Scripps Gerontology Center

Scripps Gerontology Center Publications

Miami University *Year* 1997

Ohio nursing homes : an industry in transition

Jane Straker* Robert Applebaum† Shahla Mehdizadeh‡

*Miami University, commons@lib.muohio.edu
†Miami University, commons@lib.muohio.edu
‡Miami University, commons@lib.muohio.edu

This paper is posted at Scholarly Commons at Miami University.
http://sc.lib.muohio.edu/scripps_reports/32

Ohio Long-Term Care Research Project

OHIO NURSING HOMES: AN INDUSTRY IN TRANSITION

Jane Karnes Straker
Robert Applebaum
Shahla Mehdizadeh

September 1997

Scripps Gerontology Center Miami University Oxford, Ohio 45056

Dr. Jane Karnes Straker is Director of Policy for the Ohio Long-Term Care Research Project, Scripps Gerontology Center, Miami University, Oxford, Ohio. Dr. Straker has been involved in the evaluation of Ohio's long-term care programs since coming to Miami in 1993. Dr. Straker was recently the Project Director on *Evaluating Long-Term Care Initiatives in Ohio*, funded by the Ohio Department of Aging, and a researcher on *Elderly Services Program: System Development and Evaluation*, funded by the Robert Wood Johnson Foundation. Her research interests include quality and consumer satisfaction in institutional and community-based long-term care, autonomy in institutional settings, and long-term care decision making.

Dr. Robert Applebaum is Professor in the Department of Sociology and a Research Fellow at the Scripps Gerontology Center, Miami University, Oxford, Ohio. He has been involved in the development and evaluation of long-term care programs since 1978, working on the Wisconsin Community Care Organization, Wisconsin Community Options Program, Ohio's PASSPORT program and the National Long-Term Care Channeling Demonstration. Dr. Applebaum has been involved in the design and evaluation of quality assurance systems for case management programs and for in-home services provided under the Older Americans Act around the nation. He has recently been involved in studying Assisted Living in Ohio and in evaluating Ohio's Universal Pre-Admission Screening Program.

Dr. Shahla Mehdizadeh is Director of Research for the Ohio Long-Term Care Research Project, Scripps Gerontology Center, Miami University, Oxford, Ohio. Dr. Mehdizadeh was Co-Principal Investigator of the project *Evaluating Long-Term Care Initiatives in Ohio* funded by the Ohio Legislature, and she is currently Co-Principal Investigator of the project *Evaluation of Community Based Long-Term Care in Ohio* funded by the Ohio Department of Aging. With a background in economics and a keen interest in the aging population, most of her research is related to cost of care for the aging population in different long-term care settings. A relatively recent such work is *The Economics of Long-Term Care in Ohio* with Robert C. Atchley.

This research was funded through a grant from the Ohio Department of Aging. Report printing and dissemination is funded by a grant from the State of Ohio, Board of Regents, Ohio Long-Term Care Research Project. Reprints available from the Scripps Gerontology Center, Miami University, Oxford, OH 45056; (513) 529-2914; FAX (513) 529-1476; http://www.muohio.edu/scripps.

Ohio Nursing Homes:
An Industry in Transition

Jane Karnes Straker
Robert Applebaum
Shahla Mehdizadeh

Scripps Gerontology Center
Miami University
Oxford, OH 45056

September 1997

Executive Summary

Ohio has over 990 long-term care facilities with licensed nursing home beds, and over 95,000 licensed nursing home beds. Recent federal and state legislative initiatives and the development of new long-term care services, including home care and assisted living, have resulted in a nursing home industry that is clearly different from that of a decade ago. In 1993, the Ohio Legislature implemented several important pieces of legislation designed to slow the flow of Medicaid dollars into the state's nursing homes. The legislature expanded the state's participation in the Medicaid home and community-based waiver program (PASSPORT), implemented a long-term care pre-admission review program, and enacted a Medicaid moratorium that prevents the construction of a new nursing home bed if it increases the total bed supply in the state (Applebaum, Mehdizadeh, & Straker, 1997). The effects of these actions are dramatic in some areas. For example, the number of ongoing client places available in the PASSPORT program increased from 2,700 in FY 1991 to 15,864 in FY 1995, and will continue to expand to almost 23,000 clients in FY 1998.

To understand how the industry has responded to these initiatives we examined data from several sources: the Ohio Department of Health's 1995 Annual Survey of Long-term Care Facilities, Online Survey Certification and Reporting data for 1995 from the Health Care Financing Administration, data collected at the Scripps Gerontology Center from a mailed survey of a random sample of Ohio long-term care facilities, and data from published reports.

Our analysis of these data shows that the Ohio nursing home industry has responded to Ohio's legislative reforms. The industry has become more diverse through increased availability of specialized services, home and community-based services, and multiple types of care provided in one setting. Issues that the industry may face in the future include: attempts to limit the amount of Medicare dollars going to skilled nursing facility services, quality and cost issues related to obtaining managed care contracts, standardization and certification issues related to the provision of subacute care, and improving strategies to recruit and retain frontline paraprofessional nursing home workers. Increased attention must be given to these issues before we confront the challenge of an aging baby-boom population.

Ohio's nursing home industry shows a great deal of variation in its response to current challenges. Some nursing homes are remaking the image of the nursing home by expanding services into the community, providing sub-acute and rehabilitation services, obtaining managed care contracts, and working within integrated service delivery organizations. Other facilities have retained a more traditional orientation. What remains unclear is whether a new direction for the industry is emerging or whether current and future opportunities for change will result in even greater industry diversity.

Acknowledgements

A number of people made significant contributions to the research reported here. Michelle Crepeau had a large hand in managing our original data collection from beginning to end, and along with Chris Bickel conducted many of the telephone interviews. Janice Angel spent hours carefully and accurately entering the data we collected. Clerical staff Cheryl Johnson, Lois Watson, and Betty Williamson entered Ohio Department of Health Data and John Paulson at ODH assisted in interpreting and using the data file. A number of administrators and nursing home staff took the time to answer our questions and to give us their opinions about what issues were important to learn about. Roland Hornbostel, Robert Atchley, and Suzanne Kunkel provided helpful comments on an earlier version of this report.

Table of Contents

BACKGROUND AND INTRODUCTION 1

METHODS 2

FINDINGS 2

What does Ohio's nursing home industry look like? 2
Who are the residents in nursing homes? 5
To what extent are there changes in nursing home admissions, discharges, and transfers? What trends can be ascertained from occupancy rates in Ohio's nursing homes? 5
What challenges does the industry face in terms of its labor force? What do nursing homes say about recruitment and retention issues? 9
What specialized services do nursing homes provide? What home and community-based services are provided by nursing homes? 14
How are Ohio's nursing homes meeting the challenges of subacute care and managed care? 15

IMPLICATIONS 18

What does today's picture tell us about the future of the nursing home industry in Ohio? 18

REFERENCES 19

APPENDIX: Survey of Nursing Home Industry Trends 23

List of Figures and Tables

Figure 1
Profile of Nursing Homes in Ohio, 1995 3

Figure 2
Profile of Nursing Home Residents, 1995
Selected Characteristics 6

Figure 3
Profile of Ohio Nursing Homes, 1995
Admission Rate per 100 Beds 11

Figure 4
Profile of Ohio Nursing Homes, 1995
FTE Employees per 100 Nursing Home Beds 13

Table 1
Ohio Nursing Homes with Licensed Beds by Selected Characteristics, 1995 4

Table 2
Resident Characteristics by Type of Facility License 6

Table 3
Ohio Nursing Facility Admissions, Discharges, and Occupancy Rates: 1992-1995 8

Table 4
Admissions, Discharges, and Occupancy of Nursing Home Beds by Selected
Facility Characteristics, 1995 10

Table 5
Full-Time Equivalent Employee and Nursing Home Bed Ratios by Ownership
and Certification 12

Table 6
Percentage of Facilities Offering Alternative Long-Term Care Services 16

Background and Introduction

Nursing homes are a key component of the health and long-term care system in the U.S. Over 1.5 million Americans are residents of nursing homes, spending about $80 billion annually for care. Ohio, with one of the largest aged populations in the nation (ranked 7th), relies heavily on nursing homes to deliver care. Ohio's nursing home industry has the third highest number of facilities nationally, and ranks 5th in the number of nursing home beds. Ohio has more nursing home beds in proportion to its elderly population as well, with 63 beds per 1,000 older people compared to a nationwide ratio of 53 per 1,000. The supply for those eighty-five and over is even greater; 596 beds per 1,000 persons compared to a national average of 491 per 1,000 (Bedney, Carillo, Studer, Swan, Harrington, 1996). More than $3.3 billion was spent on nursing home care in Ohio in 1995, with public Medicaid expenditures (1.7 billion) accounting for just over half the total.

