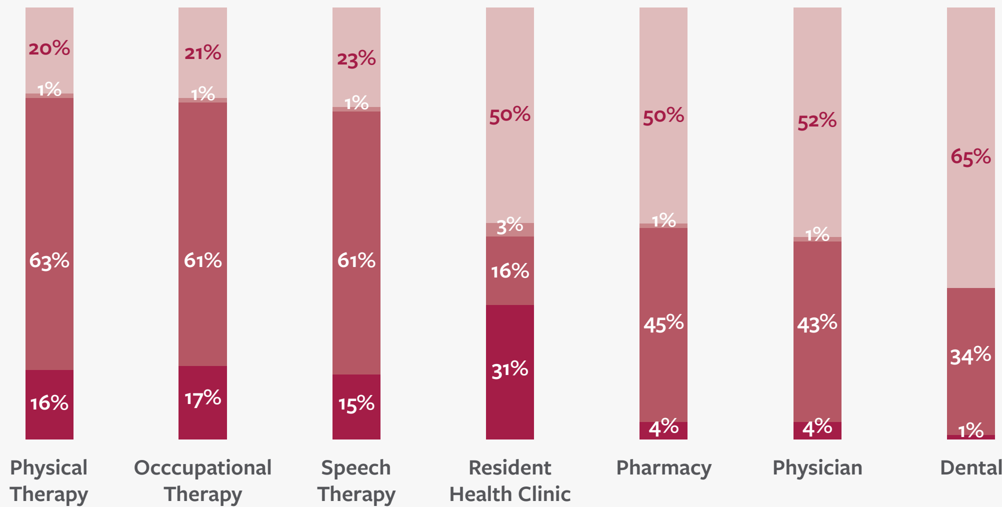
IL Communities by Number of Units (n=503)



Size: Market-rate independent living communities (IL) reported having a mix of less than 50 units, 50-99 units, 100-199 units, and more than 199 units. The communities ranged in size from two to 1,333 units, with an average of 153 units. These units were most likely to be either one-bedroom (42%) or two-bedroom apartments (42%), although studio apartments (9%) and apartments larger than two bedrooms (7%) were also available. A small percentage of IL units—2% on average—were subsidized. The communities reported an average annual occupancy rate of 92%.

Residents: Independent living communities served an average of 183 residents, although the number of residents in a community could range widely, from only one resident to 2,400 residents. The majority of IL residents were women (69%) and white (95%). IL communities served an older population: more than 88% of residents were 75 years and older, and almost half of residents were older than 85 (48%).

Services in IL Properties (Range of Ns: 508-513)



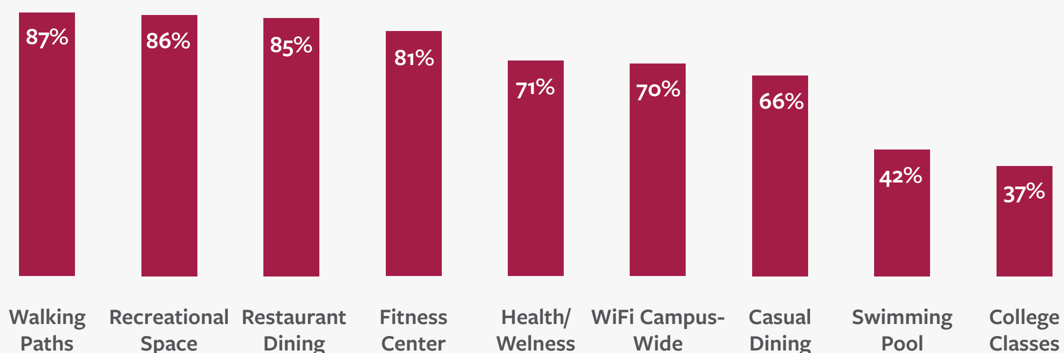
Does not Provide | Provides Directly and Through Arrangement with Outside Service Provider | Provides Through Arrangement with Outside Service Provider | Provides Directly

Services: More than three-quarters of IL communities provided physical, occupational, or speech therapy, primarily through arrangements with contractors or partners. Half of IL communities provided a resident health clinic or pharmacy services. The majority of IL communities did not use their own employees to provide services directly to residents. The services least frequently provided to IL residents, either directly or through a contractor or partnership, were physician and dental services.

