LeadingAge®

Portrait of Our Members:

Results of the LeadingAge Virginia Member Survey 2019

October 2020

Acknowledgment

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

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

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

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

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A Message for Members

The 2019 Member Survey produced a host of meaningful data about LeadingAge members and the important services they provide to residents and clients. A close working relationship between LeadingAge National and state partners helped us achieve a national survey response rate of 37%.

We are pleased to present you with a report on data collected from members of LeadingAge Virginia. This report shares information from 40 surveys completed by LeadingAge Virginia nursing home members, 37 surveys from assisted living members, 18 surveys from affordable housing members, 36 surveys from market-rate independent living members, and 25 surveys from adult day service centers. Data for home health, non-medical home care, and hospice settings are not included in this report because LeadingAge received fewer than 15 completed surveys from Virginia members with those service lines.

The 2019 Member Survey allowed us to collect important baseline information about the LeadingAge membership. Subsequent member surveys, conducted every two years beginning in 2021, will help LeadingAge build on this data infrastructure and will allow us to track national and state trends in the field of long-term services and supports (LTSS), conduct in-depth research to learn more about specific trends, and share information about those trends with you.

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

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

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About the LeadingAge 2019 Member Survey

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

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

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

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

Research and Report Information

Methodology

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

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

Data describing the average number of residents living in affordable housing (AH) and market-rate independent living (IL) are based on the number of residents at the time of the survey.

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

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

Workforce data is presented only for:

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

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

IL providers were not asked about staffing.

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

Services data: This report's data on NH services describe services delivered in addition to standard services that are mandated by federal regulations for NHs.

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

The following services were assessed for each setting:

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

Data Presentation

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

Defining Setting

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

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

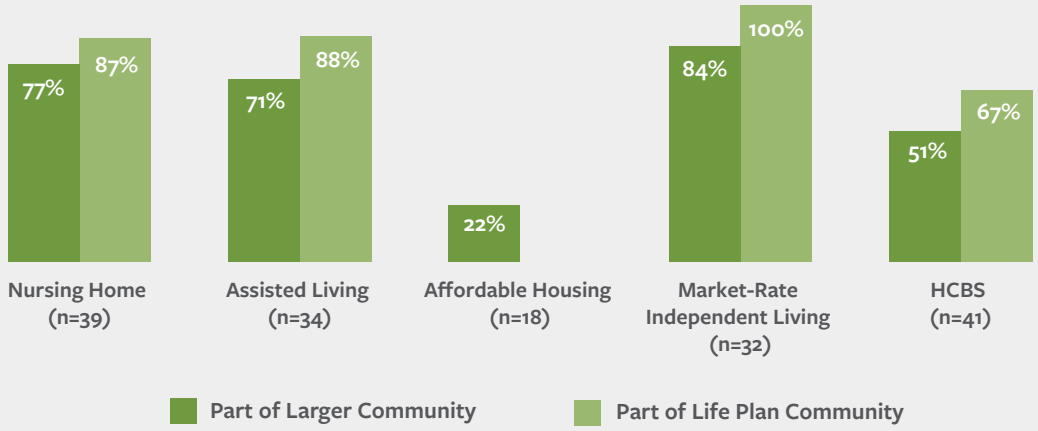
Profile of LeadingAge Virginia Members

The report highlights findings from LeadingAge Virginia member organizations representing nursing home, assisted living, affordable housing, market-rate independent living, and home and community-based (HCBS) providers.

LeadingAge Virginia members are generally well-established organizations that have been operating, on average, for 29 to 41 years. Nursing homes and assisted living communities have the longest history of operation. Affordable housing communities have been in operation the fewest number of years.

The majority of LeadingAge Virginia settings reported being part of a larger community, most often a life plan community. The one exception was affordable housing: 88% of these communities reported that they were freestanding.

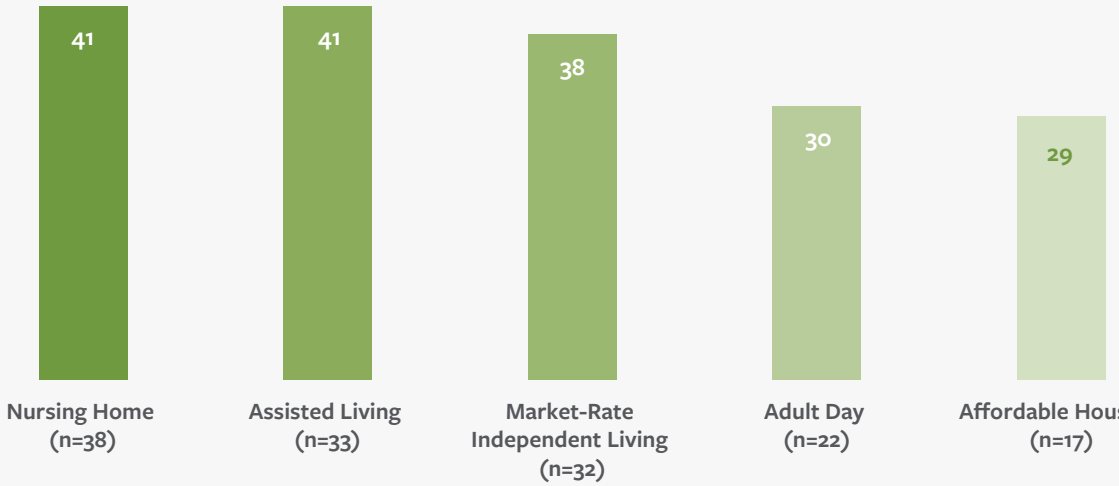
Percentages of Providers that are Part of Larger Community and Part of Life Plan Community*