In recent years federal and state legislative initiatives and the development of new long-term care services, including home care and assisted living, have created a nursing home industry that is clearly different from that of a decade ago. In 1993, the Ohio Legislature implemented several important pieces of legislation designed to slow the flow of Medicaid dollars into the state's nursing homes. The legislature expanded the state's participation in the Medicaid home and community-based waiver program (PASSPORT), implemented a long-term care pre-admission review program, and enacted a Medicaid moratorium that prevents the construction of a new nursing home bed if it increases the total bed supply in the state (Applebaum, Mehdizadeh, & Straker, 1997). A RUGS-based (Resource Utilization Groups) prospective payment system for Medicaid payments was also implemented that year. The effects of these actions are dramatic in some areas. For example, the number of ongoing client places available in the PASSPORT program increased from 2,700 in FY 1991 to 15,864 in FY 1995 and will continue to expand to almost 23,000 client places by FY 1998.

Federal emphasis on controlling the use of hospitals through the Medicare prospective payment system has reduced hospital use by an average of three days per visit, and has increased short stay nursing home use (GAO, 1996). A governmental and industry emphasis on increasing participation in managed care organizations such as Medicare HMO's could also have an effect on nursing homes. Finally, the implementation of a prospective payment RUGS based system for Medicaid nursing home reimbursement in Ohio could increase the fiscal challenges faced by the industry.

One positive outcome of these shifts is a greater understanding of the need for information for planning and policy-making. Administrators need information about their industry as a whole and they need to understand the place of their organization within that industry. Policy-makers need to understand the industry that they regulate, reimburse, and rely on for the care of the public. This report provides an in-depth

picture of the nursing home industry in Ohio two years after Ohio's legislative changes were implemented. Comparative information about changes over time is provided in *A Study of Home Care and Nursing Home Use Patterns in Ohio*, (Applebaum et al., 1997).

Methods

Data sources for this work include the Ohio Department of Health's 1995 Annual Survey of Long-term Care Facilities, Online Survey Certification and Reporting data for 1995 from the Health Care Financing Administration, data collected at the Scripps Gerontology Center from a mailed survey of a random sample of Ohio long-term care facilities, and data from published reports. The analysis includes those facilities that report having licensed nursing home beds. Intermediate care facilities for the mentally retarded, county homes, and rest homes (currently called residential care facilities) with no nursing home beds are excluded. Comparisons made among large (60 and over beds) and small (fewer than 59 beds) facilities, facilities operated for profit and not for profit (including governmental owned/run facilities), or institutional facilities operating with different types of licenses provide insights about different segments of the industry.

Research Questions

The research questions to be addressed are as follows:

1) What does Ohio's nursing home industry look like? What different types of facilities are there, how many are there, and what does it cost to care for individuals in institutions?

2) What are the demographic and functional characteristics of residents of long-term care facilities?

3) To what extent are there changes in nursing home admissions, discharges, and transfers? What trends can be ascertained from occupancy rates in Ohio's nursing homes?

4) What challenges does the industry face in terms of its labor force? What do nursing homes say about recruitment and retention issues?

5) What kinds of specialized services do nursing homes provide? To what extent are home and community-based services provided by nursing homes?

6) How are nursing homes meeting the current challenges of subacute care and managed care?

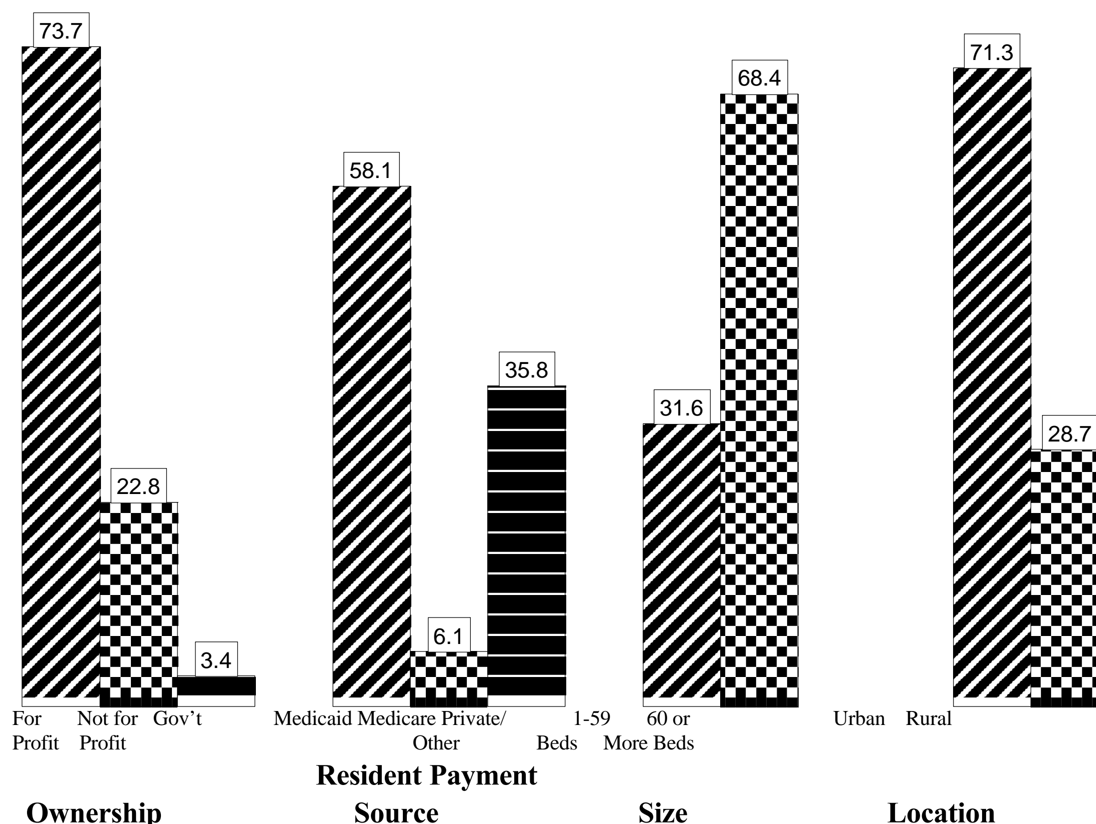
7) What does today's picture tell us about the future for long-term care in Ohio?

Findings

What does Ohio's nursing home industry look like?

Ohio has about 990 facilities that report having licensed nursing home beds. As shown in Figure 1, about three-quarters (73.7%) of facilities are operated for profit; of these about 10 percent (9.8%) are owned by

Figure 1. Profile of Nursing Homes in Ohio, 1995



individuals or partnerships, the remaining 90.2% are owned by corporations. Not surprisingly, most facilities are located in urban areas and have more than sixty licensed beds. On average, county homes have the largest number of beds, followed by homes for the aging.

Within a single institutional entity, beds may be licensed for different purposes. Part of the facility may be licensed as a nursing home, another as a residential care facility, and a third part could be licensed as a facility for the mentally retarded. Table 1 shows how nursing home beds are distributed, according to a facility's primary license, ownership, location, and size. Institutions licensed primarily as nursing homes (some also have second licenses) have most of the nursing home beds. Hospital-based long-term care units have a small proportion of the states' total nursing home beds (4.8%). About one-fifth of the licensed beds in homes for the aging are not certified, compared to less than 2% of the beds in hospital based long-term care units and 9% of nursing home beds.

Total estimated expenditures for one day across all institutional care settings are $10.9 million, with the bulk of expenditures going to nursing homes.

