2013 National Research Report
EMPOWERING CUSTOMER-CENTRIC HEALTHCARE
FOR POST-ACUTE PROVIDERS
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Foreward

The healthcare profession has historically been (and continues to be, in many respects) a segmented, “cottage” industry with individual groups or types of providers serving patients in silos, addressing only one aspect of the patient’s needs at a given time. Now, professional and policy movement continues to accelerate toward the need for care providers in all segments to integrate across the continuum. In order to sustain their organizations through this major structural shift, healthcare leaders need to develop provider capabilities to care for the “whole patient,” in interdisciplinary teams of caregivers who communicate and share information, via convenient access points for the patient, with seamless transitions from one segment of care to the next.

Post-acute, sub-acute, and non-acute providers play an increasingly important role in acute care as outcomes are being tied to readmissions and value-based payments, increasing the importance of care coordination and creating joint accountability for patients across providers. Due to this essential connection, post-acute providers also have a growing role to play in quality improvement and enhancing providers’ ability to deliver customer-centric care at all points along the care journey. The healthcare profession can no longer focus on physicians and hospitals; providers across the continuum will be playing more equal roles in patient outcomes and value strategies. Achieving this kind of cultural transformation will require innovative leadership.

This integrated report presents information regarding workforce, the healthcare ecosystem, and “person-centered care” for all post-acute providers: skilled nursing, assisted living, independent living, home health, and hospice. This is the first time this kind of information has been presented together in one publication. As National Research Corporation continues to expand its services and research across the care continuum, this report will serve as a blueprint to develop best practices for driving improvements in quality and customer experience in all care segments.

Healthcare leaders across the industry are confronting the challenge of improving quality while lowering costs, and we believe the answer lies in addressing these challenges together, as a continuum of providers.

Jona Raasch
CEO
The Governance Institute
A service of National Research Corporation
Introduction

The dynamics of healthcare and markets tangent to healthcare are undergoing unprecedented change and uncertainty. Some themes are familiar and give those whose histories span decades in the profession a sense of *déjà vu* (for example, tightening reimbursement and changes to payment models causing providers to rethink their approach to delivering care). Other trends we have seen coming, but they are no longer a safe distance in the future and require action (for example, the ballooning of the population over the age of 65).

Across all segments of healthcare and senior care services, there are three dominant trends:

1) **Person-centeredness and the evolution of the healthcare customer.** Between increasing availability of information about customer experience across markets, families spending more out-of-pocket on healthcare, and government and payer efforts to increase transparency on cost and quality in healthcare, healthcare consumers are behaving more like customers. As such, it is continually important that organizations focus on creating a culture of person-centered care and increasingly important that providers and other stakeholders have a solid understanding of quality, experience, and satisfaction—as well as buyer behavior.

2) **The importance of staffing.** Everything about staff—from availability to quality of work to decisions about how to deploy services—has a direct and critical impact on the success of healthcare and senior service providers. It is widely known that the nation is facing a shortage of nurses and that turnover is costly, but there is also concern about the bench depth of the profession’s future leaders as well as an increasing awareness of the direct impact of staff on the quality of a provider’s care and the experience of its consumers. A better understanding of how decisions related to staff can impact staff satisfaction and outcomes can result in a domino effect through other aspects of the organization.

3) **Healthcare as an ecosystem.** The virtual walls separating various types of service providers are thinning and collapsing due to healthcare reform, the gaining popularity of accountable care and payment bundling concepts, and the demands of healthcare market dynamics. More information and different perspectives on these dynamics prepare a provider to meet oncoming changes and drive their future role in the continuum and for customers.

“Post-acute” providers (a difficult group to name, given they care for patients immediately before and after hospitalization, over the course of long-term needs, at the end of life, plus provide communities for senior living) are especially affected by these dynamics. They sit in a unique position to shift their thinking and change the way they meet the needs of customers and provider partners. Nursing homes, assisted and independent living communities, home health agencies, and hospice organizations offer distinctive value to consumers and other healthcare providers. Operators of these important organizations have the opportunity to re-establish their role in the care continuum, and can best do that, as well as best prepare for the uncertain elements in their future, by developing a solid understanding of the dynamics of the greater healthcare continuum, other segments in the “post-acute” realm, and their direct peers.

It is with these ideas in mind—the importance of information about the immediate and the broader peer groups, and the driving themes of customer, staff, and continuum—that we offer the first integrated “post-acute” National Report. This report builds off the legacy of the National Reports produced for the skilled nursing profession over the past six years and the assisted living report first offered in 2011. It includes a data profile at the back of the report for each segment of this neighborhood of healthcare—skilled nursing, assisted living, independent living, home health, and hospice—and highlights key observations related to customer, staff, and healthcare peers, from each segment in the front.

As the only true cross-continuum healthcare data company with a customer base that represents more than 12,000 skilled nursing, assisted and independent
living, home health, and hospice providers, National Research Corporation has unrivaled operational knowledge, experience, and available data resources to deliver this information. It is our honor to be able to help inform the profession’s leaders and stakeholders through the sharing of these insights. Unless otherwise noted, all statistics contained in this report are from National Research Corporation data assets, either My InnerView surveys of skilled nursing, assisted living, and independent living customers and employees or OCS HomeCare analyses of OASIS, utilization data, and HHCAHPS experience from home health providers or quality data submitted by hospices.

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Skilled Nursing

Person-Centeredness: Perspectives on Improvement

In each year of studying long-stay customer satisfaction with skilled nursing homes, we have seen approval rates approaching 90% and steadily, if slowly, creeping higher. These statistics represent the percent of residents and their family members who report that they would recommend the skilled nursing care center as either an “excellent” or “good” place to receive care. The same holds true this year, with 88% of residents and 87% of families recommending their provider.

The numbers are similar for short-stay skilled nursing residents nationally, with 87% recommending their care center in 2012. Among this population, however, we have seen more rapid improvement on a national level in the past few years. In 2010, the recommendation rate was 85%.

While the changes in national rates haven’t been dramatic over the past few years, we know that the profession is moving forward with respect to the customer experience. This movement hasn’t been by accident, but by the deliberate efforts put forth by quality-focused campaigns (such as Advancing Excellence), associations (including the American Health Care Association’s Quality Initiative), states (including numerous pay-for-performance programs with customer experience as a core component), and providers.

As a result of these efforts, we know that the ranks of skilled nursing homes meeting or exceeding the AHCA Quality Initiative goal of 90% customer satisfaction has increased over the past four years, from 52% of providers meeting the goal with residents in 2009 to 55% in 2012, and 42% meeting the goal with families in 2009 to 48% in 2012 (figure 1). Each year, between 2010 and 2012, between 12% and 16% of providers moved from not meeting the goal, to achieving it.

Delving deeper into the data available to us on improvement, we know that providers at every starting level of performance improve, as well as decline, but that providers starting with a lower base score improve more, on average, than those starting at a higher score (figure 2). This holds true for all types of satisfaction assessments. When we group skilled nursing homes by their baseline performance (2010 results in this analysis), we discover that providers in the bottom quartile improve over a two-year time frame by about 3% on average (2.4% for family
scores, 3.2% for resident scores), while providers in the top quartile decrease their score by about 2% on average (2.1% for families, 2.4% for residents). While top performers decline, on average, we find that 28% of the best performers (those in the top quartile of performance in 2010) got even better over the two-year window, and an additional 19% decreased their scores by less than 1%.

Staffing: Workforce Satisfaction and Star Ratings

Employee satisfaction is one of the most important measures of quality in senior care. Every other measure of quality is correlated with employee satisfaction. The top two drivers of both resident and family recommendation are both related to employees—care (concern) of staff and competency of staff. Employees who remain satisfied over time become engaged with their employer and the mission of the nursing home, and more dedicated to their work. This dedication translates into more compassionate care. Compassionate care improves clinical outcomes and contributes to the overall quality of life for residents and family who in turn become more satisfied.