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

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

Average Years in Operation



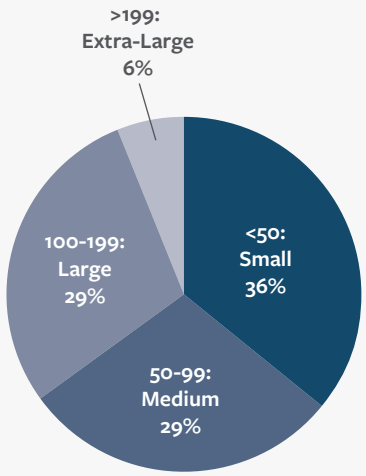
Nursing Homes

Sixty-two percent of the 40 LeadingAge Virginia nursing homes (NHs) responding to the survey indicated that they had designated post-acute (PA) and long-stay (LS) beds within their care settings. The remaining 38% of NHs did not have separately designated beds for PA and LS.

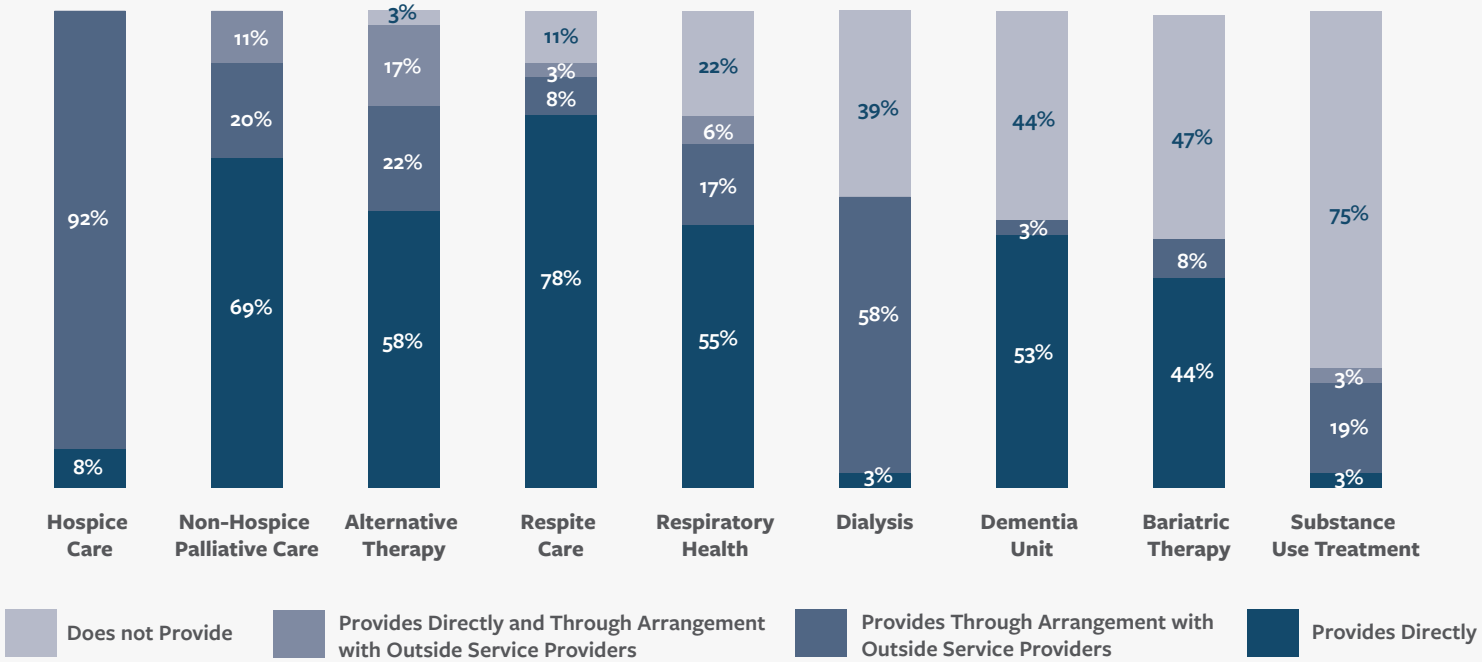
Size: The nursing homes surveyed reported having a mix of less than 50 beds (36%), 50-99 beds (29%), and 100-199 beds (29%). Less than 10% of communities reported having over 199 beds (6%). Most NH beds were Medicare- and Medicaid-certified.

Residents: The average annual occupancy rate was 86%. The majority of NH residents were women (71%) and white (91%). More than half of NH residents (56%) were aged 85 and older, and one-third were between the ages of 75 and 84 (30%).

NH Size by Number of Beds (n=34)



Services in the NHs (Range of Ns: 35-37)



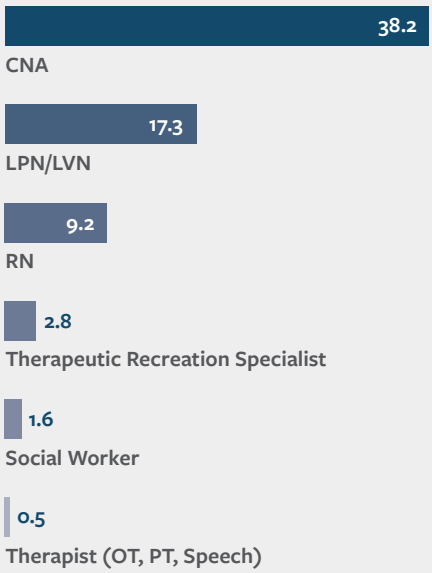
Services: Most of the services asked about in the survey were provided by at least half of the nursing homes. The top services provided only through arrangements with outside providers were hospice care (92%) and dialysis (58%). Services most often provided directly by nursing home employees included respite care (78%), non-hospice palliative care (69%), alternative therapy (58%), and respiratory health treatment (55%). Substance use treatment was the service least frequently provided in NHs, either directly or through an arrangement with outside provider: 75% of NHs did not provide the service. More than half of the NHs (53%) reported having specialized dementia units.