Table 1. Ohio Nursing Homes with Licensed Beds by Selected Characteristics, 1995

	Total	Nursing Home	Home for the Aging	County Home	Hosp. Based Long-term Care
Number of Facilities	990	874	44	23	49
Size of Facilities (percent)					
1-59 (Beds)	31.6	29.7	18.2	8.7	87.8
60 and over (Beds)	68.4	70.3	81.8	91.3	12.2
Number of Licensed Beds	96,609	86,965	4,832	2,890	1,922
(percent of total)		(90.0)	(5.0)	(3.0)	(2.0)
Average Number of Licensed Nursing Home Beds[a]	98	100	110	126	39
Certified Nursing Home Beds by Funding Source (percent of total)					
Medicaid	53.4	54.9	38.5	61.9	8.4
Medicare	2.2	1.5	1.2	0.0	37.5
Medicaid/Medicare	35.4	34.7	41.2	35.6	52.5
Not Certified	9.0	8.8	19.2	2.5	1.6
Location (percent)					
Urban	71.3	70.9	81.8	43.5	81.6
Rural	28.7	29.1	18.2	56.5	18.4
Ownership (percent)					
For Profit	73.7	82.0	18.2	0.0	10.2
Not for Profit	22.8	17.4	81.8	0.0	77.6
Government	3.4	0.6	0.0	100.0	12.2
Average Daily Charge (dollars)					
Medicaid	94	93	102	92	132
Medicare	187	179	179	143	295
Private Pay	111	105	112	94	260
Resident Payment Source (percent)					
Medicaid	58.1	63.1	38.6	56.7	41.3
Medicare	6.1	6.0	3.4	2.8	45.4
Private	26.8	27.4	51.6	30.9	12.9
Other	9.0	3.5	6.4	9.6	0.4

[a] Total Licensed beds on 12/31/95 minus Licensed rest home beds.

Source: Annual Survey of Long-Term Care Facilities, Ohio Department of Health, 1995.

An important issue facing the nursing home industry, government, and private individuals is the cost of care. Depending upon the type of facility and payment source, charges vary widely. Table 1 shows average facility charges across types of facilities and by payment source. Hospital-based long-term care units provide the most expensive care and county homes have the lowest charges. This may be due to different resident acuity levels in different types of facilities.

The total cost for institutional care can be examined by identifying the number of residents in a facility receiving funds from each payment source and multiplying that number by the average daily charge for a resident with that payment source. Total estimated expenditures for one day (based on the ODH survey day) across all institutional care settings are $10.9 million, with the bulk of expenditures ($9.1 million) going to nursing homes. If these charges for one day are typical of an entire year, in 1995 Ohioans spent over four billion dollars on institutional care through all public and private sources; $3.3 billion went to nursing homes. For fiscal year 1996, the budgeted Medicaid amount for nursing facility services was $1.7 billion (Madden-Petering & Phillips, 1997). As shown in Table 1, other payment sources besides Medicaid provide funding for about 42 percent of Ohio's nursing home residents.

Who are the residents in nursing homes?

Information about nursing home residents comes from three sources. The first is the MDS+, a quarterly assessment that is completed for every resident in a Medicaid certified bed on the last day of each quarter. A second source is the OSCAR data base, compiled by the Health Care Financing Administration (HCFA), from a survey of a random sample of residents of facilities certified for Medicare, Medicaid or both. In addition, the Annual Survey of Long-term Care Facilities from ODH provides information about age, gender and race of <u>all</u> facility residents. Table 2 provides a comparison of resident characteristics across different types of licensed facilities, and Figure 2 shows the functional characteristics of residents in certified facilities.

As shown in Table 2, most institutional residents are women, and an overwhelming majority are over the age of sixty-five. There are some differences in the type of residents served in different facilities. On average, hospital-based long-term care units have younger residents and a higher proportion of nonwhites than other nursing homes. This may reflect the transitional nature of care for residents coming from an acute experience, rather than for residents who are making nursing homes a long-stay home.

As shown in Figure 2, most nursing home residents show high levels of impairment, with over a third unable to eat independently. Over three-quarters have four or more ADL impairments.

To what extent are there changes in nursing home admissions, discharges, and transfers? What trends can be ascertained from occupancy rates in Ohio's nursing homes?

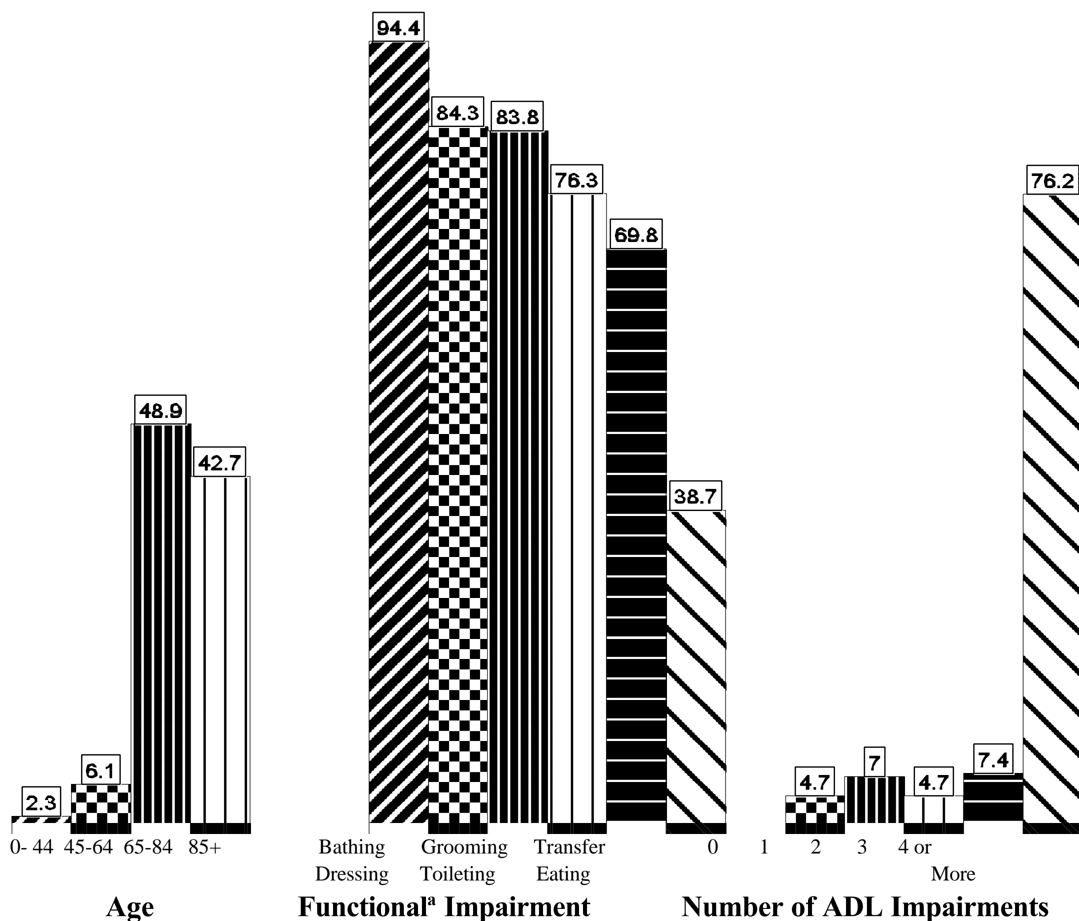
In 1995, there were 990 facilities with an adjusted number of nursing home beds totaling 95,255. (The total number of licensed beds is adjusted to reflect beds that were unavailable for some portion of the year.) In that year there were about 102,000 admissions to nursing home beds. Admissions to nursing

Table 2. Resident Characteristics by Type of Facility License

	Total	Nursing Home	Home for the Aging	County Home	Hospital Based Unit
Age		(%)	(%)	(%)	(%)
0-44	5.5	2.3	.2	2.8	7.7
45-64	7.5	6.1	1.3	10.3	15.1
65-84	46.0	48.9	38.8	46.7	54.1
85+	41.0	42.7	59.7	40.2	23.1
Gender					
Female	71.4	72.0	81.0	67.7	62.8
Race					
Non-White	10.2	10.8	1.8	4.2	23.7

Source: Annual Survey of Long-Term Care Facilities, Ohio Dept. of Health, 1995.

Figure 2. Profile of Nursing Home Residents, 1995: Selected Characteristics



[a] ***Source:*** Minimum Data Set Plus, June-Sept., 1995, ODHS.

homes come primarily from hospitals. According to data from Ohio's Pre-Admission Review Database, six out of ten (62.1%) pre-admission review nursing home applicants come from hospitals, one out of eight (12.9%) from the community, and one-quarter are already nursing home residents requesting transfer or a change of pay from private pay or Medicare to Medicaid.