In past years we have illustrated the connection between employee satisfaction and family and resident satisfaction. The 2012-2013 analysis shows the same relationship, where skilled nursing homes that have higher employee satisfaction scores also share higher customer satisfaction scores. Further, by cross-referencing the employee satisfaction data with data publicly available from CMS on Nursing Home Compare, we can objectively demonstrate that employee satisfaction is also correlated with CMS Five-Star Ratings and negatively correlated with survey deficiencies (figures 3 and 4).

To illustrate the relationship between employee satisfaction and survey deficiencies, skilled nursing homes were grouped twice, once based on their relative employee overall satisfaction average score and the other based on their relative overall satisfaction among nurses only, and then each group’s average number of deficiencies cited in 2012 was graphed (figure 3).

To illustrate the relationship between employee satisfaction and CMS Five-Star Ratings, communities were grouped based on their star rating in each of five categories, as defined by CMS, and then each group’s average overall satisfaction rating for all employees and nurses was graphed (figure 4). The CMS Five-Star Ratings come from health inspections, staffing calculations, and quality measures, and are designed to give consumers one source of insight into the quality of operations of Medicare-certified nursing homes. For more information, please review documentation available from CMS at Nursing Home Compare.

The correlation or relationship is strongest between overall employee satisfaction scores and the Overall and Survey CMS Star Ratings. Nurse satisfaction is slightly less correlated to the Overall and Survey Star Ratings than employee satisfaction. On the flip side, lower nurse satisfaction is slightly more tightly correlated to a higher rate of deficiencies than overall employee satisfaction. Interestingly, despite the correlation with the Overall Star rating, neither category of employee satisfaction is strongly correlated with the other CMS Five-Star Ratings for Quality, Staffing, or Nurse Staffing.

To be sure, this level of analysis only indicates
correlation, and does not provide insight into cause and effect. We cannot determine if a lack of survey deficiencies leads to higher nurse satisfaction, or if higher nurse satisfaction leads to fewer survey deficiencies. We know, however, that lower rates of deficiencies, higher Overall Star Ratings, and higher employee satisfaction tend to occur together.

Healthcare Ecosystem: Increasing Hospital Transfers, Decreasing Occupancy

According to the Kaiser Family Foundation, every day between 2011 and 2029 10,000 Americans will turn 65, and between 2010 and 2050 the number of Americans requiring long-term care will more than double from 12 million to 27 million. The demographic trends have been at the heart of many discussions around the increasing national healthcare bill and policy efforts to control the total cost of care.

One such effort to control costs has been the payment penalty imposed by CMS for hospitals with higher-than-expected 30-day readmission rates for patients discharged after stays for pneumonia, heart failure, and acute myocardial infarction (AMI). This new payment policy increases the pressure on hospitals to ensure appropriate patient discharges and effective transitions out of the hospital to post-acute care. It also increases the pressure on post-acute providers to keep patients out of the hospital in order to maintain their referral source status with nearby hospitals.

While the payment penalty will certainly impact the relationship between hospitals and nursing homes, and potentially increase referrals, especially for...
post-acute rehab needs, it piggybacks on a trend of increasing hospital discharges to skilled nursing homes and rehab over the past 20 years (figure 5). After a dramatic spike in transitions to nursing homes and rehab facilities in the late 90s, the rate of referrals has continued to creep up almost every year (data source: Agency for Health Research and Quality HCUPnet database).

At the same time, occupancy rates in Medicare-certified skilled nursing homes have been decreasing slightly almost every year over the past decade. (data source: Kaiser Commission on Medicaid and the Uninsured, analysis of 2011 OSCAR data). A concern for providers and families alike is the cost of long-term care in communities like skilled nursing homes.

According to a national market research study conducted in early 2013 through Market Insights, the largest online U.S. healthcare survey by National Research Corporation, nearly half of all households expect a member of the household to require either temporary or long-term services of a skilled nursing home. While more than half of those respondents didn’t expect to require skilled nursing home services for 10 years or more, evidence points to just cause for worrying about the resources to pay for this care. The average cost of nursing home care in 2012 was $82,000 and only 35% of Americans 40 years or older say that they have set aside money for their long-term care needs (data source: Kaiser Family Foundation).
Assisted Living

Person-Centeredness: Services Matching Seniors

In 2011, 41.4 million people in the United States, representing 13.3% of the population, were 65 years or older (data source: 2012 U.S. Census Bureau data released by the U.S. Department for Health and Human Service’s Administration on Aging). Individuals who celebrated their 65th birthday in 2011 were expected to live another 19.2 years on average. By 2040, it is expected that 21% of the population, or 79.7 million people, will be 65 or older, and that the proportion of our population that is 85 or older will nearly triple from 5.7 million in 2011 to 14.1 million in 2040.

According to an analysis released by the American Society of Aging in 2010, Americans over the age of 65 have more than a 70% chance of needing help with activities of daily living (ADLs), for example, dressing, bathing, and using the bathroom. Not surprisingly, Medicare beneficiaries are likely to wrestle with chronic conditions and other physical and mental health challenges (figure 6, data source: Urban Institute and Kaiser Family Foundation, 2012; Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services data).

Independence can be a challenge for this segment of the population, which is where assisted living communities provide support and value. The CDC reported that 74% of residents living in residential care facilities received assistance with at least one ADL while nearly 40% received assistance with three or more ADLs (data source: NCHS Data Brief No. 91, April 2012). In the publication Older Americans 2012, Key Indicators of Well-Being, the Federal Interagency Forum on Aging-Related Statistics reported that residents of community housing facilities cited wide accessibility to exactly these types of services (figure 7).

Staffing assisted living communities appropriately to meet resident needs and expectations in these daily support activities can be a challenge and has been the subject of scrutiny. When we evaluate the perspectives of assisted living customers—residents and their families—we find most have a positive outlook on the ability of their communities to provide these services. Further, the profession has appeared to make progress in better meeting these expectations in recent years.

Data shows that 91% of residents and 90% of families assess their assisted living community’s sufficiency of healthcare needs as “good” or “excellent.”
Sufficiency of personal assistance lags behind, but only slightly, with 90% of residents and 87% of families offering a positive rating. What’s perhaps even more important is the progress seen in these areas over the past couple of years. The percent of customers rating each of these areas as “excellent” has increased across the board when comparing 2010 results to 2012 (figure 8).

Given these dynamics, it’s not surprising that the way in which healthcare and personal care services is administered most impacts the overall satisfaction of assisted living residents and their families. Two of the top five drivers of both resident and family recommendation of an assisted living community are related to how the community staff provides services: care (concern) of staff and competency of staff. Performance in these two areas is not only important to customers, it is also highly rated by those same customers. More than 90% of assisted living customers rate positive experiences in both of these measures, with 45% to 58% giving “excellent” ratings (figure 9).

Staffing: Spheres of Influence

It’s intuitive to draw the conclusion that a community’s staff and the quality of services they provide have a dramatic impact on the experience and the satisfaction of residents and their families. It’s also an easy link to believe that staff satisfaction impacts the quality of a staff’s work. In fact, in last year’s assisted living national report from National Research, and again in this year’s, we show a data relationship between staff satisfaction and customer satisfaction, demonstrating that communities with higher staff satisfaction do achieve higher family and resident satisfaction.

We also have data to understand the primary drivers of employee satisfaction in assisted living communities, and how well the profession is doing at meeting the needs and expectations of the people who provide care to their residents on a daily basis. The challenge is that the story surrounding these indicators is different from the story told about the drivers of customer satisfaction.

All types of employees share the same top three drivers for their recommendation of a community as a place to work: care (concern) of management, attentiveness of management, and assistance with job stress. These three items have been the most tightly tied to recommendation and overall satisfaction for as long as the My InnerView workforce satisfaction survey and improvement tools have been used in assisted living communities. Nationally, performance across these three measures is in the bottom half of scores on individual items. Perhaps more importantly, the profession’s success in these areas has actually decreased over the last three years.

Focusing in on nurses and personal care aides we find that not even one out of every four ranked their employers as “excellent” in these three categories in 2012 and only between 49% and 61% offered any positive feedback, combining “excellent” & “good” (figure 10). Most measurements—both “excellent” and positive ratings—also decreased between 2010
and 2012, with the exception of personal care aide’s rating of attentiveness of management.