Workforce: Certified nursing assistants (CNA) were the most frequently employed staff across NH settings, with an average of 38 full-time equivalents. The least frequently employed profession at NHs was therapy staff, including occupational therapists, physical therapist, and speech therapists.

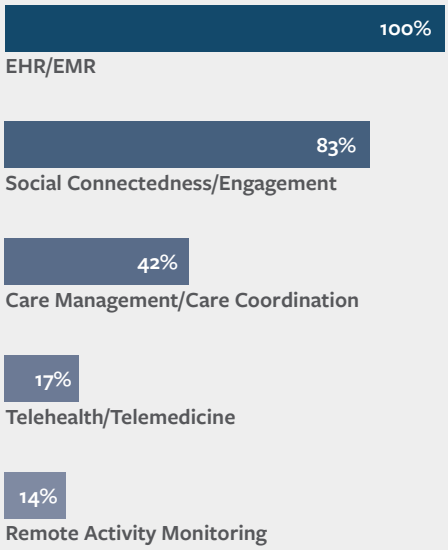
Nursing homes reported that, on average, CNAs spent three staff hours per resident per day. This was the highest average staff hours per resident per day reported for NHs. Licensed practical nurses/licensed vocational nurses spent an average of 1.3 hours per resident per day, followed by registered nurses (.7 hours or 42 minutes), and therapeutic recreation specialists (.3 hours or 18 minutes). Social workers (.14 hours or eight minutes) and therapy staff (.01 hours or 30 seconds) spent the fewest staff hours per resident per day.

Technology Use: The most frequently used technology tools in NHs were electronic health records or electronic medical records, which were used by 100% of respondents. External providers participating in electronic health information exchange with NHs included pharmacies (86%), physicians (69%), hospitals (66%), behavioral health specialists (27%), and other long-term care providers (27%). Most nursing homes (83%) also reported using technologies that facilitate social connectedness and engagement among residents.

Average FTE Employees in NHs (Hired Directly) (Range of Ns: 16-25)



Technology Used by NHs (Range of Ns: 45-46)

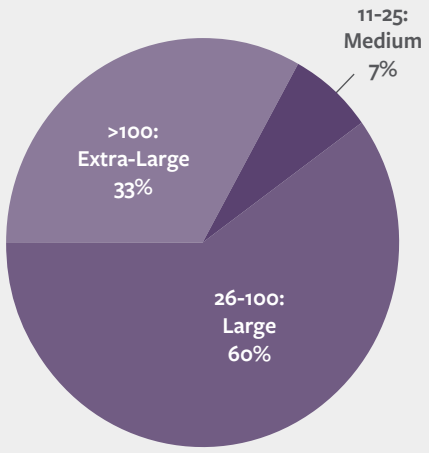


Assisted Living

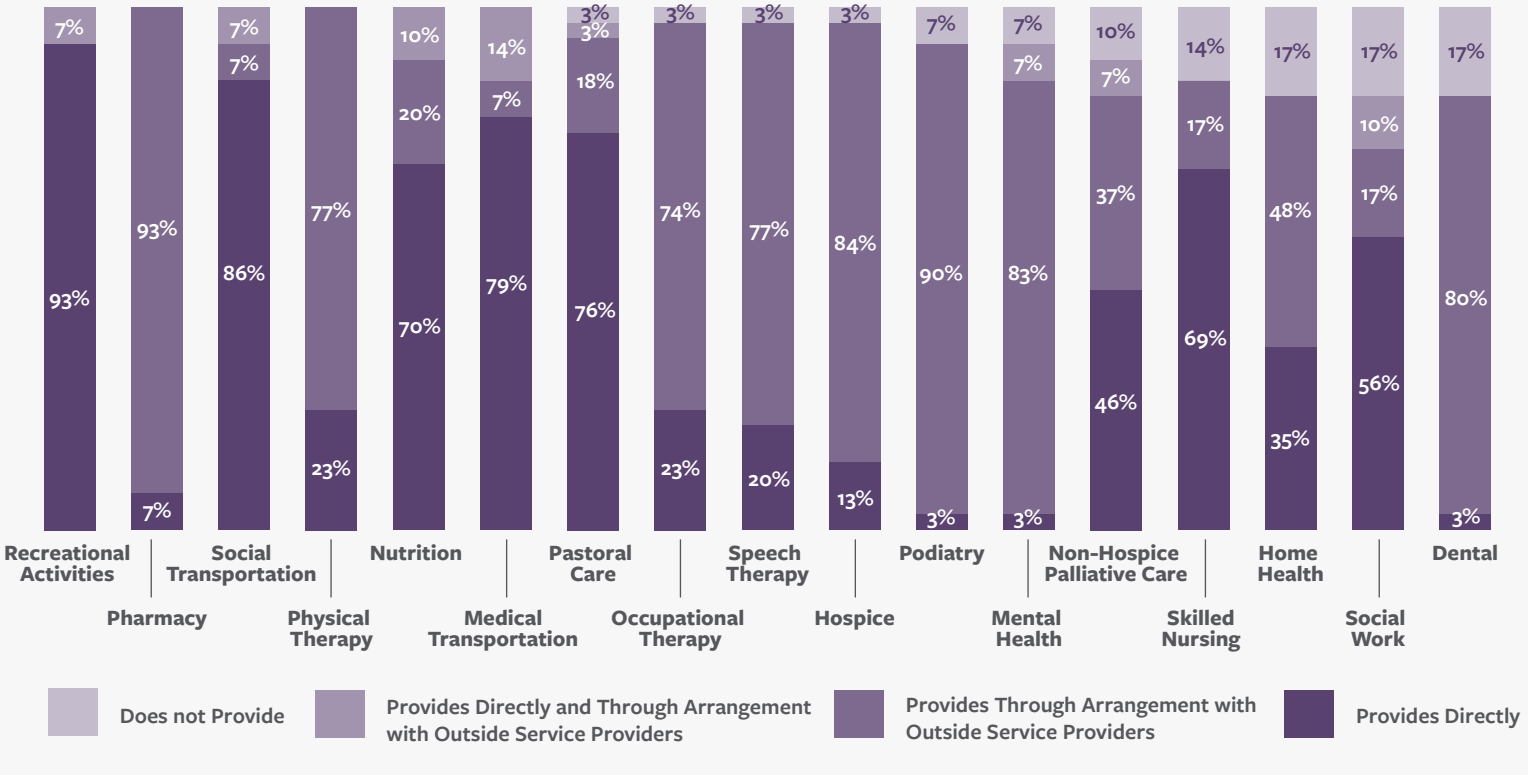
Size: Most (93%) LeadingAge Virginia assisted living (AL) communities reported having more than 25 beds, while AL communities participating in the survey reported an average of 86 beds. Over half of AL communities (60%) were classified as large settings (26-100 beds), while one-third were classified as extra-large because they had more than 100 beds.