Reductions in hospital lengths of stay over the last several years have resulted in increasing numbers of short-stay rehabilitation clients using nursing homes after a hospital stay with Medicare coverage. In 1992, Ohio nursing homes had a total of 71,000 new admissions to nursing home beds, of which approximately 30,000 were residents admitted under Medicare. By 1995, this number had doubled to over 60,000 Medicare admissions (see Table 3, taken from Applebaum et al. 1997). Some long-term care administrators received all of their new admissions in July 1996 from the hospital (20% of respondents to our Scripps survey). Given Medicare's brief payment policy (20 days of full payment and 100 days with co-pay) Medicare beds turn over much more quickly than other nursing home beds in general (see Table 4).

The pre-admission review process implemented in late 1993 has also influenced the nursing home admission process. All new admissions with Medicaid as a payment source must meet nursing home level-of-care requirements before they are admitted to a nursing home. For applicants from the community, regardless of payment source, an in-person assessment must be completed before admission. Previous work (Applebaum, Mehdizadeh, Straker, & Pepe, 1995) found that this review process was conducted in a timely manner. Our recent Scripps survey found that 75% of nursing homes had not experienced any admission delays in the previous three months due to the pre-admission review process. Of those who lost resident days, over half had lost fewer than five. These delays may be due to weekend closures, delays in getting physician signatures, problems with scheduling meetings with responsible parties, delays in conducting the assessment, additional information that must be provided after an initial review, or may be related to the pre-admission screening requirement for mental health services. Only 5.8% of facilities reported any admission denials due to level-of-care requirements.

Discharge planning is an important activity in nursing homes.

Discharge trends mirror admissions in terms of absolute numbers but some additional information is available about where people go when they leave the nursing home. As is evident from the discharge destinations reported by respondents to our Scripps survey, discharge planning is an important activity in nursing homes. Our respondents reported the largest group of discharges (37.5%) in July 1996 returned to the community. Of community discharges, about 6% were connected with PASSPORT and 37% were connected with other home and community-based services before leaving the facility. Discharges to another facility mirror admission proportions, with about 9% of total discharges going to another nursing facility. A little more than 10 percent (11.13%) of discharges were discharged to the hospital without a bedhold, and a very small percentage (5.3%) were discharged to another

Table 3. Ohio Nursing Facility Admissions, Discharges, and Occupancy Rates: 1992-1995

	1992	1993	1994	1995
Adjusted Nursing Facility Beds				
Total beds	91,531	93,204	94,471	95,255
Medicaid certified	80,211	82,207	84,893	85,568
Medicare certified	37,389	36,140	38,318	36,284
Number of Admissions				
Total	70,879	82,800	87,909	102,006
Medicaid certified	17,968	17,542	17,307	18,321
Medicare certified	30,359	41,733	49,038	60,704
Number of Discharges				
Total	68,195	79,977	84,980	99,383
Medicaid certified	23,568	25,466	25,219	26,334
Medicare certified	20,443	28,810	35,540	47,318
Occupancy Rate (Percent)				
Total	91.9	90.7	90.3	88.1
Medicaid certified	67.4	67.0	66.2	64.7
Medicare certified	9.9	12.4	13.6	16.3

Total beds include private, Medicaid and Medicare certified beds. Some beds are dually certified for Medicaid and Medicare, the individual categories cannot be summed.

Source: Annual Survey of Long-Term Care Facilities. Ohio Department of Health 1992-1995.
Note: From Applebaum et al., 1997.

level of care within the same facility. One-quarter (26.2%) of all July 1996 discharges were due to death. About one-third of our respondents felt that the availability of home and community-based services had increased the number of their discharges and allowed them to discharge residents with greater functional impairment.

Higher numbers of admissions and discharges also mean increased costs for facilities. Completing the Minimum Data Set Plus for new admissions in Medicaid certified beds and completing appropriate discharge plans place increased time demands on providers. We asked our respondents to estimate the cost of an average admission and an average discharge. Across all facilities, admissions were more costly than discharges, averaging $375 compared to $257 for discharges. It appears that there are few economies of scale; that is, a facility's admission and discharge rate shows a weak correlation with admission and discharge costs.

Another factor related to admissions and discharges is occupancy rates--the percentage of available beds occupied over the course of a year. Overall occupancy rates are probably the most important indicators of nursing home use (Strahan, 1997). As shown in Tables 3 and 4, the total occupancy rate for Ohio nursing home beds in 1995 was about 88%; nationwide occupancy rates were 87.4%. Medicaid occupancy rates have declined by 4 percent since 1992; Medicare occupancy rates have climbed by 65 percent in the same period (see Table 3).

On most comparisons Ohio's occupancy rates are quite close to national averages. Government facilities had the highest nationwide occupancy rate, 91.5% in contrast to Ohio's government facility occupancy rate of 80.7%. Non-certified beds nationally showed an 83.2% occupancy rate, about 10 percent higher than Ohio's non-certified beds. Urban nursing home beds were 87.7% occupied nationwide, very close to Ohio's numbers for urban nursing home beds (Strahan, 1997). Smaller facilities (many of which are hospital-based long-term care units) have lower occupancy rates. This may be because beds sit empty when transitions between discharges and admissions are not made rapidly enough.

Increasing acuity levels present special challenges in terms of staffing, reimbursement policy, and facility resources.

These trends in admission rates, discharge rates, and occupancy patterns reflect some important changes in the nursing home industry in recent years. Although some residents have always been short stayers, evidence suggests that these short-stayers exhibit increasing acuity levels, reflecting hospitals' earlier discharge of residents with higher care needs, (Mehdizadeh, Applebaum, & Straker, 1997). Increasing acuity levels present special challenges in terms of staffing, reimbursement policy, and facility resources. The increasing reliance on Medicare reimbursement, as evidenced by the changes discussed above, may result in some shifting of costs between Medicaid and Medicare. As this occurs nationwide, it seems likely that the federal government will attempt to shifts costs away from Medicare. As shown in Figure 3, admission rates are much different in Medicare certified facilities than in other types of nursing homes suggesting a much shorter average length of stay.

What challenges does the industry face in terms of its labor force? What do nursing homes say about recruitment and retention issues?

In 1995, there were about 112,000 full-time equivalent (FTE) positions in all long-term care institutions in Ohio (Ohio Department of Health Annual Survey, 1995). Nursing assistants are the largest staff category with about 42,000 full-time equivalent positions. The next largest employee group is non-health workers (for example, clerical and maintenance positions) with about 28,000 employees. Across all job categories about 4,200 full-time equivalent positions (approximately 3.7%) were vacant at the time of reporting.

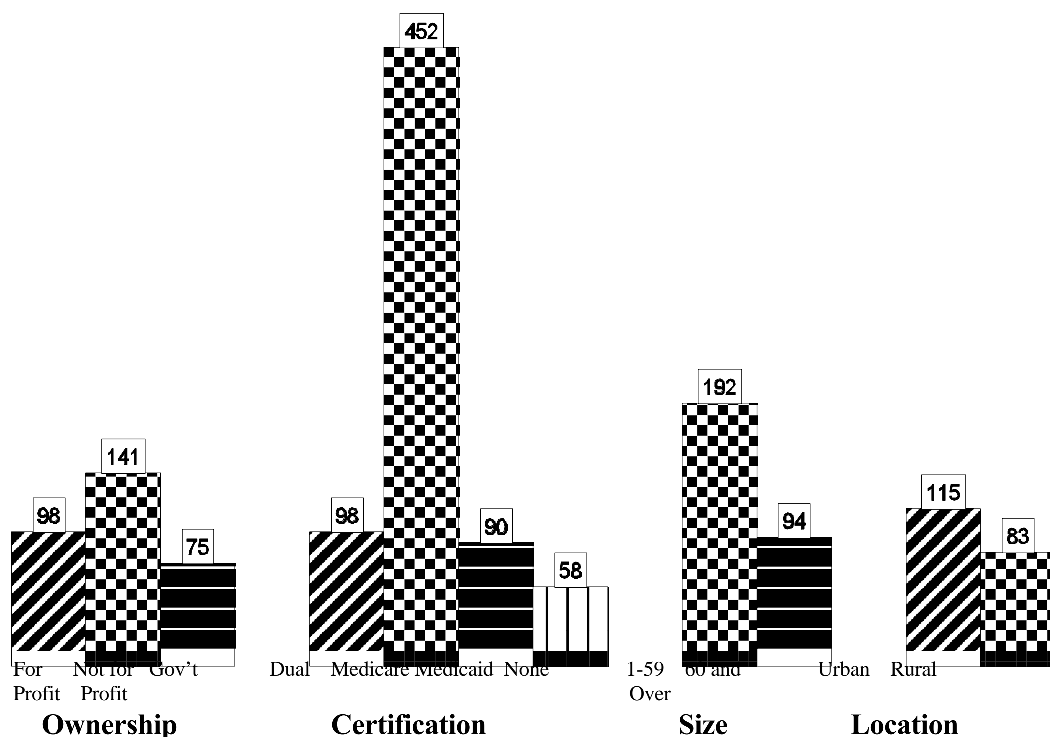
Table 4. Admissions, Discharges and Occupancy of Nursing Home Beds by Selected Facility Characteristics, 1995