Assisted living employees do have good things to say about their employment—nationally they offer positive scores above 90% about both the sense of accomplishment they feel in their job and the respectfulness of the staff. Further, while measures related to management receive relatively low marks, measures related to supervisors routinely score above 70%, including communication by supervisor and care (concern) of supervisor.

Healthcare Ecosystem: Link in the Chain

Assisted living communities may not always be thought of under the umbrella of “healthcare provider,” yet they certainly fulfill a distinct care need and fit into the broader spectrum of services provided to our nation’s senior population. The more than 31,000 communities housing nearly 1 million seniors in 2010, as estimated in a group publication, “Overview of Assisted Living,” provide a range of services, including meals and housekeeping. But communities also offer activities and social services, personal care, and various healthcare support services that may include medication management and memory care.

In addition to providing services directly and sometimes coordinating the delivery of more intensive healthcare services, assisted living communities are often an important phase in the long-term care continuum. According to the same “Overview of Assisted Living,” 70% of assisted living residents moved into the assisted living community from a private home or apartment, 7% moved from living with a younger family member, and 9% moved from a retirement or independent living community. At the end of their stay in the community (the median length of which was 22 months), 59% moved into a skilled nursing home.

Many say that the lines have blurred when it comes to determining the residential setting that is most appropriate given an individual’s condition. While only about 3% of the population of senior Medicare beneficiaries in 2009 lived in residential communities with available services, “the availability of personal services in residential settings may explain some of the observed decline in nursing home use” (data source: Federal Interagency Forum on Aging-Related Statistics, Older Americans 2012 Key Indicators of Well-Being).

Certainly as the demographics of our population are changing, so are the needs of our seniors. According to the U.S. Department of Health and Human Services, data tells us that the U.S. life expectancy rose from 75.2 years in 1990 to 78.2 (78.2 in 2010) years and that during the same window, the “good
“health expectancy” (the years predicted to be without short- or long-term disabilities) rose from 65.8 years to 68.1. While this data point predicts to offer Americans another 2.3 “good health” years, it also predicts almost an additional full year of life with disabilities. At the same time, Americans over the age of 65 have a greater than 70% chance of needing help with activities such as dressing, bathing, and using the toilet (data source: American Society on Aging, 2010) and 70% or more will require some amount of long-term care (data source: U.S. Department of Health and Human Services).

Assisted living offers a potential solution for the hundreds of thousands of seniors who require some level of regular assistance, but are not one of those living with a spouse or younger relative capable of providing that support. In most measures, assisted living customers (residents and families) assess their communities with high rates of positive (“excellent” and “good”) responses. Even at the low end, nearly three in four customers are satisfied with the appeal of the food and variety of the meals. On the high end, assisted living customers provide greater than 90% positive responses nationwide to questions that rate 12 specific areas, in addition to offering a 91% rate of overall satisfaction and recommendation (figure 11). In the top six of that list (marked with an asterisk), the “excellent” ratings were between 50% and 60%.
Independent Living

Person-Centeredness: A New and Easier Home

According to a survey conducted by the Pew Research Center in early 2013, two-thirds of Americans ages 65 and older expect their lives to be better or about the same in another decade. In 2008, the primary reason, at 63%, for seniors moving was a desire for a maintenance-free lifestyle (data source: MetLife Mature Market Institute). These, combined with the senior population trends, explain the emergence and growth of the senior housing and independent living markets. Independent living offers apartment-like communities specifically developed for the 55 and older population with a wide range of potential amenities, ranging from none to programs that offer opportunities for social, physical, and mental activities, plus services to make life as easy and comfortable as possible as residents continue to age and need more support.

The market demands are present, but the question remains if independent living communities are sufficiently meeting the expectations of their residents. The data collected through the My InnerView independent living customer and workforce satisfaction tools have not been previously published through a report similar to this; hence this is our first opportunity to provide a snapshot of the population and the perspectives of individuals residing in independent living communities.

Independent living and assisted living communities are very different—they offer different services and target different markets. As such, it is not surprising that their populations also differ, but given that they are the closest related among categorizations that exist, there is some value in comparing their resident populations as a point of reference. Residents in independent living communities tend to be younger and visited less often than their assisted living counterparts (figure 12). Independent living residents are more likely to have lived in their community longer (figure 13).

Overall satisfaction rates tend to be very high among this population, with 94% of residents reporting a positive overall experience with their community and 93% saying that they would recommend their community as an “excellent” or “good” place to live. Satisfaction does diminish slightly over time. During the first year, residents report overall satisfaction rates of 95% to 97%, and consistently rate over 50% in “excellent” responses (figure 14). Even with the declining “excellent” rating over time, satisfaction remains high.

Figure 12

Comparing Resident Demographics - Assisted Living and Independent Living
It is not just measures of overall satisfaction where independent living communities seem to be meeting their residents’ expectations. Positive ratings exceed 90% for two-thirds of the individual areas of measurement, including in four out of the five primary drivers of a resident’s likely recommendation of a community as a place to live. Those areas include home-like atmosphere, commitment to independence, care (concern) of staff, and sufficiency of personal assistance. Responsiveness of management, at 79% positive ratings, is the only one of the service areas that didn’t achieve the same level of high marks.

**Staffing: Similar Needs, Different Profile**

While the primary drivers of satisfaction are slightly different for the independent living resident than the skilled nursing or assisted living customer, the primary drivers of employee satisfaction are identical, demonstrating that management challenges are similar across the continuum.

The five areas of satisfaction most tightly linked to an employee’s likely recommendation of an independent living community as a place to work are all directly related to the community’s approach to management: care (concern) of management, assistance with job stress, attentiveness of management, clear expectations of management, and support of career. Also similar to skilled nursing and assisted living organizations, independent living management teams struggle to find success in these areas, with positive assessments from employees ranging from 57% to 71% and falling in the bottom half of measures.

Also, like their peers in assisted living, independent living providers seem to have struggled more with these areas in 2012 than they did in 2010 (figure 15).
While “good” ratings dropped in all three areas, “excellent” scores had a less consistent trend with care (concern) of management remaining at the same level, assistance with job stress slightly improving, and attentiveness of management dropping by only 1%.

The drivers and the challenges in independent living are similar, despite the fact that the profile of an “average” employee is notably different in this setting. The biggest difference, unsurprisingly, is in the mix of roles employed at an independent living community relative to the other residential settings. With very limited hands-on services offered, the nurses and personal care aides that represent over half of the employees in assisted living comprise only one in ten in the independent living workforce (see Data Profile in the Independent Living Appendix).

Less intuitively, independent living employees tend to be older than those in assisted living and tend to have had a longer tenure with their employers (figure 16). Nationally, assisted living employees are almost evenly split between age ranges of under- and over-40 (46% and 54%), while 37% of independent living employees are under 40 and 63% are over. Similarly, just over half of assisted living employees have been working at their community for more than two years (54%) while 64% of independent living employees share that experience level. Notably, almost one out of five (18%) among the independent living staff have been with their employers for ten years or longer, a benchmark reached by just over one in ten (11%) among assisted living employees.

Healthcare Ecosystem: A Prime Time for a Social Media Strategy?

The move to independent living is almost always a choice. It is rarely brought on by an event that creates an urgent need for frequent residential and care services, which often predicates a move to skilled nursing. It is also rarely the result of a
declining functional or mental status and the need for care at a level of intensity that a family is no longer able to support, as is often the case with moving into assisted living. Independent living competes with seniors staying in their own homes or moving into a condo or apartment that isn’t part of a designed senior community to either downsize or move closer in proximity to family.

According to the Administration on Aging, based on data from the American Housing Survey available from the U.S. Census Bureau, in 2011, 81% of the 25.1 million homes headed by older persons were owned while 19% were rented. Of homeowners, the median family income was $32,900, the median value of owned homes was $150,000, and 65% of seniors owned them outright.