Amenities: Two-thirds of independent living communities offered residents several amenities, including walking paths, social/craft/recreational space, restaurant-style dining, a fitness center, health/wellness programs, campus-wide Broadband Wi-Fi, and casual dining. Less than half had a swimming pool (42%) or offered classes in conjunction with an area college or university, either on campus or at the school (37%).

Technology Use: While care management and care coordination tools were the most common types of technology reported by IL communities, less than half of IL providers (42%) used these tools. Smaller percentages of IL providers used sensor technologies (16%), or technologies that facilitate social connectedness and engagement among residents (27%).

Percent of IL Properties Providing Amenities (Range of Ns: 502-524)



Home and Community-Based Services

Home and community-based services (HCBS) agencies provided adult day services, hospice, home health care, and non-medical home care. Few HCBS agencies—only 8%—reported being providers of the Program of All-Inclusive Care for the Elderly (PACE).

ADULT DAY

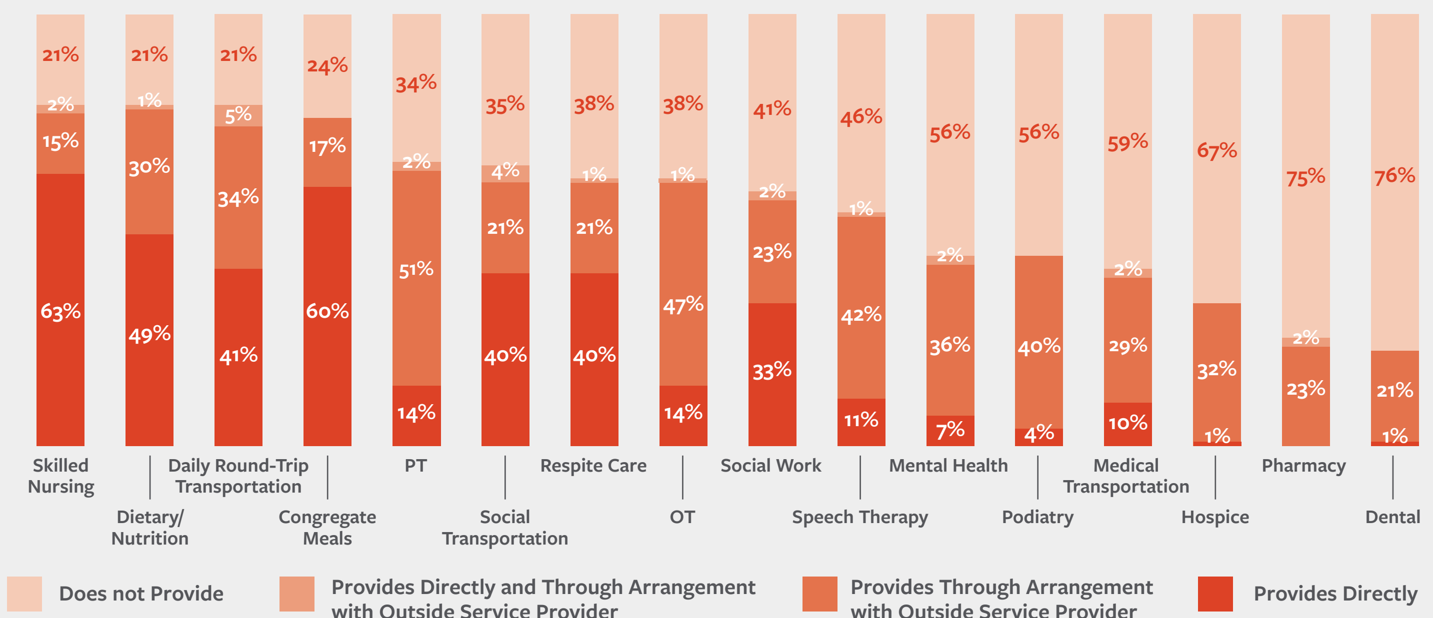
More than half of LeadingAge adult day (AD) service centers employed an approach that combined social and medical models (57%). Approximately one-quarter of the centers (27%) employed the social model. The medical model (16%) was the least common type of model among LeadingAge adult day service centers surveyed.