Residents: An average of 73 residents lived in the AL communities surveyed. Resident census across AL survey respondents ranged from 18 to 144 residents. Roughly three-quarters of AL residents (76%) in the surveyed communities were women and two-thirds (67%) were 85 and older. Nearly all residents (98%) were white. Survey respondents reported small populations of residents (under 1%) identifying as Black, Hispanic, Asian, or another race/ethnicity.

AL Community Size by Number of Beds (n=27)



Services in AL Communities (Range of Ns: 29-30)



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

Dementia Care: Few assisted living communities (15%) served only adults with Alzheimer's disease or other dementias. Of those AL communities serving a mixed population, 69% reported having a distinct unit, wing, or floor designated as a dementia, Alzheimer's, or memory care unit. These units contained an average of 19 licensed beds.

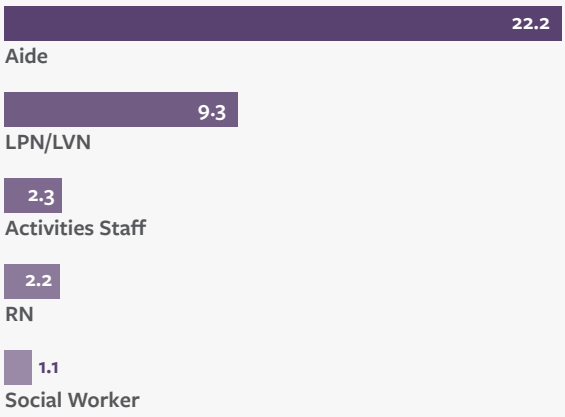
Workforce: Aides were the most commonly reported staff employed at assisted living communities, with an average of roughly 22 full-time equivalent aides employed. Those aides spent more time with residents—an average of two hours per resident per day—than any other AL employee, including activity professionals (.17 hours or 10 minutes), social workers (.09 hours or 5 minutes), licensed practical/licensed vocational nurses (.69 hours or 41 minutes), and registered nurses (.17 hours or 10 minutes).

Social workers were least likely to be employed by assisted living communities. On average, AL communities reported an average of 1 FTE social workers.

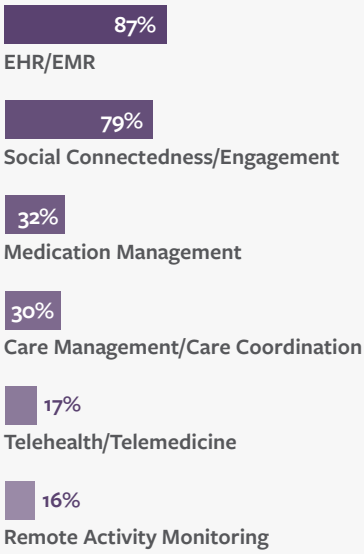
Technology Use: Electronic health records or electronic medical records were the most commonly reported technology used by assisted living communities (87%). Over three-quarters of the surveyed communities (79%) also reported using technologies that facilitate social connectedness and engagement among residents. Assisted living communities were least likely to use telehealth/telemedicine (17%) and remote activity monitoring (16%).

Most AL communities used a computerized system to support electronic health exchange with pharmacies (87%), followed by physicians (68%), skilled nursing facilities (58%), hospitals (48%), and other long-term care providers (10%).