	Admissions		Discharges		Occupancy Rate[a]
	Number	Rate per 100 Beds	Number	Rate per 100 Beds	
All Facilities	101,392	106	98,752	104	88.1
Ownership					
For-profit	67,934	98	66,016	95	88.0
Not-for-profit	30,439	141	29,775	138	89.4
Government	3,019	75	2,961	73	80.7
Certification					
Dually certified	71,154	98	68,933	95	89.6
Medicare only	25,386	452	25,061	446	78.5
Medicaid only	58,359	90	56,541	88	88.5
None	1,533	58	1,360	52	73.1
Number of Beds					
1-59	23,561	192	23,332	190	85.5
60 and over	77,831	94	75,420	91	88.4
Location					
Urban	81,459	115	79,244	111	88.2
Rural	19,933	83	19,508	81	87.4

[a] Determined by dividing average daily resident census in a category by number of beds in that category.

Source: Annual Survey of Long-Term Care Facilities, Ohio Dept. Of Health, 1995.

Figure 3. Profile of Ohio Nursing Homes, 1995
Admission Rate per 100 Beds



As shown in Table 5, there are 48 FTE nursing staff for every 100 Ohio nursing home beds, compared to 51.6 FTE nursing staff nationally (Strahan, 1997). Nursing aides and orderlies show the highest ratio, 39 per 100 beds, compared to 34 per 100 nationally. Registered and licensed practical nurses show a ratio of 9.2 per 100 beds. The ratio of all staff to nursing home beds is 103 for every 100 nursing home beds. Ohio's staffing patterns are much higher than national averages; national data show a ratio of 75.3 FTEs for every 100 beds (Strahan, 1997). As shown in Figure 4, proprietary facilities show the lowest ratios between staff and the number of nursing home beds, 46 nursing staff per 100 beds, and 97 total staff per 100 beds. Not-for-profits have the highest ratios, 121 per 100 for all employees, and 54 per 100 for nursing staff. Government homes fall between with ratios of 119 and 48 respectively.

Different types of facilities need different types of employees. As shown in the staff ratios in Table 5, Medicare certified facilities have much higher ratios for medical and therapeutic staff and nursing staff than other types of facilities. Facilities with dual certification also have higher staff ratios than those with Medicaid only. Among our Scripps survey respondents, those with subacute services or special units provided a total of about 9 more medical and therapeutic staff per 100 beds than respondents without subacute services. These staff trends reflect the needs that Medicare residents have as they leave the hospital. A continued increase in Medicare nursing home admissions may further increase

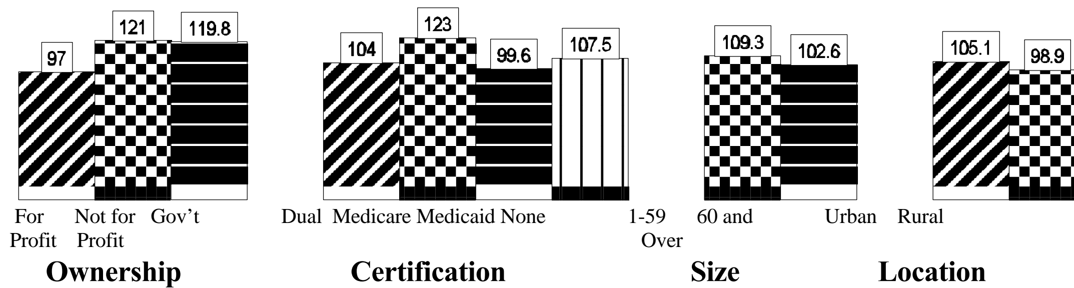
Table 5. Full-Time Equivalent Employee and Nursing Home Bed Ratios[a] by Ownership and Certification

	All FTE Employees	Nursing	Administration	Medical & Therapeutic
	Employees per 100 Beds	Employees per 100 Beds	Employees per 100 Beds	Employees per 100 Beds
All Facilities	103.0	47.8	2.0	10.9
Ownership				
For-profit	97.0	46.0	2.0	9.9
Not-for-profit	121.0	53.7	2.2	13.5
Government	119.8	48.2	1.5	14.1
Certification[b]				
Dually certified	104.0	48.6	1.9	11.1
Medicare SNF	123.4	53.0	2.8	22.4
Medicaid only	99.6	46.8	2.0	10.0
None	107.5	45.0	1.8	7.0
Number of Beds				
1-59	109.3	48.0	3.3	14.6
60 and over	102.6	47.8	1.8	10.3
Location				
Urban	105.1	48.3	2.0	11.8
Rural	98.9	46.6	2.1	8.2

[a] Ratios are based on adjusted nursing home beds for 1995.

[b] Numbers sum to more than total because some facilities checked more than one category, for example dual and Medicare certification.

Figure 4. Profile of Ohio Nursing Homes, 1995
FTE Employees per 100 Nursing Home Beds



demands for medical and therapeutic and nursing staff.

We asked respondents to our nursing home survey to provide a little information about recruitment and retention issues, staff benefits, and salaries. Staff shortages, particularly in paraprofessional positions such as nurse aides and orderlies, are a common problem for nursing homes in Ohio. Among our Scripps survey respondents, nearly three-quarters (74.7%) reported that recruitment had been a problem in the last year, and over two-thirds (68.0%) reported that retention of employees had been a problem in the last year.

The most common strategies used to solve recruiting problems were increasing facility visibility in the community, increasing wages, and providing longevity and attendance bonuses.

Over half of the respondents (54.9%) reported that more than 10% of their direct care staff had been employed three months or less. On the other hand, a large pool of employees does stay on the job--three-quarters (74.1%) of facilities reported one year or longer of tenure for over half of their staff. Over four-fifths (83.5%) of facilities with retention problems reported nursing assistants as the position that caused them the most problems. Other positions causing recruiting problems include social workers, dieticians, and environmental workers. The most common strategies used to solve recruiting problems were increasing facility visibility in the community (20.5%), increasing wages (15.3%), and providing longevity and attendance bonuses (14.3%). Interestingly, these same strategies were also used by facilities that reported no recruiting problems. Facilities without problems were slightly more likely to mention improvements in orientation and training programs, and implementing employee motivation programs as strategies to address employee recruitment.

Retention problems were also prevalent among the same types of positions causing recruitment problems. Reasons for problems included employees who move quickly from facility to facility, characteristics of staff that result in firings or personal difficulties after they are hired, and the characteristics of the job that cause workers to seek an altogether different kind of work after

they have been hired. Similar strategies were used by facilities to address retention problems and recruiting problems.

Temporary workers are often used to maintain appropriate staff to resident ratios when recruitment and retention are serious problems. According to our survey respondents, about one percent of their total employee hours had been filled by temporary employees over the previous three months. Not-for-profit facilities, urban facilities, and facilities with sixty beds or more showed slightly higher percentages of temporary hours compared to other kinds of facilities.

Salaries are a particularly salient issue for these paraprofessional workers who generally receive low pay. On average, our survey respondents reported starting salaries for nursing assistants of $6.23 per hour. Facilities in urban areas paid about 35 cents more per hour to beginning nursing assistants than those in rural areas. Urban facilities also compensated their highest-paid nursing assistants about $.75 per hour more than rural facilities. The top wage provided to nursing assistants was, on average, $8.65 per hour. Those with recruitment problems started their nursing assistants at a higher average wage than facilities without problems; $6.28 compared to $6.06 per hour.

