In Search of Quality Care

Low-Income Seniors Left Behind

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Northwest Federation of Community Organizations

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INTRODUCTION

An estimated 42 percent of the U.S. population aged 70 years or older will spend some time in a nursing home before the end of their lives.[1] The aging "baby boomer generation" will drive demand for long-term care services over the next half century. The number of individuals using nursing facilities, alternative residential care, or home care services is expected to increase from 15 million in 2000 to 27 million in 2050.[2] Most of this increase will be driven by the growth in the number of elderly in need of such care, which is expected to double from approximately eight million in 2000 to 19 million in 2050. It is not surprising then, that the availability and cost of quality nursing home care is a growing public concern.

As the population of the elderly increases, so do the average costs of nursing home care. In 2004, the average daily cost of a private room in a nursing home in Washington was $217/day or $79,205 a year, according to the 2004 MetLife Market Survey of Nursing Home and Home Care Costs. Nationally, annual nursing facility costs rose over $4,000 from the prior year.[3] Low- and middle-income seniors and their families struggle to afford these rising costs.

Many of these families can rely on the support of Medicaid to cover their nursing home costs that would otherwise be impossible to afford. According to 2005 cost reports, Washington State's 246 nursing homes served over 60,000 individuals in 2005. Medicaid covered the costs of 50 percent of all nursing home patients in Washington. These patients make up 65 percent of the total number of patient days.

However, nursing homes that cater to those that cannot afford the rising costs are caught in a dilemma. Medicaid payments are on average less than private payments; hence, by offering care at this lower cost, their revenues decrease. In some cases quality of care may suffer. These facilities are also caught in a Catch-22; Medicaid calculates reimbursement rates based on nursing facilities' previous costs for care. Since their costs are lower, they receive a lower reimbursement rate from Medicaid. Lower reimbursement rates further decrease revenues.

Low- and middle-income seniors and their families bear the brunt of this funding dilemma, as the high Medicaid load nursing homes may not have the revenue to offer the highest quality of care.

This report will analyze nursing facilities in Washington, and answer the question of whether or not facilities are put at a financial disadvantage by serving families who cannot afford to pay high out of pocket costs. Additionally, this report will determine if this decreased revenue corresponds to a lower quality of care for patients.

The findings are that facilities with low-Medicaid loads do indeed offer higher quality care than do those that serve higher Medicaid loads based on the amount of resources they dedicate to direct care. Quality measures defined by the U.S. Department of Health and Human Services also indicate substandard care in nursing facilities with a high Medicaid load. Also, lower Medicaid load corresponds to higher private pay patients, which generates more revenue and increases Medicaid reimbursement rates. The increased funds can then be directed to improving the quality of care. Low- and middle-income seniors then are left fewer choices in facilities.

The result is a disparity in care between wealthy seniors who can afford to pay out of pocket costs and low- and middle- income seniors and their families who are dependent on facilities that serve a high Medicaid population. This report recommends an increase in funding for those facilities that serve a high proportion of Medicaid residents, allowing them to provide the highest possible care.

METHODOLOGY

Medicaid load was determined by dividing the total number of Medicaid patient days by the total number of patient days. These ratios were then divided into six categories that will be referred to in this report.

- Lowest Medicaid Load = Facilities in the lowest ten percent of facilities by Medicaid load. Ratios are below 40 percent.
- Lower Quartile = Facilities in the lower quartile of facilities by Medicaid load. Ratios are below 54.99 percent.
- Below Median = Facilities with Medicaid loads below the median of 65.33 percent.
- Above Median = Facilities with Medicaid loads above the median of 65.33 percent.
- Upper Quartile = Facilities in the upper quartile of facilities by Medicaid load. Ratios are above 74.93 percent.
- Highest Medicaid Load = Facilities in the top ten percent of facilities by Medicaid load. Ratios are above 85.71 percent.

Averages were taken of each of these groupings and are referred to in this report.

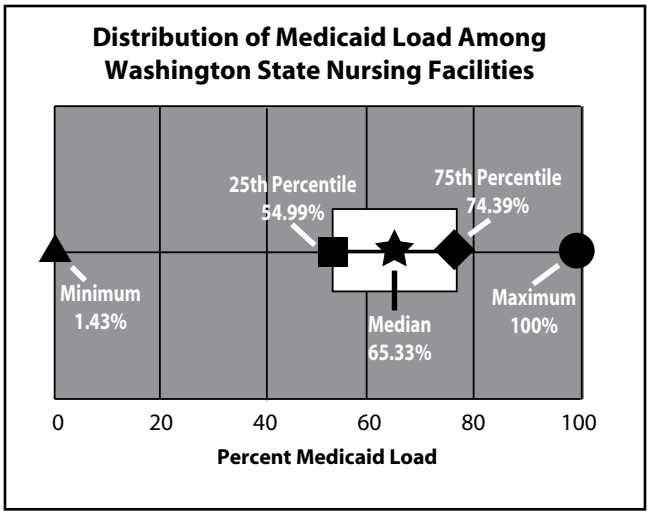
Data for this study comes from publicly available 2005 cost reports for 246 nursing facilities in Washington.

FINDINGS

Medicaid Load Varies: Some Seniors Have Limited Choice

The proportion of Medicaid patients in Washington State nursing facilities ranges from as little as 1.43 percent at the Corwin Center at Emerald Heights, a non-profit facility in Redmond, WA, to 100 percent at the Coulee Community Hospital of Grand Coulee, which is municipality owned. Across this range, there is an average Medicaid load of 63.58 percent. (Figure 1)

Many of the facilities with higher Medicaid loads are in rural areas where seniors may not have much of a choice of nursing facility in their area. For example, the nursing facilities at North Valley Hospital in Tonkaset, Sunbridge Special Care Center in Moses Lake, St. Joseph Hospital of Chewlah in Chewlah, and Harmony House Health Care Center in Brewster, all have Medicaid loads above 85 percent, and are geographically isolated.