Average FTE Employees in AL Communities (Hired Directly) (Range of Ns: 20-23)



Technology Used by AL Organizations (Range of Ns: 29-31)



Affordable Housing

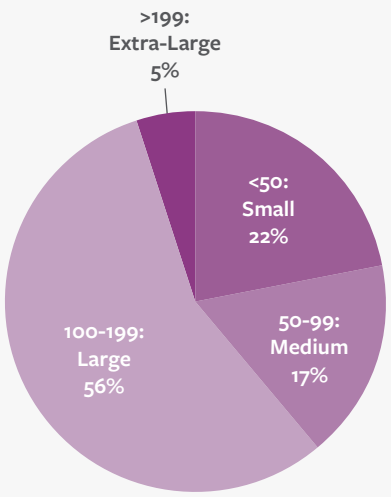
Size: Over half of LeadingAge Virginia affordable housing (AH) communities (56%) responding to the survey reported having 100-199 units. The average number of units reported by surveyed communities was 109 units, with the number of units across all survey respondents ranging from 23 to 314 units. Few affordable housing communities—2 of the 18 communities completing the survey—reported that they also offered market-rate units.

Occupancy: Most (89%) AH communities reported an average annual occupancy rate of 98% or higher, and nearly all (94%) had a wait list. Of those housing communities with a wait list, the average wait time was 17 months.

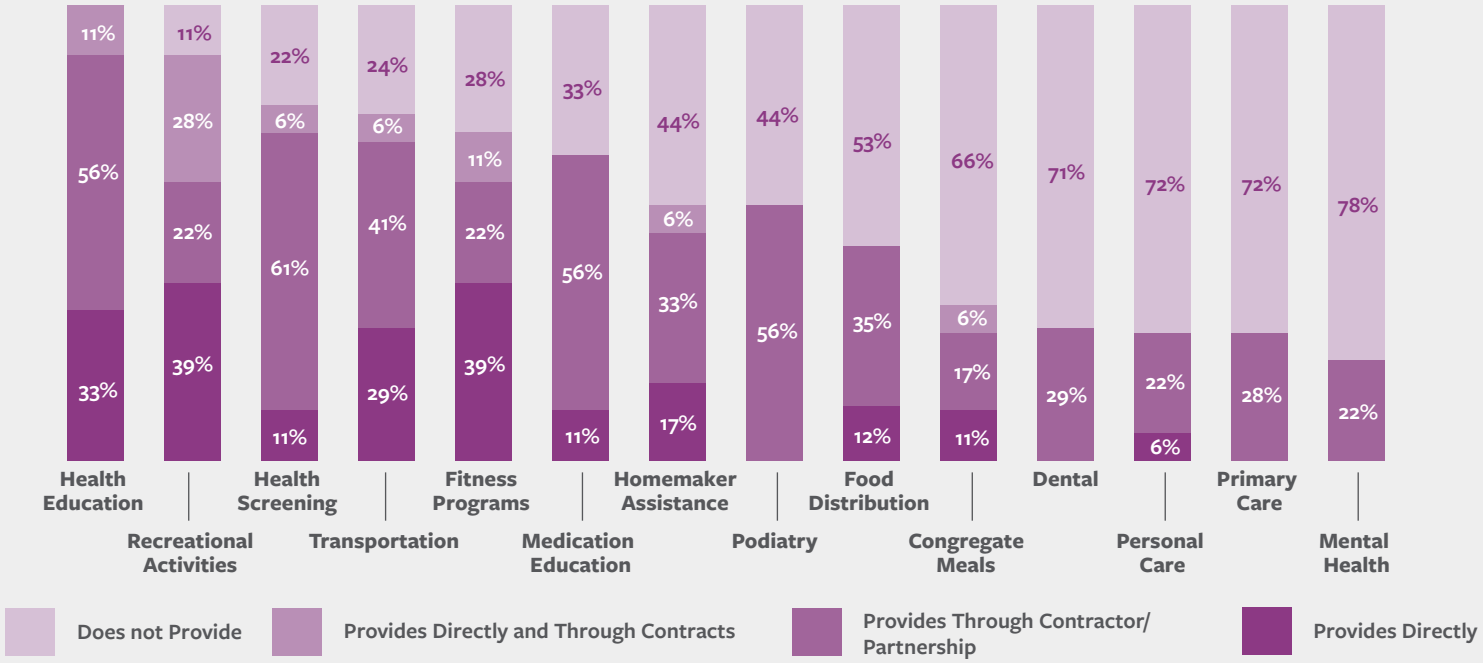
Residents: The average number of residents in AH communities was 115 at the time of the survey. Roughly three-quarters of affordable housing residents (72%) were women. Affordable housing communities reflected more resident diversity than most other settings surveyed. When asked about resident ethnicity, AH communities reported that 5% of residents were Hispanic. Survey data about race showed that 56% of residents were white, 38% were Black, and 6% were Asian.

Most AH residents (73%) were aged 65 to 84, with equal portions of residents between the ages of 65 and 74 (36%) and between the ages of 75 and 84 (39%). Seventeen percent of residents were 85 years and older.

AH Community Size by Number of Units (n=18)



Services in AH Communities (Range of Ns: 37-40)



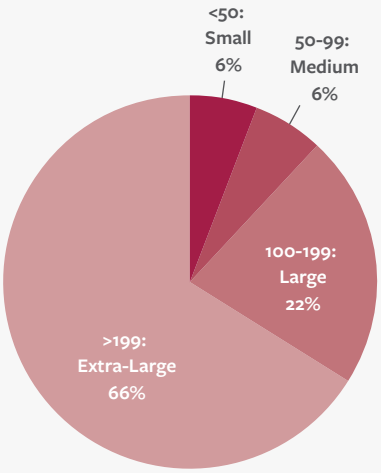
Services: More than two-thirds of the AH communities offered the following services either directly by a staff member or through a contractor: health and education programs, recreational activities, health screening and monitoring, transportation, fitness programs, and medication education. The services least frequently provided to AH residents, either directly or through a contractor or partnership, were dental, personal care, primary care, or mental health. Less than half of the AH communities provided services or programs directly.