Benefits are also perceived to make a difference in attracting and keeping employees. We asked about nine employee benefits provided to nursing assistants. More than one-fifth (21.9%) of facilities without recruiting problems offered seven or more benefits to employees. Only 8% of facilities with recruiting problems offered this many benefits. Almost all (98.3%) facilities offered paid vacations and holidays. The next most common benefit offered was employee health insurance (94.9%) although only 10% of the facilities paid the cost of employee premiums. Three-quarters of the facilities offer paid sick leave, and over half offer continuing education benefits (59.6%) and bonuses for good attendance (59.3%). Slightly less than half (46.3%) offer other kinds of cash bonuses. Very few (4.5%) offer daycare assistance for employees with children.

Recruitment and retention difficulties with paraprofessional workers in nursing homes are mirrored in the home and community-based care industry as well. To address this issue, a Long-term Care Paraprofessional Shortage Task Force has been formed at the State level. As resident acuity levels increase, numbers of available family caregivers decrease, and absolute numbers of disabled elderly increase with the aging of the baby boomers, the ability of nursing homes to attract and retain qualified employees will continue to increase in importance (Even, Ghosal, & Kunkel, 1997).

What specialized services do nursing homes provide? What home and community-based services are provided by nursing homes?

One indicator of the changing role of nursing homes within the health care industry is the extent to which nursing homes increasingly specialize, and provide special types of service units.

One indicator of the changing role of nursing homes within the health care industry is the extent to which nursing homes increasingly specialize, and provide special types of service units. A published report,

based on data collected through the Online Certification and Survey Report (OSCAR) by the Health Care Financing Administration, indicated that in 1992, 2.43% of all Ohio's certified nursing home beds (Medicare, Medicaid, or dually certified) were located in special care units (Zinn & Mor, 1994). This amounts to approximately 2,360 special care beds. Published data from OSCAR in 1995 show that there are now 4,925 special care beds, an increase of approximately 109% in three years (Cowles, 1995). Clearly, the drive to care for residents with increased acuity, with increasingly sophisticated technologies, and to benefit from hospital discharges of Medicare patients to nursing homes has had an impact on how care is provided in Ohio nursing homes.

The largest proportion of special care beds, in both 1992 and 1995, were in dedicated Alzheimer's units. In 1992, these constituted 2.09% of Ohio's total certified beds. By 1995, using Dept. of Health data (that includes non-certified beds), there were 4,076 dedicated Alzheimer's beds, amounting to 4.3% of all nursing home beds. The Scripps survey also collected information about special care units and services. Over one-quarter (27.7%) of the respondents offer subacute services; 18 percent provide these services in a specialized unit. Three-quarters (76.0%) of these providers have added these services in the last five years. Over three-quarters of the facilities provided inpatient respite services, but only 5% provided these services in a special unit. Sixteen percent of facilities offer services in an Alzheimer's unit; another quarter (25.8%) offer special services, not in a unit. Five percent of all facilities added Alzheimer's services in 1995 or 1996.

The Department of Health also collects information about other long-term care services. As shown in Table 6, the alternative services most commonly provided are hospice and respite care, which are offered by about one-third of all facilities. About 14% of nursing homes now offer assisted living. Not-for-profit facilities (30%) are more likely to offer this option. In general, homes with sixty or more beds are more likely to offer alternative services.

The Scripps long-term care survey also collected information about home and community-based services. About one-quarter (26.6%) of facilities offer some type of home and community-based service. Outpatient respite care and outpatient rehabilitation were both offered by 12% of facilities. About 7% offered in-house adult day care, education for families, personal care services, transportation, home delivered meals, and home health services.

Many nursing homes have expanded their services beyond traditional inpatient long-term care. The image of a nursing home as strictly a place that provides inpatient custodial care does not fit many of Ohio's nursing homes.

How are Ohio's nursing homes meeting the challenges of subacute care and managed care?

Subacute care is an important topic for nursing homes serving residents with higher acuity levels. Subacute services are designed to both maximize Medicare reimbursement, and to increase the availability of sophisticated medical technologies outside the hospital. Managed care organizations view sub-acute care in nursing homes as a cost-

Table 6. Percentage of Facilities Offering Alternative Long-Term Care Services

	AlzheimerU nits	Assisted Living	Mobile Meals	Respite	Adult Day Care	Hospice	Indep. or Congregate Living Facilities
	%	%	%	%	%	%	%
All Facilities	12.9	13.9	5.7	31.2	6.0	35.2	10.7
Ownership		9.5					
For-profit	9.3	29.6	3.6	33.3	4.1	37.5	5.3
Not-for-profit	23.0	5.9	12.4	27.0	11.5	27.9	28.3
Government	23.5		5.9	14.7	8.8	32.4	8.8
Certification		14.5					
Dually certified	16.9	22.4	7.3	35.0	6.4	42.5	10.0
Medicare SNF	12.9	10.2	4.7	36.5	7.1	40.0	20.0
Medicaid only	11.5	24.3	4.7	30.6	5.3	34.5	7.6
None	16.2		2.7	43.2	13.5	21.6	24.3
Number of Beds		9.1					
1-59	3.2	16.2	3.2	23.0	4.7	24.9	5.4
60 and over	17.5		6.8	35.1	6.5	40.0	13.2
Location		16.4					
Urban	13.9	7.7	5.5	32.9	5.5	35.8	14.6
Rural	10.6		6.0	27.1	7.0	33.5	7.2

Source: Ohio Department of Health 1995 Annual Survey of Long-Term Care Facilities.

effective alternative to lengthy inpatient hospital stays. But, exactly what is subacute care?

In telephone interviews with a sample of thirty subacute providers in Ohio, Scripps found that about half defined their subacute program in terms of residents who were discharged from the hospital, implicitly most of these residents were also eligible for Medicare reimbursement. The other respondents defined their subacute programs in terms of service intensity, resident acuity levels, or the types of services provided. In our interviews, we found that about half (54%) identified with a discharge-oriented rehabilitation model, about one-quarter (27%) identified with a transitional medical model, and one-third identified with specialized care for particular problems. The remaining 10 percent could not choose one area which their facility had identified as their primary service focus.

Nearly half of the subacute providers (43%) have transfer agreements with local hospitals to admit patients, and nearly three-quarters (71%) have managed care arrangements. The average length of resident stay in nearly half (48%) of these subacute

facilities was three weeks or less. Another quarter (25%) had average lengths of stay of thirty days or less. Clearly, most facilities are managing fairly quick turnarounds to discharge, and we can assume that managed care contracts in a majority of facilities are also driving rapid admissions as well. About 20% of these subacute providers had staff physicians. In one-quarter of facilities subacute residents were seen by a physician once a week or more, but in about one-fifth (21.8%) residents were seen by a physician only once a month. To meet the demands of higher acuity residents, more physician involvement in Ohio's subacute programs may be necessary.

More and better trained staff has also been identified as an important element of subacute care. Almost half (43.5%) the facilities in our survey typically provide four or fewer nursing hours per patient per day. Over one-fifth (21.5%) provide between four and five hours per day, and another quarter (26.1%) provide five to six hours a day. Two facilities provide more than six hours of nursing care per day. Over one-third (37%) share nursing staff between the subacute service and the rest of the facility. On the other hand, over one-third (37%) share none of their staff between the subacute unit and the rest of the facility. Over half (53%) also have other personnel that are specifically designated to the subacute unit. The most common positions were case managers, directors of nursing, and discharge planners; each position was mentioned by nearly a quarter (23.3%) of facilities. Four facilities had a director or manager for subacute services. Half of the facilities provide the same training to subacute staff as for staff in the rest of the facility. The other half of the facilities provided a more extensive training program.

These factors can drive costs well above those expected for a typical long-term care stay. For example, base daily costs for subacute care ranged from $95 to $750. It was difficult for facilities to provide cost information since different managed care providers had negotiated different service packages for their clients. Some facilities included only room and board in their rates; others included a full package of treatments in their daily rates. For these reasons cost comparisons among facilities are difficult to make. For subacute providers, however, the ability to separate out costs for different modes or levels of treatment is important. Evaluation of resident outcomes in comparison to the cost of treatments provided will become an even more important strategy for subacute providers in the future. Only two of the subacute providers in our survey received less than half of their payments from Medicare. Almost half (43.3%) received 80% or more of their subacute payments from Medicare. As managed care affects Medicare, these cost-effectiveness analyses will become an important part of negotiations for inclusion as a provider in Medicare HMO's.