The median family income of older renters was $16,200. In 2011, almost 50% of older households spent more than one-fourth of their income on housing costs—43% for owners and 71% for renters—as compared to 50% of all households. These estimates are in line with a similar study released by the Kaiser Family Foundation, which relied on data from the Bureau of Labor Statistics to understand the expense allocation of Medicare households as compared to non-Medicare households. In that analysis, they found the average Medicare annual expenses to total nearly $31,000 per year, with 36%, or almost $11,000, spent on housing (figure 17).

Compare those numbers to the estimates of the monthly cost of independent living. According to Genworth, a long-term care insurance carrier, the average cost of a one-bedroom unit in an independent living or retirement community in the U.S. was $2,750 per month in 2012. This average monthly expense represents $33,000 a year, $2,000 more than the average household’s total expenses. Clearly, a move into an independent living community is not a given for all seniors.

On top of the competition of individuals choosing to remain in their own homes, senior living communities often are in close competition with other local independent or senior residential options. Nearly 60% of independent living residents who participated in the My InnerView customer satisfaction surveys fielded by National Research in 2012 visited two or more residential communities prior to selecting the one they decided to call home (figure 18). The single most common factor for selecting a community was location (40%), but that was actually surpassed by the broader category of reputation and recommendation, which collectively represented the main reason for selection in 44% of residents’ surveys (figure 19).

These statistics reinforce the importance for...
Between May 2011 and June 2012, National Research surveyed more than 300,000 healthcare consumers through Market Insights, the largest online U.S. healthcare survey, to better understand what drives their healthcare choices and behavior. One emerging trend is the use of social media as a source of healthcare information, which increased over the year-long study to a rate of 22% (figure 20). From July 2011 to August 2012, Market Insights further explored the social media topic and discovered that the main use was to search for health information, but that the second most common was to ask for health advice (33%), the third was to seek out support from others (28%), the fourth was to ask for medical recommendations (28%), and the fifth was to share stories about experiences (27%).

This consumer trend parallels acute healthcare provider activities. The Mayo Clinic reported through its Health Care Social Media List that 1,500 hospitals nationwide are now engaged in social media, with most of them maintaining a Facebook site and/or a 4square site (1,264 and 1,116 respectively).

One may be quick to assume that this trend applies less to the independent living target market, but that
may be exactly the best way to reach out to the individuals who will be considering senior housing options in the coming years. Pricewaterhouse Coopers surveyed more than 1,000 consumers in 2012 to better understand how they are currently interacting with social media when it comes to healthcare-related activities. They found lower rates of social media utilization among the 65+ population, but still at least one in 20 reporting the use of social media for posting or commenting about their experiences or sharing reviews (figure 21). Expect that rate to climb, as they reported higher rates of social media utilization in the 55 to 64 age group—especially among those with higher incomes.

When asked about how likely healthcare customers would be to share information with other patients through social media, the responses were even higher (figure 22).

These trends may point to the short-term and long-term benefit of independent living communities establishing and fostering a strong online and social media presence. It is worth mentioning that the benefits of social media aren’t necessarily limited to advertising. Providers are using social media for more conventional purposes, such as marketing, brand management, and customer relations, but they are also using it for building community, encouraging wellness, providing education, fostering professional collaboration, and recruiting staff, among other purposes (data source: Computer Sciences Corporation Healthcare Group).
Home Health

Person-Centeredness: Assisting Elders to Age in Place

The average home health patient is a white, 74 year old female. Medicare is covering the cost of the 62 days of care that she is receiving in her home after a stay in the hospital. She lives with someone else and has assistance available to her around the clock. We can provide a profile of demographic averages, but in reality, home health patients represent a diversity of characteristics and present a range of healthcare and service needs. For example, most (65%) don’t have any risk factors but nearly 20% are obese; most (66%) live at home with someone else but one in four live alone; and for 34% their primary diagnosis is a procedure or aftercare, and for 20% a circulatory— but the next six most common categories of conditions represent between only 4% and 7% of the population each.

What all home health patients share is an expressed desire to remain in their home and receive skilled services from nurses and therapists in their home at the order of their doctor. They are not alone. AARP studies conducted in 2010 and 2011 found that 80% of adults age 45 and older and 90% of adults 65 and older plan to stay at home for as long as possible. Many of these seniors have taken steps to ensure home as an option—82% have a full bath on the main level and 81% have a bedroom or room that could be used as a bedroom also on the main level.

As we consider the needs and perspectives of these patients, we look to the top five drivers of a home health patient’s recommendation of a home health agency to understand what’s most important to them and how, generally speaking, the industry is doing in those areas (figure 23).

We can also consider the diversity of the patient population, and which elements of care most impact their experience with home health and influence their long-term health and well-being. By segmenting patients based on specific characteristics, we learn more about the needs of different types of patients and the outcomes of the care they receive, which better prepares us to provide the appropriate care and assess the profession’s ability to deliver that care.

As there are multiple factors that influence a patient’s needs, there are a multitude of appropriate ways to segment the patient population—by clinical condition, living situation, current functional status, co-morbidities, frailty indicators, and medical past, to name a few. At a high level, it makes sense to start with primary diagnosis as the basis for drill-down analysis. Four of the most common primary diagnoses in home health are orthopedic aftercare...
(ICD-9 code V54, 11% of the patient population), therapy aftercare (V57, 9%), heart failure (428, 7%), and diabetes (250, 5%). Patients grouped by these diagnoses demonstrate different levels of clinical outcomes (figures 25 and 26). Typically, the patients with the aftercare diagnoses tend to have better outcomes than the patients with the chronic disease diagnoses, but that rule doesn’t hold true across the board, demonstrating the complexity in the patient population and the value in doing analyses such as these.

Staffing: Diversity in Utilization

The utilization of staff is one of the challenging elements of home health management. Visits make up the bulk of the cost of home health, and the shortage of staff in many regions, combined with the financial pressures of reducing reimbursement and the lack of clear best-practice visit guidelines, results in home health agencies continually working to refine and perfect their staff utilization.

The average Medicare home health PPS episode of care receives 8.5 skilled nursing visits, a total of 7 therapy visits (physical, occupational, and speech), 2.1 home health aide visits, and just 0.5 of a social work visit. The challenge of working with averages, however, is the diversity in the utilization of staff for different types of patients, in different areas of the country, and even simply at the agency level.

Consider for a moment the range in utilization among different types of services. Nationally speaking, 24% of Medicare patients receive at least one occupational therapy (OT) visit and 6% receive at least one speech therapy (ST) visit. At the agency level, however, between 6.4% and 43.8% of patients receive at least one OT visit (at the 10th and 90th percentile) and between 1.1% and 11.6% of patients receive at least one ST visit. Whether it’s due to availability of the discipline, agency practices, or patient mix, home health providers demonstrate considerable diversity in how they use different types of services (figure 25).

There is also considerable range in the way that disciplines are used for different types of patients, which makes sense given that certain conditions are a more natural match for some specific services than others. Patients with a primary diagnosis of late effect cerebrovascular disease (ICD-9 438) are the most likely to receive both OT visits (60% of patients nationally receive at least one OT visit, compared to 24% of all patients) and ST visits (38% receive at least one ST visit, compared to 6% of all patients). Even for this specific patient population, the percent of patients with this diagnosis receiving OT and ST ranges from 25% to 84% (OT) and 16% to 60% (ST) (figure 26).

Understanding diversity in utilization practice patterns can be helpful to organizations evaluating their own protocols, but it can also be useful to understand the
impact of different services on quality outcomes. For example, we know that patients with a primary diagnosis of late effect cerebrovascular disease who receive at least one OT visit have better outcomes across most clinical and functional measures than the same type of patients who do not receive at least one OT visit (figure 27).

Healthcare Ecosystem: Home Health in a Key Position

Home health care, when it’s appropriate, is often the most economical care setting. According to CMS, the average reimbursement per skilled nursing home resident in 2010 was $13,064, while the average reimbursement per home health patient was $5,691. Many patients do not receive care in only one setting or the other—14% of home health patients were in a skilled nursing home in the 14 days prior to home health. Residential care is the best option for many, but for others, the home is the preferred place to live for a number of reasons. Sometimes an independent or assisted living community is the home where the patient is being seen by home health clinicians, so the populations and choices are not mutually exclusive.