Size: The allowable daily capacity of adult day service centers ranged from one to 234 participants, with an average of 43 participants per center. The number of participants enrolled at AD service centers at the time of the survey averaged 50, and ranged from one participant to 626 participants.

Participants: Adult day service centers had a more equal distribution of participants than other HCBS settings. More than half of participants (57%) were women and 43% were men. While 73% of participants were white, AD providers also reported that 17% of participants were Black, 5% were Hispanic, and 5% were classified as "other." Adult day service centers reported serving a younger population, with one-quarter of participants under age 65 and 21% between the ages of 65 and 74. Approximately one-third of participants were 75 to 84 years old.

Services: The top services available to AD participants were dietary and nutrition, skilled nursing, daily round-trip transportation, and congregate meals. These services were provided directly or through arrangements with outside service providers. Less than half of AD service centers provided medical transportation, mental health, podiatry, pharmacy, hospice, or dental services. Adult day service centers were most likely to provide three services directly: skilled nursing, congregate meals, and dietary/nutrition services. Therapy services were more likely to be provided through arrangements with outside service providers than provided directly by center employees.

Services in AD Centers (Range of Ns: 131-135)



HOSPICE

Hospices services were most commonly provided by free-standing hospice agencies (40%). Hospices were less likely to be based in hospitals (10%), home health agencies (15%), or nursing homes (11%).

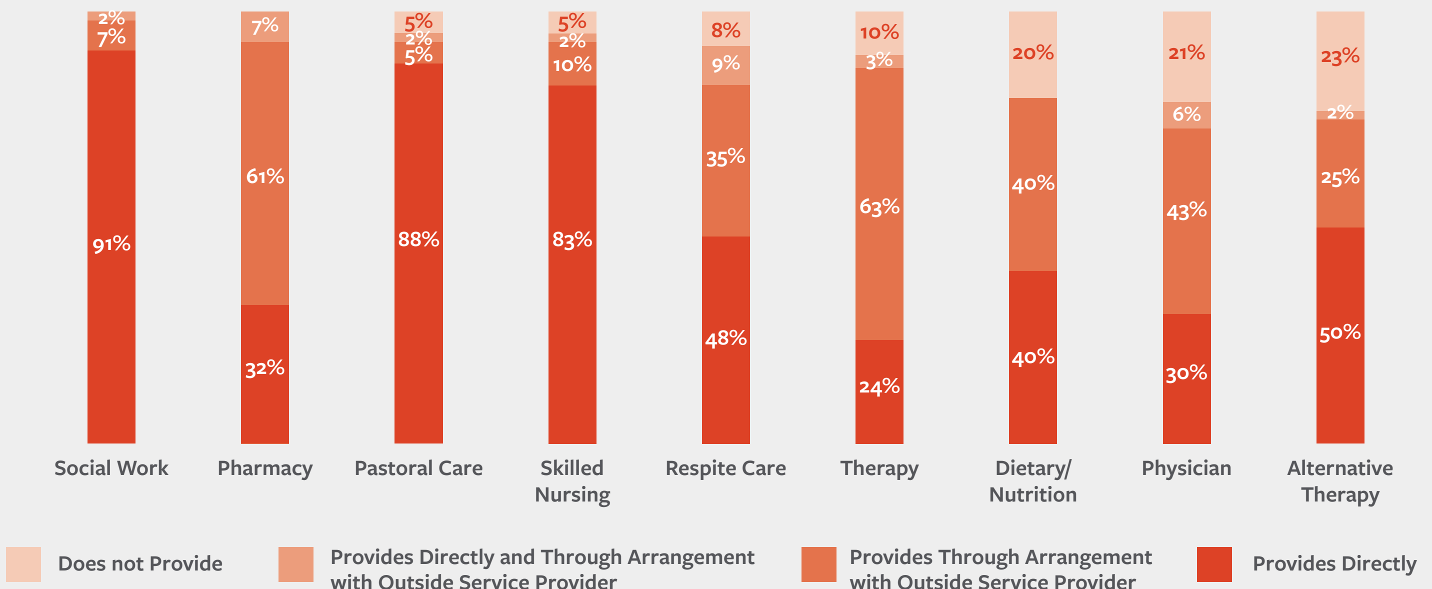
Size: Hospice agencies participating in the survey served an average of 88 clients at the time of the survey. The number of current clients ranged from two clients to over 1,400 clients.