Many of our respondents mentioned this lack of agreement about definitions, services, and staffing levels as one of the major challenges that subacute care faces.

Ohio's nursing home industry has taken some important steps toward involvement in managed care organizations and provision of subacute care, although a great deal of work still needs to be done. The diversity of subacute services shows that little

consensus has been reached regarding a "status quo" for subacute care. Many of our respondents mentioned this lack of agreement about definitions, services, and staffing levels as one of the major challenges that subacute care faces. As HMO's and others begin to purchase subacute services, agreement about what is expected will increase in importance. A subacute program that does not meet the needs of managed care is one that is likely to be left out when the Medicare HMO market further expands into Ohio. Currently, over one-third (39.3%) of all the nursing homes in the Scripps survey have some type of managed care contract. Participation in a preferred provider organization is the most common. Managed care organizations can be expected to have an increasing impact on how and where care is provided and the types of services expected with that type of care.

Implications

What does today's picture tell us about the future of the nursing home industry in Ohio?

The picture of the 1995 Ohio nursing home industry shows an industry that is trying to respond to Ohio's legislative reforms and changing market conditions. The increased diversification of the industry through increased attention to specialized services, home and community-based services, and multiple types of care provided in one setting shows that nursing homes of today in Ohio do not, in general, fit the stereotypical image of long-term providers of custodial care. Issues that the industry may face in the future include concerns from the federal government regarding increasing amounts of Medicare dollars going to skilled nursing facility services, quality and cost issues related to obtaining managed care contracts, standardization and certification issues related to the provision of subacute care, and increasing strategies that work to recruit and retain frontline paraprofessional nursing home workers.

Some nursing homes are remaking the image of the nursing home by expanding services into the community, providing sub-acute and rehabilitation services, obtaining managed care contracts, and working within integrated service delivery organizations.

Ohio's nursing home industry shows a great deal of variation in its response to current challenges. Some nursing homes are remaking the image of the nursing home by expanding services into the community, providing sub-acute and rehabilitation services, obtaining managed care contracts, and working within integrated service delivery organizations. Other facilities have retained a more traditional orientation. What remains unclear is whether a new direction for the industry is emerging or whether current and future opportunities for change will result in even greater industry diversity.

References

Applebaum, R., Mehdizadeh, S., Straker, J. K. (1997). A Study of Home Care and Nursing Home Use Patterns in Ohio. Oxford, OH: Scripps Gerontology Center, Miami University.

Applebaum, R., Mehdizadeh, S., Straker, J. K., Pepe, C. (1995). Evaluating Long-Term Care Initiatives in Ohio. Oxford, OH: Scripps Gerontology Center, Miami University.

Bedney, B., Carillo, H., Studer, L., Swan, J. H., Harrington, C. (1996). 1995 State Data Book on Long Term Care Program and Market Characteristics. San Francisco: Dept. of Social and Behavioral Sciences, University of California.

Cowles, C. M. (1995). Nursing Home Statistical Yearbook, 1995. Tacoma, WA: Cowles Research Group, Inc.

Even, W., Ghosal, V., Kunkel, S. (in press). Long-Term Care Staffing Needs for Older People in Ohio. Oxford, OH: Scripps Gerontology Center, Miami University.

General Accounting Office (1996). Skilled Nursing Facilities Approval Process for Certain Services May Result in Higher Medicare Costs. Washington DC: U.S. Government Printing Office.

Madden-Petering, B. & Phillips, C. (1997, Feb. 20). Looking ahead at long-term care. Ohio Issues, 1-19.

Mehdizadeh, S., Applebaum, R., Straker, J. K. (1997). Deja-vu All Over Again: Or Is It? Unpublished Manuscript.

Strahan, G. (1997). An overview of nursing homes and their current residents: Data from the 1995 National Nursing Home Survey. Advance Data, 280, 1-12.

Zinn, J., Mor, V., (1994). Nursing home special care units: Distribution by type, state, and facility characteristics. The Gerontologist, 34(3), 371-377.

Appendix

Survey of Nursing Home Industry Trends

Scripps Gerontology Center
Oxford, Ohio 45056
513 529-2914

MIAMI UNIVERSITY

August 20, 1996

Dear Nursing Home Administrator,

Two years ago the Scripps Gerontology Center at Miami University conducted an evaluation of pre-admission review for the state of Ohio. As a result of that research, some questions were raised about current trends in Ohio nursing homes. We are fortunate to be continuing our evaluation of long-term care in Ohio for the Ohio Department of Aging, allowing us to seek answers to the questions raised by our previous work. We are writing today to ask for your time and assistance.

We are relying on you and other Ohio nursing home administrators, to provide the information about your facility that will help us to better understand the industry as a whole. We will also be using information from the Ohio Department of Health and federal nursing home data to get the most complete picture we can. However, some of the answers we are interested in can only be addressed with your assistance.

The questionnaire we have enclosed should take about 30-45 minutes of your time to complete. Other administrators have indicated that most of the information we are seeking is usually readily available. Feel free to involve other members of your staff who may have more immediate access to some of the information we are seeking. The facility ID appears on your questionnaire so that we may link this information with other data sources, and so that we will know who has not returned their questionnaire and should receive a follow-up telephone call. Your responses will remain confidential and no information will be reported that will allow identification of you or your facility. Your answers are extremely important since only a limited number of administrators were chosen to respond. We need responses from many administrators and kinds of facilities to develop the best industry picture possible. We hope you will be able to complete and return your questionnaire to us in the enclosed envelope no later than September 13. Thank you for your time and assistance.

Sincerely,

Jane Karnes Straker
Project Director

Robert Applebaum
Principal Investigator

Excellence is Our Tradition

FACILITY ID __________

Survey of Industry Trends--Nursing Facilities in Ohio
Scripps Gerontology Center, Miami University
Oxford, OH 45056
(513) 529-2914

Please answer the following questions by recording a number in the blank, or placing a checkmark next to the one answer that **most closely matches** your opinion.

WAITING LISTS

1. Do you keep the names of prospective nursing home residents on a **waiting list**?
   ______NO➞ If no, go to **ADMISSIONS** section at the bottom of this page.
   ______YES

2. **How many names** are currently on your waiting list for a place in your licensed nursing home?__________________________________

3. **Approximately how long** would it take for someone put on your waiting list **today** to be admitted to your nursing home?____

4. **Approximately how long** did it take for a person on your waiting list in **July 1995** to be admitted to a nursing home bed? ____

5. How accurately does the length of time on your waiting list reflect the demand for nursing home beds in your facility?
   ______ Not accurately at all
   ______ Somewhat accurately
   ______ Very accurately

ADMISSIONS

1. How many **new admissions** (excluding residents returning from the hospital with a bedhold) to your nursing home beds did you have during the month of **July 1996** __________?

2. How many new admissions during **July 1996** came from the following settings:
   (Please specify on the lines provided)

   _________From the **community**
   How many of these received PASSPORT in the community? _____
   _________From the **hospital**
   _________Transfer from **another nursing facility**
   _________Transfer from **another level of care** in this facility
   _________**Other**.
   From?_____________________

3. Of the new admissions during **July 1996**, how many came from your waiting list?_____________

4. How many new admissions to your nursing home beds did you have during the **calendar year** of **1995**?___________

5. During the **last three months** have any clients applying for admission to your facility or for change of payor to Medicaid been **denied** due to the pre-admission level-of-care review process? (NOT the PASARR component).
______NO

______YES➜ If yes, approximately how many residents?___________

6. During the **last three months** have any admissions been **delayed** due to the pre-admission level-of-care review process (NOT the PASARR component)?
______NO

______YES➜ If yes, approximately how many **patient days have been lost** due to pre-admission delays?______________

7. Considering staff time and other requirements, (such as an initial MDS+) from the time an admission date is decided, what is the **approximate cost to admit** a new resident to your nursing home? _____

8. How has the increased availability of PASSPORT and other community-based services affected the **number** of requests for admission to your facility?