Workforce: All of the affordable housing communities participating in the survey reported having a service coordinator, and 78% of service coordinators were employed full-time. Most AH communities (89%) employed service coordinators directly through the property owner or management agent. The U.S. Department of Housing and Urban Development funded salaries for 78% of service coordinators working in affordable housing communities. Twenty-seven percent of AH communities reported having a wellness nurse on staff.

Technology Use: About one-third of the affordable housing communities surveyed (29%) reported using a web-based software for resident documentation and outcomes. Eleven percent of AH communities also reported using technologies that facilitate social connectedness and engagement among residents.

Market-Rate Independent Living

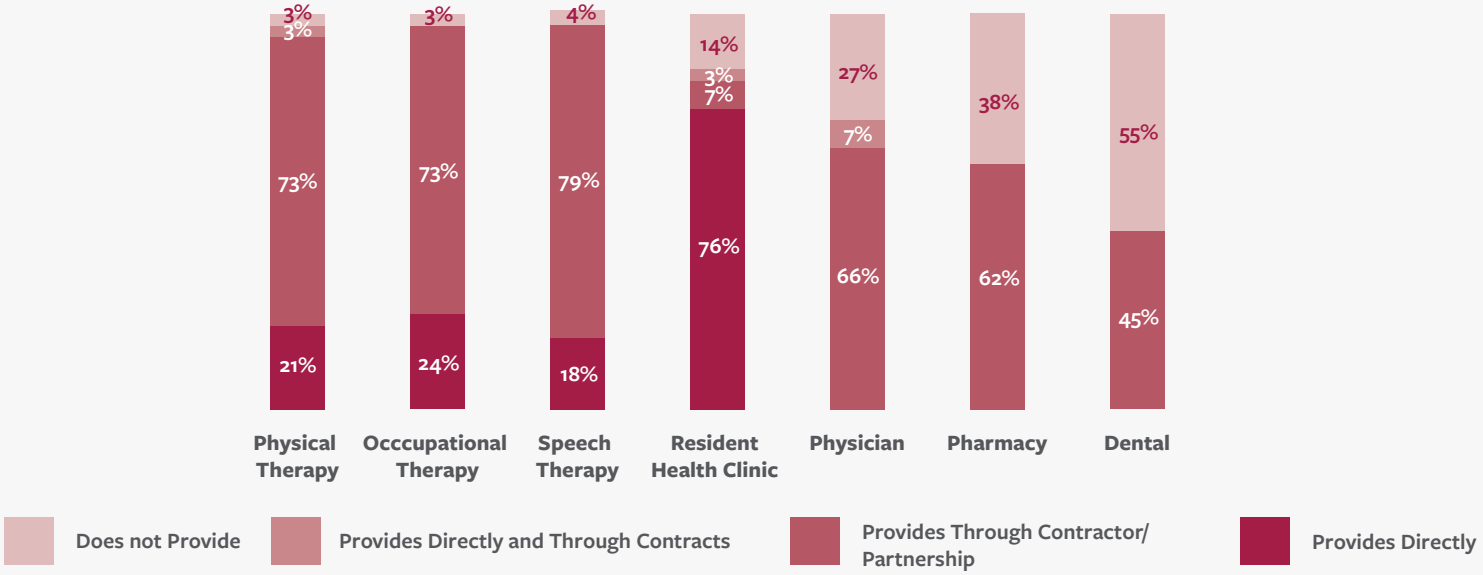
IL Communities by Number of Units (n=32)



Size: Two-thirds (66%) of LeadingAge Virginia market-rate independent living communities (IL) reported having over 199 units. Less than one-quarter reported having 100-199 units and less than 10% had 50-99 units or less than 50 units. The communities ranged in size from 22 to 496 units, with an average of 230 units. These units were most likely to be either one-bedroom (32%) or two-bedroom apartments (49%), although studios (8%) and apartments larger than two bedrooms (11%) were also available. A small percentage of IL units—4% on average—were subsidized. The communities reported an average annual occupancy rate of 95%.

Residents: Independent living communities served an average of 292 residents, although the number of residents in a community could range widely, from 24 residents to 545 residents. The majority of IL community residents were women (65%) and white (98%). These communities served an older population: 86% of residents were 75 years and older, and almost half of the residents were older than 85 (43%).