Clients: The users of hospice services were overwhelmingly women (67%) and white (94%). The majority of hospice users were over the age of 74 (87%). More than half of the participants were aged 85 years or older (52%).

Services: At least three-quarters of hospice agencies reported that they provided all services asked about in the survey, either directly by hospice staff members or through arrangements with outside service providers. These services included social work, pharmacy, pastoral care, skilled nursing, respite care, therapy, dietary/nutrition, physician, and alternative therapy services.

Hospice agencies were most likely to provide social work, pastoral, and skilled nursing services directly to clients. While hospice agencies offered pharmacy and therapy services, these services were more commonly delivered through arrangements with outside service providers.

Services in Hospice Agencies (Range of Ns: 40-41)



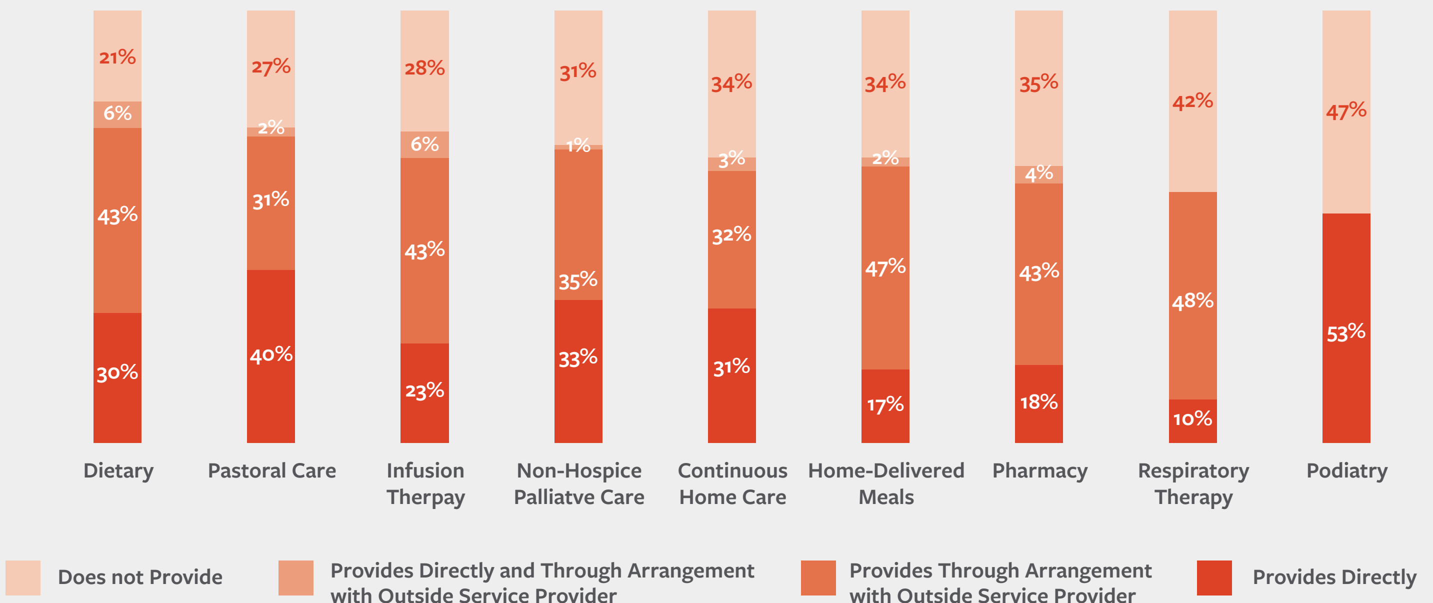
HOME HEALTH CARE

Size: On average, home health care (HHC) agencies reported that their average number of current clients was 84 at the time of the survey. Resident populations ranged widely from 14 clients to more than 400 clients. The average number of HHC visits per episode was 17.

Clients: Home health care clients were primarily women (65%) and white (93%). HHC agencies served an older population: three-quarter of clients were 75 years and older, 37% were 75 to 84 years old, and 40% were 85 years and older.