Hospitals have been increasing their discharges to home health steadily over the past 20 years, from less than 5% in 1993 to almost 11% in 2010 (figure 28, source: AHRQ HCUPnet database). The patterns of home health utilization are continually evolving, as greater recognition of the value it provides is earned and as the payment and quality policies evolve.

Data shows that 55% of all home health patients were in a short-stay acute hospital in the 14 days prior to home health, but that rate varies depending on payer, demonstrating different patterns in home health utilization (figure 29). Consistently, we see
higher rates of pre-home health hospitalization from managed care providers than from their traditional payer counterparts—at the extreme end of the scale, less than 60% of traditional Medicaid patients were in a hospital prior to home health, but more than 70% of Medicaid HMO patients were.

Another factor driving home health utilization trends is the increased attention paid to hospital readmissions and avoidable hospitalizations. The majority of recent efforts, on the part of hospitals, home health providers, and other stakeholders alike, have been the hospital payment penalty for higher-than-expected 30-day Medicare readmission rates imposed by CMS starting in the fall of 2012. Performance on this measure changed little in 2012 for home health agencies—monthly rates ranged from 19.2% to 19.9% (not in a consistent trend). It will be interesting to observe if and how this changes after the actual implementation of the payment penalty. Despite emphasis on Medicare readmissions, there is reason to expand focus to the broader issue of hospitalizations. By some estimates, avoidable hospitalization cost our healthcare system $30 billion or more each year. As our whole healthcare system moves toward accountable-care type
payment and accountability models, the incentive for all healthcare providers to avoid hospitalizations when possible increases, regardless of the timing of the hospitalization or the payer. When we look at hospitalization rates in home health by payer, we do see diversity in today’s current performance (figure 30).

Figure 30

Acute Care Hospitalization, by Primary Diagnosis

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Hospice

Person-Centeredness: Bringing Comfort to Life

Hospice provides services to persons in the last days or months of their lives. But hospice is not about dying; it’s about bringing as much comfort as possible to the patient’s remaining days, and giving comfort and support to family members. It’s unique from other healthcare segments for two main reasons: 1) the care recipient, or the customer, is not just the patient but also the patient’s family; and 2) it is truly patient- and family-driven, where the decisions that are made are based largely, if not solely, on the desires of the patient rather than on the medical opinion of the doctor. Customers in hospice, therefore, include both the patient and the patient’s family. This dynamic adds a layer of complexity to understanding the customers’ needs and to offering sufficient services to meet their expectations and providing the best possible customer experience.

More specific details are known about hospice patients than their families. Over 60% of hospice patients are cared for in their home, about one in three has a cancer diagnosis, approximately half of all patients receive hospice services for three weeks or less, more than one in four are uncomfortable due to pain upon admission, and all are expected to have a life expectancy of six months or less.

Two of the primary goals of hospice care include making the patient as comfortable as possible and making sure patient wishes about the level of care and treatment in the last days of life are honored. In both of these areas, hospice providers demonstrate high rates of success. Nationally, almost 100% of patients who state that they would prefer to avoid hospitalization if their condition worsens are able to avoid it (figure 31). More than half of all hospices achieve 100% success in avoiding unwanted hospitalizations. And, 72% of patients who are uncomfortable due to pain upon admission to hospice have their pain brought to a comfortable level within 48 hours of admission.

Providing services and support to hospice patients’ families both at the end of life and for the 13 months post-death is another of the main goals of hospice. Data collected directly from families about their experience also demonstrate a high level of success in this category of services. The median level of family caregiver recommendation at the hospice level is greater than 90% nationally (figure 32). This demonstrates the ability of hospice to impact the overall experience of the family members. Measures of satisfaction in specific tasks are not always as high, but remain strong. The median level of “excellent” satisfaction ratings with the responsiveness of hospice in evenings and on weekends is more than 70%.
Staffing: The Critical Role of Volunteers

The hospice staffing profile is very diverse, by design. Hospice relies on an interdisciplinary approach to providing holistic care and services to patients and their families; the interdisciplinary team is a core characteristic of hospice care and hospice operations.

According to the National Hospice and Palliative Care Organization (NHPCO), two-thirds of hospice full-time employees (FTEs) provide direct patient care, and nearly half of those are nurses. Other direct patient care FTEs include home health aides (almost a third of direct patient care FTEs), social services, chaplains, physicians, other clinical, and nurse practitioners (data source: 2012 Edition of NHPCO Facts and Figures: Hospice Care in America). Home health aides make the most visits per week (just over 25 on average), while the other disciplines have very similar weekly visit loads, between 14.8 (social services) and 18.6 (physicians) (figure 33).

The remaining one-third of hospice hours are spent on indirect clinical nursing, non-clinical work, bereavement services, and volunteer coordination. The last role is another element of staffing that is unique to hospice. Hospice is the only provider type required by the Medicare Conditions of Participation to have volunteers providing at least 5% of total patient care hours. NHPCO estimates that more 21 million hours of service, including both direct work with patients and families and behind the scenes administrative and fundraising efforts, were provided by approximately 458,000 hospice volunteers in 2011.

The involvement and recruitment of volunteers adds another dimension to the issue of staffing for hospice providers. These individuals, who provide on average almost 45 hours of unpaid service each year (source: NHPCO), require training, coordination, and support. Volunteers are an essential element of hospice, yet one that can be costly to manage. As the demand for hospice services grows, so too will the need for volunteers and the expense involved in recruiting, training, and managing a pool of volunteers. Although they are not employed by the hospice, understanding the motivation and drivers of satisfaction for volunteers can add to the efficiency and effectiveness of these activities.

Studies on the topic of hospice volunteers consistently found motivation and satisfaction tied to two main ingredients—1) feeling valuable and helpful, and 2) clearly defined and aligned roles and responsibilities. The most common motivations identified in one study include, in order, “to help others and learn, foster social relationships, feel better, and pursue career goals.” (data source: American Journal of Hospice and Palliative Medicine).

Similarly, volunteer satisfaction was most influenced by gratitude of patients and their families (data source: American Journal of Hospice and Palliative Medicine, Stephen Claxton-Oldfield), and “...feeling
like a team member, receiving feedback from staff, feeling valuable and having expectations match the position.” (data source: American Journal of Hospice and Palliative Medicine). On the opposite side of the spectrum, role ambiguities, struggling with patients’ suffering, and dealing with family dynamics represented some of the biggest detractors to volunteer satisfaction. (Claxton-Oldfield, et. al.)

These findings reveal the need to not only measure satisfaction and engagement among clinical and support personnel for hospice programs, but also the need to measure volunteer experiences. Findings through an organized effort to measure hospice workforce and volunteer satisfaction would uncover significant intelligence that can be applied to the growing evolution of hospice services, including increased patient referrals from hospitals and health systems, more focused volunteer recruitment efforts, and lower costs related to staff turnover and volunteer programs.

If the data from other care segments is any indicator, the hospice programs with higher satisfaction will likely show higher satisfaction from staff and volunteers. But this can only be verified through a consolidated, worthwhile effort to measure engagement among those who provide care and those who volunteer.

Healthcare Ecosystem: Referral Timing and System Savings

One of the most difficult aspects of hospice care is referral timing. There are a number of factors in play influencing this event—for example, predictability (or lack thereof) around the expected progression of a patient’s condition, the difficulty of the conversation between the physician and the patient and their family, and the readiness of the patient and family to accept that the time for healing is past. Yet there are so many reasons to look at hospice as an option for patients sooner rather than later, including quality care, comfort, family satisfaction, cost savings, and the belief of many that we too often refer too late.

In one study evaluating the perspective of family members related to hospice timing, one-third of those with family members on hospice for two weeks or less reported that it would have been easier if hospice had been referred earlier (data source: Home Health Care Management Practice, “Assessing Satisfaction While the Patient Receives Hospice Services.”). In a similar study that was conducted by interviewing 100 bereaved families, 41 said that their family member had been referred to hospice “too late.” (data source: Journal of Pain Symptom Management, “It is “too late” or is it? Bereaved family member perceptions of hospice referral when their family member was on hospice for seven days or less”).