Services in IL Properties (Range of Ns: 28-29)

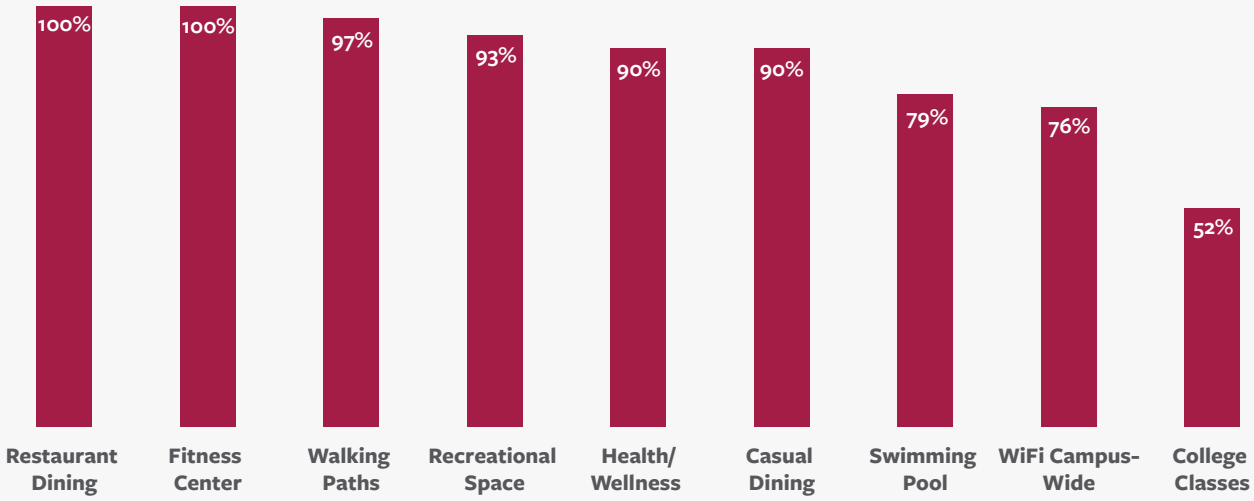


Services: More than three-quarters of IL communities provided physical, occupational, or speech therapy, primarily through arrangements with contractors or partners. Most of the IL communities also provided a resident health clinic, physician, or pharmacy services. The majority of IL communities did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

Amenities: More than three-quarters of independent living communities offered residents several amenities, including walking paths, social/craft/recreational space, restaurant-style dining, a fitness center, health and wellness programs, campus-wide Broadband Wi-Fi, swimming pool, and casual dining. The amenity that was least likely to be offered was having a class in conjunction with an area college or university, either on campus or at school (52%).

Technology Use: Social connectedness and engagement technologies were the most common type of technology used in IL communities (76%). Close to half of IL providers used care management and care coordination tools (41%) or sensor technologies (48%).

Percent of IL Properties Providing Amenities (n=29)



Home and Community-Based Services

Surveys of the home and community-based (HCBS) agencies asked about adult day service centers, hospice, home health care, and non-medical home care. The sample size for non-medical home care, home health care, and hospice is small and therefore, this section only highlights findings from the adult day service centers and questions that were asked about the overall HCBS agency.

Few HCBS agencies—only 2.5%—reported being providers of the Program of All-Inclusive Care for the Elderly (PACE).