Services: More than half of HHC agencies reported providing most of the services asked about in the survey. These services were provided either directly or through arrangements with outside service providers. Less than half of the HHC agencies provided any service directly with HHC staff, with the exception of podiatry services. Dietary/nutrition, infusion therapy, home-delivered meals, pharmacy, respiratory therapy, and podiatry services were more likely to be provided through arrangements with outside partners than provided by staff. Respiratory health and podiatry were the least frequently provided services and were delivered directly and/or through arrangements with outside service providers.

Services in HHC Agencies (Range of Ns: 52-54)

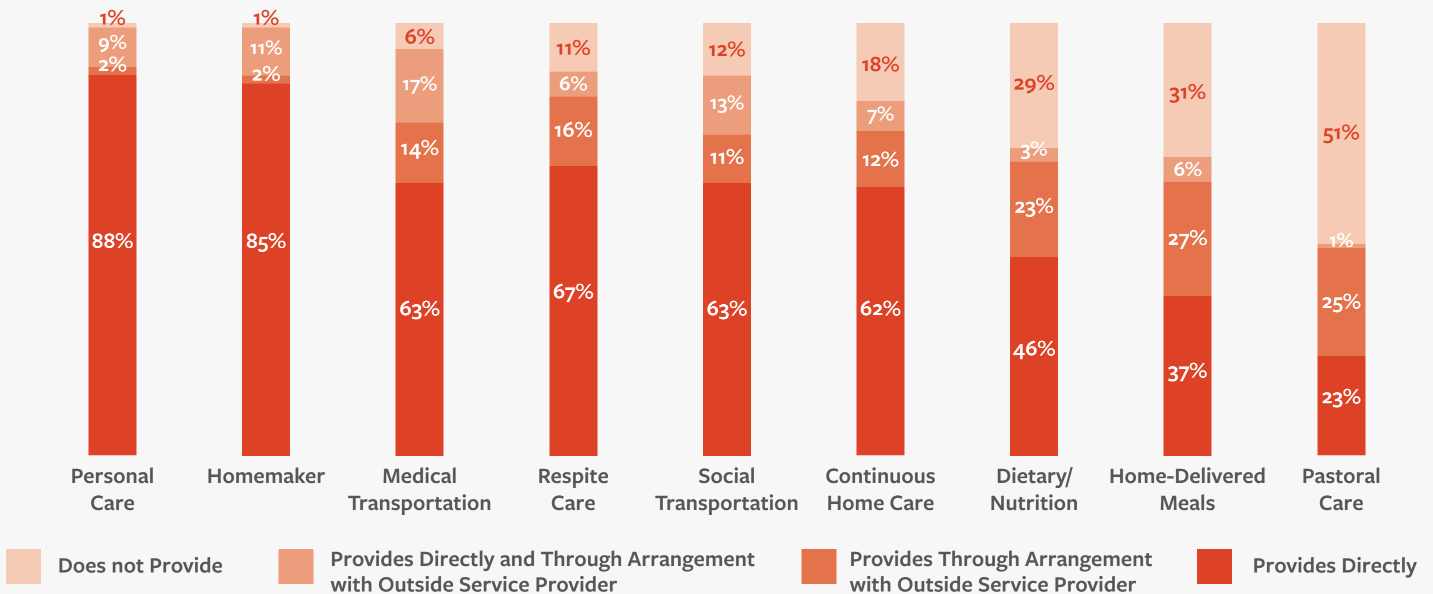


HOME CARE

Size: Non-medical home care (HC) agencies served an average of 77 current clients at the time of the survey. An average of 31 clients received between one and five hours of services during a given week, according to HC agencies participating in the survey. An average of 20 clients received between six and 20 hours of home care services, and an average of 24 clients received more than 20 hours of care, including overnight care.