The additional argument for hospice utilization is a financial one. There is mounting evidence that hospice is both a high-quality and efficient option for care at the end of life. One study found that hospice saved Medicare $2,309 on average per patient (data source: Social Science & Medicine, “What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?”). Another study found similar trends, calculating savings of between $2,561 and $6,430, based on the patient’s eventual length of service for patients enrolled up to 105 days before death. (data source: Health Affairs, “Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths of stay”). According to the authors, “If 1,000 additional beneficiaries enrolled in hospice 15 to 30 days prior to death, Medicare could save more than $6.4 million. In addition, reductions in the use of hospital services at the end of life both contribute to

Figure 34

Trended Utilization of Hospice Services

30%
25%
20%
15%
10%
5%
0%
Q1 Q2 Q3 Q4
Patients with a length of stay less than seven days
Patients with a length of stay more than 180 days
these savings and potentially improve quality of care and patients’ quality of life.”

Despite all of the arguments for hospice—quality of life, quality of care, satisfaction, financial benefits—we find that about one in four patients is enrolled in hospice within the last week of life (figure 34). As written by Don H. Taylor, Jr., assistant professor of public policy at Duke’s Sanford Institute of Public Policy, “Given that hospice has been widely demonstrated to improve quality of life of patients and families...the Medicare program appears to have a rare situation whereby something that improves quality of life also appears to reduce costs.”
Conclusion

This report focused on three dominant trends across all post-acute providers: person-centeredness and the evolution of the healthcare customer; the importance of staffing; and healthcare as an ecosystem. The first trend shapes the second and third—providers must place customer’s needs first in order to be sustainable and customer satisfaction is entirely related to the experience provided by staff. The provider’s place in the ecosystem relates to referrals and care transitions along the continuum.

For skilled nursing providers, there is continuing progress being made with respect to the customer experience. Staffing concerns focus on workforce satisfaction, as this is one of the most important measures of quality in senior care. The top two drivers of both resident and family recommendation (in skilled nursing and in other post-acute settings) are both related to employees—care (concern) and competency of staff. Skilled nursing providers in the healthcare ecosystem must keep patients out of the hospital, while also dealing with decreasing occupancy rates and addressing customer cost concerns.

In assisted living, person-centeredness means being able to match services provided to the seniors’ needs, and staffing appropriately to meet resident needs and expectations in these daily support activities. Again, two of the top drivers of customer satisfaction are the care (concern) and competency of staff. Assisted living employees share the same top three drivers for their own job satisfaction as skilled nursing: care (concern) of management, attentiveness of management, and assistance with job stress. These facilities are a link in the ecosystem chain—more than half of assisted living residents end up moving into a skilled nursing home.

Person-centeredness in independent living communities is focused on providing a new and easier home as the residents get older and their needs and demographics change. Staffing requires similar needs as skilled nursing and assisted living, but with a different satisfaction profile. When considering independent living options within the healthcare ecosystem, now may be a prime time for a social media strategy, since most seniors opt to move to independent living communities by choice, rather than due to a particular health episode or event.

Home health care is person-centered by assisting elders to age in place. Staffing is affected foremost by diversity in utilization, as this is an area where customers have the most varied needs. Staff visits make up the bulk of the cost of home health, and the shortage of staff in many regions, combined with reducing reimbursement and the lack of clear best-practice visit guidelines, results in home health agencies continually working to refine and perfect their staff utilization. When it’s appropriate, home health is often the most economical care setting. This is a key place in the healthcare ecosystem, and hospitals have been increasing their discharges to home health steadily over the past 20 years.

For hospice care, person-centeredness brings comfort and support to patients and their families at the end of life. It is truly patient and family-driven, where the decisions are based on the desires of the patient rather than on the medical opinion of the doctor. Volunteers are an essential staffing element of hospice, yet one that can be costly to manage. Although they are not employed by the hospice, understanding the motivation and drivers of satisfaction for volunteers can add to the efficiency and effectiveness of these activities. In the healthcare ecosystem, hospice providers can work with hospitals and other providers to ensure that patients are referred and transferred at the ideal time. There are so many reasons to look at hospice as an option for patients sooner rather than later, including quality care, comfort, family satisfaction, cost savings, and the belief that we too often refer too late.

Post-acute providers are in a unique position to change the way they meet the needs of healthcare customers and provider partners. These providers offer distinctive value to consumers and other providers. As post-acute providers re-establish their role in the care continuum, this report will help develop a solid understanding of the dynamics of the greater healthcare continuum.
Overview of Data Source

The Data Profile for skilled nursing homes in this National Research Report presents feedback and insights collected from long term care residents, families, and employees through My InnerView surveys administered by National Research Corporation.

Typically called satisfaction surveys, these tools were designed not just to assess satisfaction, but to collect information that support multiple efforts within the long term care profession, including quality assurance, customer engagement, employee program development, performance improvement, referral source management, community outreach, and many others.

The My InnerView Customer Program survey asked residents and families to review 22 nursing facility experiences across three broad areas:

1. Quality of life - if they felt affirmed as persons in matters of safety, privacy, dignity, choice, and other aspects of well-being
2. Quality of care - how they rated the staff and care practices in regard to adequacy, competence, and a caring attitude
3. Quality of services - how satisfied they were with meals, laundry, maintenance, and more

The My InnerView Employee Program surveys asked employees to comment on their experiences with the facility in order to provide managers and leaders perspective on three key areas:

1. Resources - if they have the tools, training, equipment, pay, feedback, and safe environment that enables them to be successful
2. Relationships - how the team, supervisors, and management interact and collaborate on a daily basis, plus the support structure they provide the employee
3. Commitment - if the employee is aligned with and integrated into the organization

Database

This 2013 National Research Report represents nearly one out of three skilled nursing facilities in the United States that surveyed customers and employees through My InnerView by National Research Corporation in 2012. It includes feedback from a half a million stakeholders—residents, families, short-stay patients, and employees. Rounded to the nearest percentage, 36% of families and 55% of residents responded to the request for the feedback. Plus, 61% of employees surveyed returned responses.

Measures Included

This Data Profile offers insights into:

Provider Profile and Customer Demographics
- Response rates, resident age and length of residence, family member relationship and frequency of visits.

Customer Satisfaction
- Overall resident and family satisfaction scores, trends, range of scores throughout the profession, highlights of top and bottom scoring items, and top drivers of customer satisfaction.

Employee Demographics
- Employee age, tenure of employment, role type, and hours worked.

Employee Satisfaction
- Overall employee satisfaction, range of performance, measures with the highest and lowest scores, and top drivers of employee recommendation.

Interdependence
- The relationship between employee and family, family and resident satisfaction.

Interdependence Notes

The last two graphs in this skilled nursing section and in the next assisted living section (pages 39 and 46) demonstrate the relationships between employee, family, and resident satisfaction.