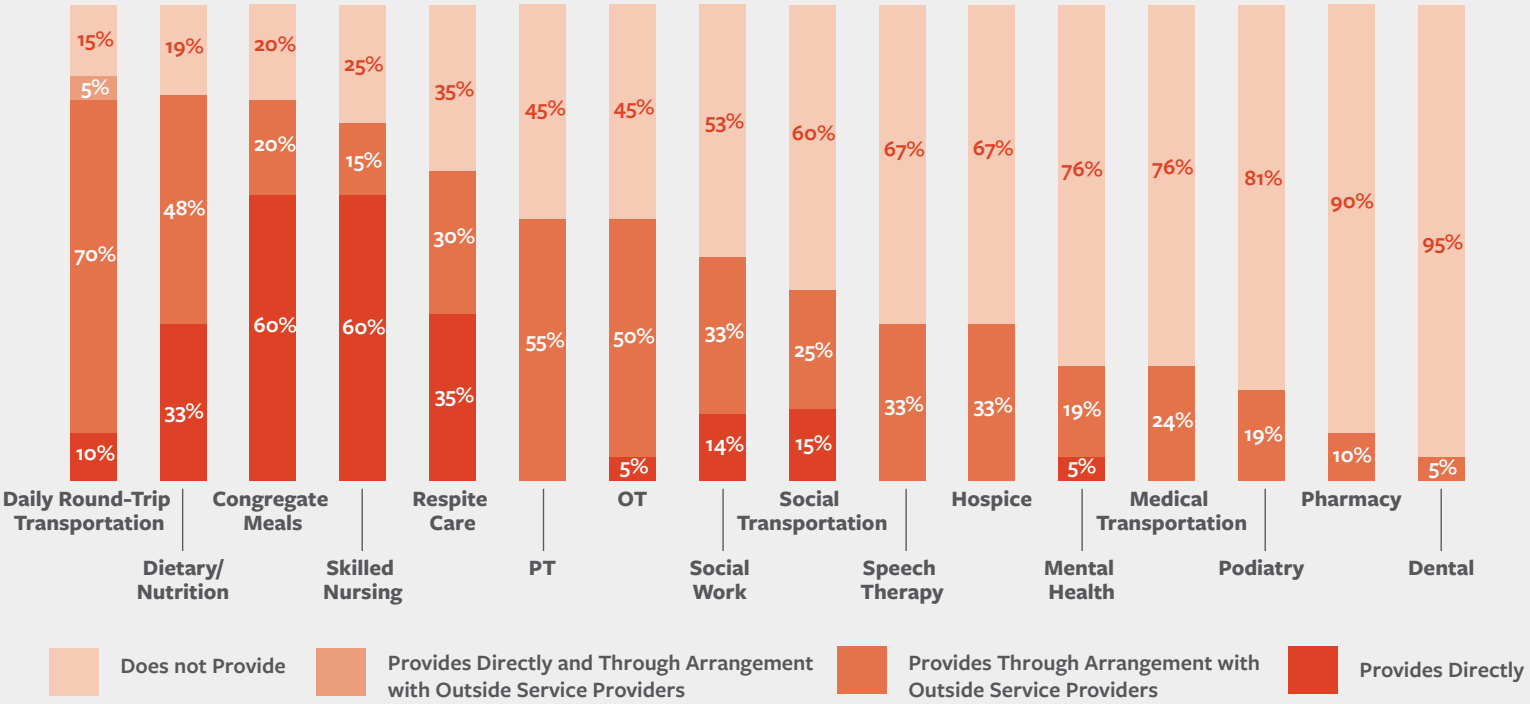
ADULT DAY

Over two-thirds of LeadingAge Virginia adult day (AD) service centers employed an approach that combined social and medical models (71%). Seventeen percent of the centers employed only the medical model. The social model (12%) was the least common type of model among LeadingAge Virginia adult day service centers surveyed.

Size: The allowable daily capacity of adult day service centers ranged from 11 to 130 participants, with an average of 42 participants per center. The number of participants currently enrolled at AD service centers at the time of the survey averaged 39 participants, and ranged from eight to 127 participants.

Participants: Adult day service centers had a more equal distribution of participants than other settings. More than half of participants (57%) were women and 43% were men. Adult day centers were also more racially and ethnically diverse than other settings. AD centers reported that 59% of participants were white, 34% were Black, 5% were Hispanic, and 2% were classified as "other." Adult day service centers also reported a more equal distribution among age of participants. Seventeen percent of participants were under age 65, 22% between the ages of 65 to 74, and almost one-third were between 75 and 84 years (30%) and 85 years and older (30%).

Services in AD Centers (Range of Ns: 20-21)



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

Revenue: Adult day centers were most likely to have an annual revenue of up to $150,000 (36%) or above $150,000 to $500,000 (41%). Few communities reported annual revenue above $500,000 to $1 million (9%) or above $1 million to $3 million (14%).

Annual Revenue Adult Day (n=22)

Workforce: Aides were the most common employee in adult day centers at an average of four full-time equivalent (FTE) employees. These agencies reported an average of two FTEs for activities staff and roughly one FTE for registered nurses (RN) and licensed practical nurses/licensed vocational nurses (LPN/LVN). Social workers were least likely to be employed by an AD service center, at an average of less than one-quarter FTE.

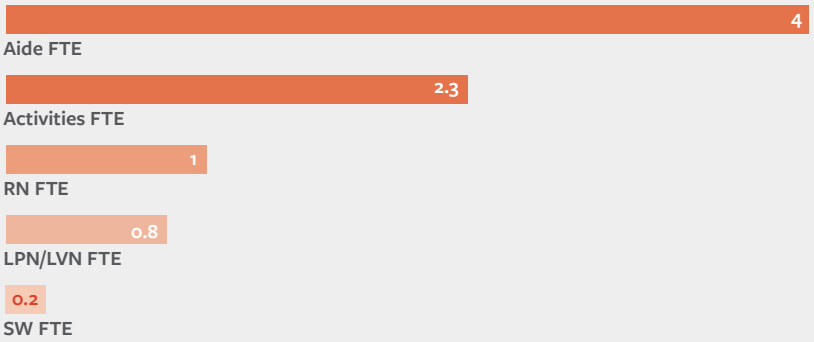
Aides spent more time with residents—an average of one hour per participant per day—than any other AL employee, including activities staff (.42 hours or 25 minutes), RNs (.2 hours or 12 minutes), LPNs/LVNs (.18 hours or 11 minutes), and social workers (.03 hours or 2 minutes).

ALL HCBS PROVIDERS

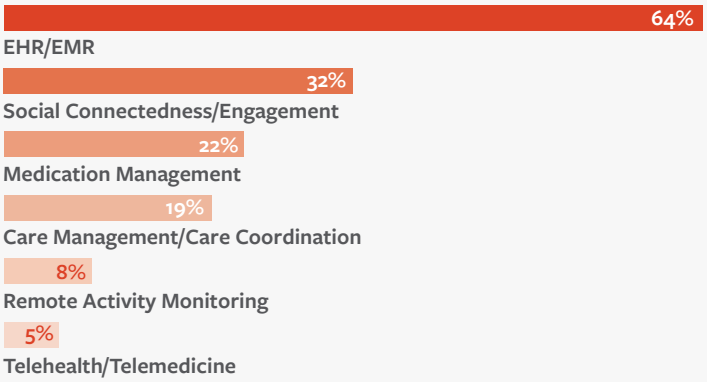
Technology Use: Almost two-thirds of HCBS agencies used electronic health records or electronic medical records. Less than half of these agencies reported using social connectedness/engagement, medication managmenet, care management/care coordination, telehealth/telemedicine, or remote activity monitoring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

HCBS agencies reported having computerized systems supporting electronic health information exchange with other skilled nursing facilities (31%), physicians (31%), hospitals (25%), pharmacies (19%), other long-term care providers (11%), and behavioral health providers (9%).

Averge FTE Employees in Adult Day Centers (Range of Ns: 13-18)



Technology Used by HCBS Organization (n=37)



Appendix: Definition of Services and Technologies

SERVICES

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

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

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

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

Pharmacy services: Filling or delivery of prescriptions.

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

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

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

TECHNOLOGY

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

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

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

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

Social connectedness/engagement technologies: Consumers connect with family, friends, and caregivers through video/audio chats, social networking tools, and activity/event sharing apps.

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

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