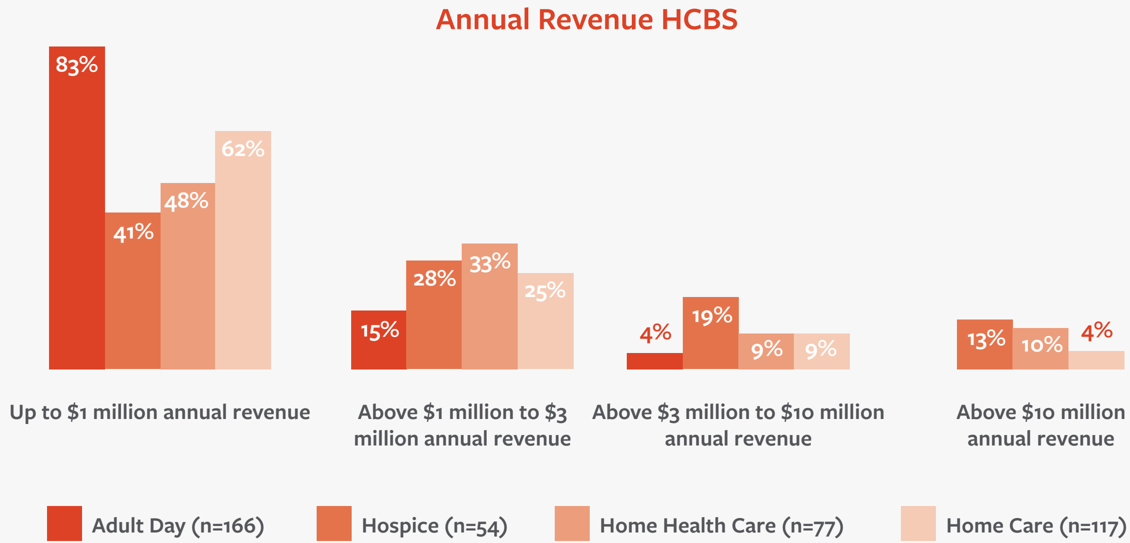
Clients: Three-quarters of home care clients were women and the majority were white (87%). Older adults who were Black—about 6% of clients—represented the second largest ethnic group served by HC agencies. The majority of HC clients were 75 years and older (84%). The largest age group served by these agencies was older than 85 years (44%).

Services: At least half of the home care agencies reported providing most of the services asked about in the survey. These services were provided either directly or through arrangements with outside service providers. The top five HC services were personal care, homemaker services, medical and social transportation, and respite care. Home care agencies were more likely to provide the majority of services directly, rather than arranging for services with outside partners. At least two-thirds of HC agencies provided three services directly: personal care, respite care, and homemaker services. Less than half of HC agencies provided pastoral care services, either directly or through outside providers.



ALL HCBS PROVIDERS

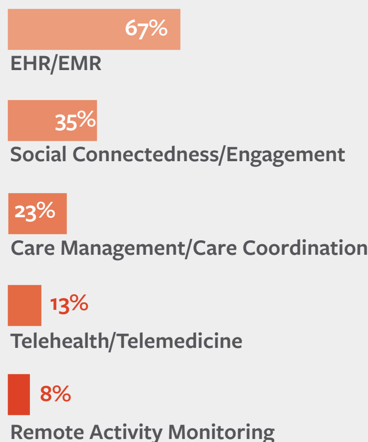
Revenue: Home health care, home care, and hospice providers were most likely to have an annual revenue of up to $1 million, and least likely to have an annual revenue above $10 million. The majority of adult day service centers had an annual revenue that was characterized as either "up to $150,000" or "above $150,000 to $500,000."