- Skilled nursing homes were grouped by their employee overall satisfaction score and then the average family overall satisfaction score for each group was calculated. The same process was repeated, grouping by family satisfaction score and calculating average resident overall satisfaction score.
- All satisfaction ratings are positively correlated.
- Homes with higher employee satisfaction have, on average, higher family satisfaction.
- Homes with higher family satisfaction have, on average, higher resident satisfaction.
Short-Stay Resident Age

- Less than 60: 18%
- 60-69: 29%
- 70-79: 29%
- 80-89: 34%
- 90 or older: 10%

Frequency of Family Visits

- Less often than once per year: 1%
- Once per year: 2%
- Once every three months: 4%
- Once per month: 15%
- Once per week: 47%
- Daily: 31%

Length of Residence

- Less than 1 month: 3%
- 1 to 3 months: 10%
- 3 to 6 months: 8%
- 6 months to 1 year: 14%
- 1 to 3 years: 33%
- 3 or more years: 32%

Trended "Excellent" and "Good" Recommendation Residents Scores for Short-Stay

- 2010: 85.2%
- 2011: 86.6%
- 2012: 87.0%
Top Areas of Customer Satisfaction

- Respectfulness of staff
- RN/LVN/LPN care
- Safety of facility

Bottom Areas of Customer Satisfaction

- Responsiveness of management
- Quality of laundry services
- Quality of meals
- Security of personal belongings
- Quality of dining experience
- Adequate staff to meet needs
Percent of "Excellent" and "Good" Responses

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- **Top Eight Drivers of Recommendation for Residents and Families**
  - Care (concern) of Staff
  - Competency of Staff
  - Choices/Preferences
  - RN/LVN/LPN Care
  - Responsiveness of Management
  - CNA/NA Care
  - Respectfulness of Staff

- **Top Five Drivers of Recommendation for Short-Stay Residents**
  - Competency of Staff
  - Care (concern) of Staff
  - Choices/Preferences
  - Responsiveness of Management
  - Quality of Medical Care

- **Top Six Drivers of Recommendation for Nurses, CNAs, and Other Employees**
  - Care (Concern) of Management
  - Attentiveness of Management
  - Assistance with Job Stress
  - Safety of Workplace
  - Fairness of Evaluations
  - Care (concern) of Supervisor
Top Areas of Employee Satisfaction

- Sense of accomplishment
- Respectfulness of staff
- Quality of in-service education
- Safety of workplace

Bottom Areas of Employee Satisfaction

- Comparison of pay
- Assistance with job stress
- Attentiveness of management
- Care (concern) of management
Percent of "Excellent" and "Good" Responses

- All Employee: Recommendation to Others (68%) vs. Overall Satisfaction (67%)
- Nurse: Recommendation to Others (65%) vs. Overall Satisfaction (65%)
- CNA: Recommendation to Others (64%) vs. Overall Satisfaction (61%)

Relationship Between Family and Resident Overall Satisfaction

- Average Resident Satisfaction
  - First Quartile: 60%
  - Second Quartile: 70%
  - Third Quartile: 80%
  - Fourth Quartile: 90%

Community Groupings Based on Relative Family Satisfaction Score

Relationship Between Employee and Family Overall Satisfaction

- Average Family Satisfaction
  - First Quartile: 60%
  - Second Quartile: 70%
  - Third Quartile: 80%
  - Fourth Quartile: 90%

Community Groupings Based on Relative Employee Satisfaction Score
Data Profiles - Assisted Living

Overview of Data Source

The Data Profile for assisted living communities in this National Research Report includes an in-depth overview of the voice of assisted living residents, families, and employees from the largest compilation of such data in the U.S. The metrics and information in this report are presented to support the advancement of the senior care and senior living professions. Measures that give stakeholders a better understanding of this care segment were selected for inclusion.

This information was gathered through surveys designed specifically to measure the satisfaction of customers and employees of assisted living facilities. The My InnerView surveys were administered by National Research Corporation. The Customer Program surveys collect information about quality of life, staff, and service, plus dining experience, environmental quality, and billing/charges from residents and families. The Employee Program surveys gather information about the work environment, training, supervision, and management. Both surveys also collect an overall satisfaction rating and recommendation ratings (to others as a place to live for customers, and to others as a place to live and as a place to work for employees).

Database

This 2013 National Research Report includes approximately 1,500 assisted living communities that surveyed customers and employees through National Research Corporation in 2012. It includes feedback from almost 50,000 assisted living customers (residents and family members) and 20,000 employees. Response rates were relatively high across the board, especially from customers—43% of families responded to the request for input, 52% of residents, and 61% of employees.
Top Areas of Customer Satisfaction

- Respectfulness of staff
- Comfort of room/surroundings
- Respect for privacy
- Courteousness of dining staff
- Safety of facility

Bottom Areas of Customer Satisfaction

- "Grow as person" opportunities
- Appeal of food
- Variety of meals
- Adequacy of storage space
Customer Satisfaction Goals

- Communities Meeting or Exceeding 90% Resident Recommendation
- Communities Meeting or Exceeding 90% Family Recommendation

Length of Employment

- Less than 3 months: 10%
- 3 months to 1 year: 19%
- 1 to 2 years: 17%
- 2 to 5 years: 25%
- 5 to 10 years: 18%
- 10 or more years: 11%

Employee Age

- Less than 30: 28%
- 30 to 39: 18%
- 40 to 49: 20%
- 50 to 59: 22%
- 60 or older: 12%

Employee Roles

- Personal Care: 34%
- Nurse: 22%
- Food: 17%
- Transportation, Other: 6%
- Community Administration: 9%
- Housekeeping, Maintenance, Laundry: 9%
**Hours Worked per Week**

- Fewer than 10: 4%
- 10 to 20: 11%
- 20 to 30: 14%
- 30 to 40: 57%
- 40 or more: 14%

**Top Six Drivers of Recommendation for Nurses, Personal Care Aides, and Other Employees**

- Care (Concern) of Management
- Attentiveness of Management
- Assistance with Job Stress
- Clear Expectations by Management
- Fairness of Evaluations
- Support of Career (4th for personal care aides)

**Top Five Drivers of Recommendation for Residents**

- Responsiveness of Management (3rd for families)
- Choices/Preferences (4th for families)
- Care (Concern) of Staff (2nd for families)
- Home-like Atmosphere (8th for families)
- Competency of Staff (1st for families)
Top Areas of Employee Satisfaction

- Sense of accomplishment
- Respectfulness of staff
- Care (concern) of supervisor
- Communication by supervisor
- Quality of orientation

Bottom Areas of Employee Satisfaction

- Staff-to-staff communication
- Attentiveness of management
- Comparison of benefits
- Assistance with job stress
- Comparison of pay
Relationship Between Family and Resident Overall Satisfaction

Community Groupings Based on Relative Family Satisfaction Score

Relationship Between Employee and Family Overall Satisfaction

Community Groupings Based on Relative Employee Satisfaction Score
Data Profiles - Independent Living

Overview of Data Source

The Data Profile for independent living communities in this National Research Report includes data specifically representative of individuals living in those communities and the employees who work in them. The specific focus on independent living, in combination with the depth of experience and unique perspective that National Research brings across the healthcare continuum, including long-term care and senior living communities, offers an exclusive and valuable viewpoint on what drives customer and employee satisfaction in this distinctive setting.

Database

This 2013 National Research Report includes data from nearly 40,000 stakeholders (residents and employees) in the United States that were surveyed by hundreds of independent living communities through My InnerView by National Research Corporation in 2012.

In total, 65% of residents surveyed responded to the request for feedback and 67% of employees invited to participate completed a survey response.

Length of Residence

- Less than 1 month: 1%
- 1 to 3 months: 4%
- 3 to 6 months: 6%
- 6 months to 1 year: 11%
- 1 to 3 years: 27%
- 3 or more years: 51%

Top Five Drivers of Recommendation for Residents

- Home-like Atmosphere
- Commitment to Independence
- Care (Concern) of Staff
- Responsiveness of Management
- Sufficiency of Personal Assistance

Top and Bottom Areas of Resident Satisfaction

- Respectfulness of staff
- Respect for privacy
- Courteousness of dining staff
- Feeling of security
- Variety of meals
- Appeal of food
- Sufficiency of dietary needs
Top Five Drivers of Recommendation for Employees

- Care (Concern) of Management
- Assistance with Job Stress
- Attentiveness of Management
- Clear Expectations by Management
- Support of Career

Length of Employment

- Less than 3 months: 7%
- 3 months to 1 year: 15%
- 1 to 2 years: 14%
- 2 to 5 years: 26%
- 5 to 10 years: 20%
- 10 or more years: 18%

Hours Worked per Week

- Fewer than 10: 5%
- 10 to 20: 10%
- 20 to 30: 11%
- 30 to 40: 56%
- 40 or more: 18%

Employee Age

- Less than 30: 23%
- 30 to 39: 14%
- 40 to 49: 22%
- 50 to 59: 25%
- 60 or older: 16%
Data Profiles - Home Health

Overview of Data Source

The Data Profile for home health agencies in this National Research Report presents insights uncovered through an analysis of OASIS (Outcome and Assessment Information Set), visit utilization, and HHCAHPS (Home Health Consumer Assessment of Healthcare Providers and Systems) data collected from clients of OCS HomeCare by National Research Corporation.