________**No Effect** on admissions compared to 2 years ago.
________**Decreased Number** of requests for admission compared to 2 years ago.
________**Increased Number** of requests for admission compared to 2 years ago.
________Other:____

9. How has the increased availability of PASSPORT and other community-based services affected the **functional status of residents** admitted to your facility?

________**No Effect** on functional status compared to 2 years ago.
________New admissions **more functionally impaired** than 2 years ago.
________New admissions **less functionally impaired** than 2 years ago.
________Other:____

DISCHARGES

1. Considering staff time and other requirements, what is the **approximate cost** to plan and carry out a resident **discharge**?______________________________

2. How many **total discharges** did your facility have during the month of **July 1996**? ____________

3. Please specify the number of discharges during **July 1996** to each destination:

_________________**Community**➜ How many of these were connected to PASSPORT before leaving your facility?_____________________________
How many of these were connected with other community services before leaving your facility?_________________

_________________**Hospital** without bed hold

_________________**Other nursing facility**

_________________**Other level of care** in your facility

_________________**Death**

_________________Other. Please specify________________________

4. How many **total discharges** (excluding hospital with bed hold) did you have during **calendar year 1995**?__________________

5. Of these discharges, how many were **deaths**?__________________

6. How has the increased availability of PASSPORT and other community-based services has affected the **number** of discharges from your facility?

________**No Effect** on discharges compared to 2 years ago.
________**Decreased Number** of discharges compared to 2 years ago.
________**Increased Number** of discharges compared to 2 years ago.
________Other:____

7. Do you think the availability of PASSPORT and other community-based services has affected the **type of residents** discharged from your facility?

________**No Effect** on functional status of discharged residents compared to 2 years ago.
________Residents discharged **more functionally impaired** than 2 years ago.
________Residents discharged **less functionally impaired** than 2 years ago.
________Other:____

8. In your county, what assistance is provided by the **County Department of Human Services** for nursing home discharge planning? ____
____

PERSONNEL

1. How many full-time equivalent **(FTE) direct care position**s do you currently have (including any positions currently vacant)?
   _______RN's
   _______LPN's
   _______Nurse Aides/assistants

2. How many hours of **direct care staffing** (RNs, LPNs, nursing assistants) did you access **from a temporary employment agency** in:
   July 1996________________
   June 1996________________
   May 1996_______________

3. Approximately what percentage of your **direct care staff** (RNs, LPNs, nursing assistants) has been at your facility **3 months or less**?________________

4. Approximately what percentage of your **direct care staff** (RNs, LPNs, nursing assistants) has been at your facility **1 year or longer**?________________

5. Has **recruitment** of employees (in all positions) been a problem for you in the last year?
   ______NO

   ______YES➞ If yes, please describe the positions and the extent of the **recruiting** problem.
   ____
   ____
   ____

6. Has **retention** of employees (in all positions) been a problem for you in the last year?
   ______NO

   ______YES➞ If yes, please describe the positions and the extent of the **retention** problem.
   ____
   ____
   ____

7. Has your facility taken any actions to aid in **employee recruitment and retention**?
   ______NO

   ______YES➞ Please describe the actions taken.
   ____
   ____
   ____

8. What is the **starting hourly rate of pay** for full-time nursing assistants? $__________per hr.

9. What is the **highest hourly rate of pay** currently being paid to full-time nursing assistants?
$__________________per hr.

10. Check each of the following **benefits** your facility provides to **nursing assistants**.

_____Health Insurance
_____employee paid
_____employer paid
_____shared cost
_____Paid sick leave
_____Paid vacation
_____Paid holidays

____ Day Care available and/or subsidized
_____ Continuing education benefits
_____ Bonuses for good attendance
____ Other cash bonuses
____ Other benefits. What? __________
____

11. What **length of time** must elapse before a nursing assistant is eligible for benefits coverage?
____

12. What is the **minimum number of hours per week** that must be worked by a nursing assistant in order to be eligible for benefits?_______________________________

MANAGED CARE

1. Do you have **managed care contracts** with outside health organizations?
_______NO

______YES

2. Is your facility part of an **integrated health delivery system**?
_______NO

______YES➜ what type? (Check all that apply)

_____Private HMO
_____Medicare HMO
_____Hospital Group
_____CCRC
_____ S/HMO
_____ Physician Group
____ Preferred Provider Organization
____ Other. (Please specify ______________)

ASSISTED LIVING

1. Is a portion of your facility designated as **Assisted Living**?

_______NO➜Are you exploring the possibility of **adding Assisted Living**?__________
(SKIP to section marked **HOMES FOR THE AGED**, below)
_______YES➜How many Assisted Living units do you have?__________________

What **features** are included in your assisted living section? Check all that apply:

____________Individual dwelling units

____________Full baths accessible without exit to a common corridor

____________Food preparation space within the unit

____________Lockable doors

____________Individual temperature controls

____________Personal furnishings owned by residents

____________Community space for resident use (e.g. dining rooms, laundry, living rooms)

____________Residential approach to construction and community space furnishings

HOMES FOR THE AGED

1. Is a portion of your facility designated as a **Home for the Aged**?

_______NO➜Are you exploring the possibility of adding a **Home for the Aged**?__________
(SKIP to section marked **HOME AND COMMUNITY BASED SERVICES**)
_______YES➜How many units do you have?__________________

What **features** are included in your Home for the Aged? Check all that apply:

____________Individual dwelling units

____________Full baths accessible without exit to a common corridor

____________Food preparation space within the unit

____________Lockable doors

____________Individual temperature controls

____________Personal furnishings owned by residents

____________Community space for resident use (e.g. dining rooms, laundry, living rooms)

____________Residential approach to construction and community space furnishings

HOME AND COMMUNITY BASED SERVICES

1. Does your facility offer home and community based services?

_______NO

_______YES➔If yes, please record the **number of community-based clients served** during **July 1996** next to each service provided.

_________ Outpatient rehabilitation services

_________ In-house adult day care

_________ Case management services

_________ Interdisciplinary geriatric assessment services

_________ Educational programming for people with chronic conditions

_________ Educational programming for families or caregivers

_________ Personal care services

_________ Homemaker services

_________ Chore services

_________ Respite care

_________ Transportation

_________ Home delivered meals

_________ Senior companion services

_________ Durable medical equipment

_________ Home Health services

_________Other. Please specify _____________________________

2. Please record the **name of the first service/s offered** and the **month and yea**r they began.____

3. How many **unduplicated clients** (number of people receiving one or more services) received these services from your organization in **July 1996**? _____________________

SPECIAL CARE UNITS

We are trying to learn more about special services and units that are available in nursing homes. Please complete the following table for **any special units or bed designations in your facility**. **IF YOUR FACILITY HAS NO SPECIAL SERVICES, TURN TO THE NEXT PAGE**. If your special services are provided in a **designated unit** (may be as small as one or two rooms) circle **"U"** in the first column below. If they are available throughout the facility, circle **"A" for all**. Second, indicate the **number of beds that are designated for special services**. Please provided the **patient days of occupancy that these beds had during July 1996** and the **month and the year that these special services became available.** If you have special services other than those listed, please add them in the boxes at the bottom of the first column, and complete the table for those special services.

Name of Special Service	Designated unit? "U" for in a Unit, "A" for "**Not a special unit, but services offered to all residents**, and "**NS**" for "**No Service**"	Number of beds	Patient Days of Occupancy July 1996	Date Service Began (Month and Year)
Sub-acute	U A NS			
Respite	U A NS			
Alzheimer's	U A NS			
Hospice	U A NS			
AIDS	U A NS			
Other_________	U A NS			
Other_________	U A NS			
Other________	U A NS			

RESPONDENT INFORMATION

In order to help us fully understand your responses it would be helpful to have the following information.

1. List all position titles of **persons involved** in completing this questionnaire.

   ____.

2. Provide the position title of the **person designated with primary responsibility** for completing the questionnaire. ____.

3. Date questionnaire completed: ____.

Thank you for your time and cooperation. Your input will provide valuable information to policymakers and planners regarding long-term care services in Ohio. If you have additional concerns or comments which were not addressed in this survey, please record them on the bottom and back of this page.

Depending upon your responses, we will be telephoning a few of you to learn more about your facility and your practices. We hope that a few of you will have additional time in a few months to provide more in-depth information. Please provide the name and phone number of a person we might contact.

_____________________________ Name

_____________________________ Title

_____________________________ Phone number