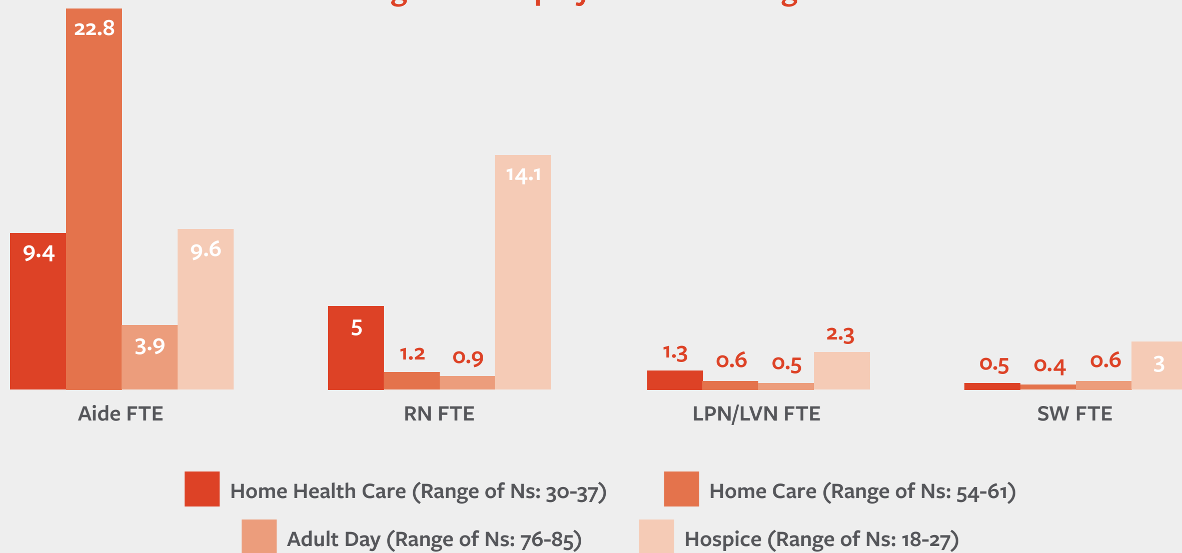


Technology Use: Almost two-thirds of HCBS agencies used electronic health records or electronic medical records. Less than half of these agencies reported using social connectedness/engagement, care management/care coordination, telehealth/telemedicine, or remote activity monitoring technologies.

HCBS agencies reported having computerized systems supporting electronic health information exchange with other long-term care providers (38%), physicians (34%), pharmacies (28%), hospitals (28%), and skilled nursing facilities (13%).

Technology Used by HCBS Organization (Range of Ns: 301-307)





Workforce: Aides were the most common employee in home health care agencies, non-medical home care agencies, and adult day service centers. With one exception, these agencies reported an average of one full-time equivalent (FTE) or less for registered nurses (RN), licensed practical nurses/licensed vocational nurses (LPN/LVN), and social workers. Home health care agencies reported an average of five RN FTEs.

Hospice agencies reported that RNs made up the majority of their employee FTEs, with aides coming in second. Social work FTE employees were more common in hospice agencies than in other HCBS settings. Hospice agencies had an average of one FTE bereavement professional and .86 FTE physician employed.

The average staff hours per adult day participant per day for licensed nursing staff was .22 hours (13 minutes) for RNs, and .16 hours (10 minutes) for LPNs/LVNs. Aides had the highest average staff hours per participant per day: .94 hours (56 minutes).

Appendix: Definition of Services and Technologies

SERVICES

Dementia care units: Separate, secured, specialized dementia or memory care with specialty-trained dementia staff members.

Hospice care: Compassionate comfort care for people facing a terminal illness with a prognosis of six months or less, based on a physician's estimate, if the disease runs its predicted course.

Mental health/behavioral health: Care targeting residents' mental, emotional, psychological, or psychiatric well-being.

Non-hospice palliative services: Compassionate comfort care providing relief from symptoms and the physical and mental stress of a serious or life-limiting illness.

Pharmacy services: Filling or delivery of prescriptions.

Respiratory health services: Delivery of a variety of tools to help with breathing.

Restorative nursing: Interventions that promote a resident's ability to adapt and adjust to living as independently as possible.

Skilled nursing services: Services that are medical in nature and must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse.

Social work services: Psychosocial assessment, counseling, referral, and other services provided by licensed social workers or persons with a bachelor's or master's degree in social work.

TECHNOLOGY

Care management/care coordination: Tools that help track and coordinate the care that patients receive across various health care specialists, especially during care transitions.

Electronic Health Record/Electronic Medical Record: A computerized version of an individual's health and personal information used to manage that person's health care.

Medication management technology: Systems that remind individuals to take their medications, or systems that dispense medications.

Remote activity monitoring: Systems using sensors to monitor a variety of activities, including an individual's functional abilities, activities of daily living, behaviors, and sleep patterns.

Social connectedness/engagement technologies: Systems allowing consumers to connect with family, friends, and caregivers through video/audio chats, social networking tools, and activity- or event-sharing apps.

Telehealth/Telemedicine: Electronic communications and information technologies allowing interaction between providers and patients who are in different locations.

2519 Connecticut Avenue NW
Washington, DC 20008
202-783-2242 | LeadingAge.org