OASIS is a comprehensive patient assessment required by the Centers for Medicare and Medicaid Services (CMS). All Medicare-certified home health agencies must conduct the OASIS at specific time points (start of care, recertification, resumption of care, transfer, and discharge) for adult non-maternity home health patients receiving skilled services and whose care is covered by Medicare (both fee for service and managed care) or Medicaid. The assessment information is the basis for the Home Health Quality Measures—both outcome and process measures are publicly reported on the Home Health Compare website.

Utilization or visit data represents billable visits performed in patients’ homes by home health agency clinicians. These are captured directly from home health agency billing systems or imported from final claims files.

HHCAHPS is a patient experience survey that home health agencies must contract with a CMS-approved third-party vendor to conduct. The surveys gather information about the care and interactions that the patient experienced with the agency as well as their assessment of the overall experience (overall satisfaction rating and recommendation). The results of these surveys are also made publicly available for each agency on the Home Health Compare website.

The information included in this report represents just a subset of the data available from these sources. The measures and the comparison groups have been selected to give a snapshot into the characteristics of home health care patients as well as outcomes of care relevant to the quality and operations of home health agencies.

Database

This 2013 National Research Report represents approximately 2,500 home health agencies, 1.3 million cases of patient care (all payers), and 1.4 million Medicare PPS episodes of care from 2012.
Inpatient Setting Prior to Home Health

- Short-stay Acute Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Hospital or Unit
- Long-term Nursing Facility or Hospital, Psych Unit, Other

Living Situation

- Lives Alone
- Lives in Congregate Situation
- Lives With Other Person(s) in the Home

Percent of Episodes That Receive at Least One Visit of Noted Discipline

- SN percent of total
- PT percent of total
- OT percent of total
- ST percent of total
- MSW percent of total
- HHA percent of total
Hospitalization Rates by Payer

- All
- Medicare
- Medicaid, any
- Medicare Advantage

Hospitalization 60-day "claims-based" rate

Average Visits

- Per Episode
- Per Episode Receiving that Service

Trended Hospitalization Rates, 2012

Average Visits per Episode

- Home Health Aide
- Medical Social Services
- Therapy
- Skilled Nursing

West Northwest Mountain Midwest Central Southwest Southeast East Northeast New England

<table>
<thead>
<tr>
<th>Region</th>
<th>Home Health Aide</th>
<th>Medical Social Services</th>
<th>Therapy</th>
<th>Skilled Nursing</th>
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<tbody>
<tr>
<td>West</td>
<td>0.9</td>
<td>0.3</td>
<td>6.4</td>
<td>7.5</td>
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<tr>
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<td>Mountain</td>
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<tr>
<td>New England</td>
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<td>0.3</td>
<td>6.4</td>
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</table>
National HHCAHPS Scores from 2012

Overall Rating of Care
Likelihood to Recommend
Patient Care
Communication
Specific Care Issues

Composite Improvement Scores, by Payer

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Outcomes</th>
<th>Functional Outcomes</th>
<th>Clinical Outcomes</th>
<th>Personal Maintenance Outcomes</th>
<th>Urinary/Bowel Outcomes</th>
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<tbody>
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<td>All</td>
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<td>60.4%</td>
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<td>67.6%</td>
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<tr>
<td>Medicare/Medicaid</td>
<td>56.9%</td>
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<td>74.3%</td>
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<td>67.6%</td>
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<tr>
<td>Medicare</td>
<td>57.4%</td>
<td>59.6%</td>
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<td>68.2%</td>
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<tr>
<td>Medicare Advantage</td>
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<td>75.4%</td>
<td>74.5%</td>
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</table>
Data Profiles - Hospice

Overview of Data Source
The measures included in this Hospice Data Profile represent targeted measures, selected due to their importance for hospice organizations to review and analyze as a part of data-driven organizational performance. These data elements inform, guide, and direct hospice leaders in operational, clinical, and financial decision making.

Data collection has historically been voluntary for hospice organizations. This standard started to change with the CMS requirement that hospices submit quality-related data starting in January 2013. The Affordable Care Act mandates the public release of hospice quality measures beginning in 2015. As part of the process to get to that point, CMS initiated pay-for-reporting data submission on “structural” measures (collecting information about the hospice’s data collection practices and measures used) as well as a single quality measure in 2013. CMS has also published regulations related to the mandated use of a Hospice Item Set (HIS)—a standardized patient data set—to start on July 1, 2014, to facilitate public reporting.

Database
This 2013 National Research Report represents data from hundreds of hospice locations across the country and the hundreds of thousands of patients they served in 2012. More than half (52%) are free standing, while nearly half (47%) are part of a chain and also nearly half (48%) are proprietary. Most of the participating hospice programs (84%) have an average daily census (ADC) of less than 100.

Measures Included
This Data Profile offers insights into:

Patient Demographics - Average daily census, average and median length of service, location of care, most common diagnosis, end of care results.

Staffing - Weekly visits per FTE by discipline, average daily census per FTE by discipline

Quality - Patients brought to a comfortable level of pain within 48 hours of admission.

Additional measures in the text of the report.

Patient Demographics
Select observations:
- The majority (60%) of the hospice patients are cared for in their home or place of residence versus an inpatient unit or nursing home.
- More than one of three hospice patients (36%) have a primary diagnosis of cancer.
- Almost one in five (18%) hospice patients do not die while on service, but are discharged to another provider or cease hospice care for another reason.
- The average length of hospice service was between 65 and 80 days during 2012.
- The median length of service hovered between 22 and 24 days.
- The median is so much lower than the average because the 50% of patients with a length of service less than 22 days was on service for between one and 21 days, while the 50% on service for more than 22 days could have experienced 180 days or more between the start and end of hospice.

Staffing
Select observations:
- The average number of visits performed per full time equivalent (FTE) employee for all hospices ranged between just under 15 (social services) to just over 25 (home health aides).
- Home Health aides are utilized more than other disciplines regardless of Hospice ADC (average daily census).
- The difference in average visits per week by FTE varied somewhat by the size of the hospice - employees of hospices with an average daily census of more than 100 performed more nursing, social service, and home health visits per week, but fewer chaplain and physician visits.
- The patient load - or the average daily census per FTE - was about eight or nine patients per nurse, between three and four patients per employee (of any discipline or role).

Quality
Select observations:
- The “comfort within 48 hours” measure
has been one of the most commonly used by hospices to track quality care for the past several years. This measure tracks the percent of patients whose pain was brought to a comfortable level within 48 hours of hospice initiation, of those who were uncomfortable due to pain upon admission.
- In 2011 and the first half of 2012, the rate was in the low- to mid-90’s.
- CMS announced a change to the parameters or definition of the measure to be applied to data collected in the the fourth quarter of 2012. Some hospices adopted the change in the definition sooner than others.
- Data reflecting performance in the fourth quarter of 2012 should follow the consistent definition and demonstrate the profession’s level of performance under those refined guidelines.
- Note: “Comfort within 48 hours” is not currently slated to be part of the Hospice Information Set or publicly reported.
Patient Characteristics

- Location: Home, Inpatient Facility, Hospice Unit, Hospital, or Assisted Living
- Diagnosis: Cancer
- End of Care: Live Discharges

Weekly Visits per FTE by Discipline

- Nursing
- Social
- HHA
- Chaplain
- Physician

- All providers
- ADC>100
- ADC<100
References


Agency for Health Research and Quality (AHRQ), Health Cost and Utilization Project (HCUPnet) database: http://hcupnet.ahrq.gov, Rockville, MD


Centers for Disease Control (CDC) (April 2012), NCHS Data Brief No. 91, http://www.cdc.gov/nchs/data/databriefs/db91.pdf, Atlanta, GA


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