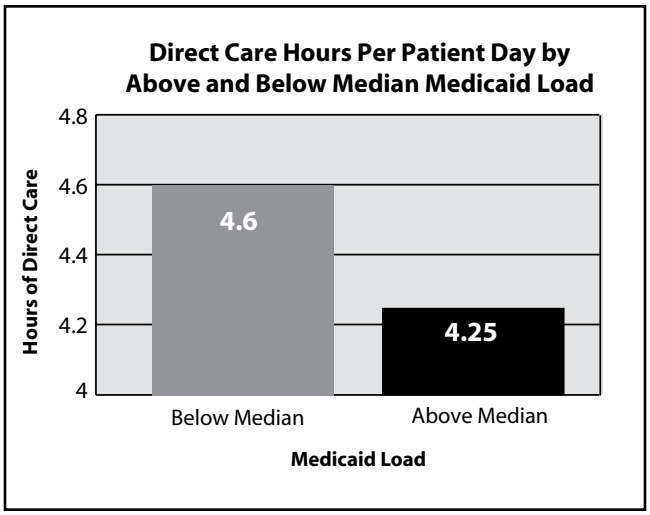


Figure 2: Facilities with above median Medicaid loads spend less time in direct care than those below the median

Direct Care Lags Behind in Nursing Facilities with High Medicaid Populations

Direct Care has often been described as the backbone of our health care system. Direct care workers, often known as certified nurse's assistants (CNAs), and direct support professionals provide patients with everyday contact, performing most of the hands on care that people receive as a patient. In fact, they provide a majority of the paid hands-on long-term care and personal assistance received by Americans who are elderly, chronically ill, or living with disabilities.[4] Direct care workers help people perform everyday tasks they would do on their own if they were able - things like preparing meals, light housecleaning, bathing, dressing, toileting and repositioning.

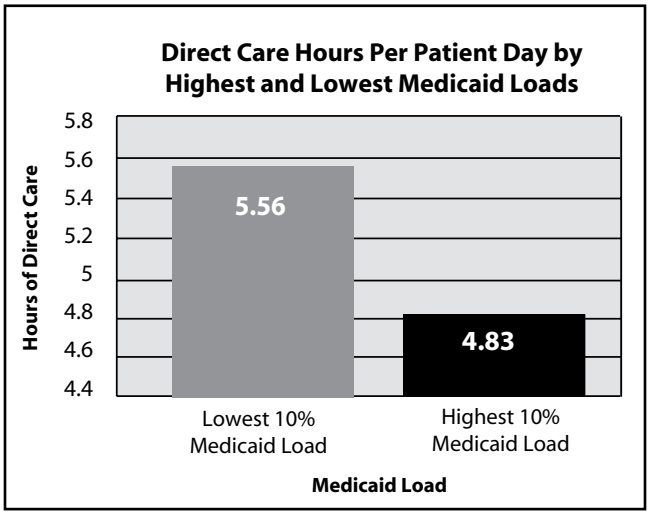


Figure 3: Nursing facilities with the lowest Medicaid loads spend an average of 44 minutes more on direct care when compared with the facilities with the highest Medicaid loads.

Because direct care workers have the most one-on-one contact with patients, health care consumers consistently cite the quality of their relationship with their direct care worker as a primary determinant of their quality of life.[5] In many cases, simply the number of hours a direct care worker spends with a patient can have a large effect on the quality of care that patient receives.

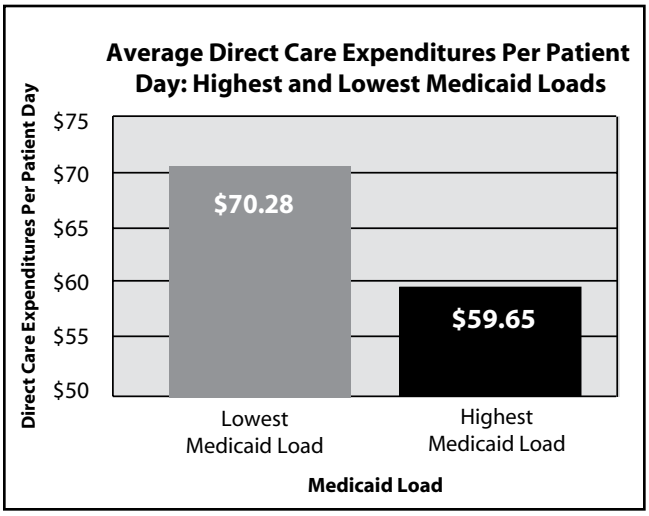


Figure 4: Facilities with the lowest Medicaid loads spend an average of $10.63 per day more than facilities with the highest Medicaid loads.

According to 2005 cost reports from Washington State nursing facilities, there is a negative correlation between the total hours spent on direct care and the proportion of Medicaid patients. Nursing facilities with above median Medicaid loads offer residents an average of a half hour less direct care per patient day when compared with facilities with below median Medicaid loads. (Figure 2) When comparing the highest and lowest loads, this difference in direct care hours increases almost an hour. (Figure 3)

Another way to consider the quality of care offered to residents is to compare the total resources spent on direct care per patient day. These costs include wages and benefits for all employees of a nursing home involved in direct care.

Again, facilities with lower Medicaid loads devote more resources to direct care than do those serving high Medicaid populations. Direct care expenditures tend to decrease as Medicaid load increases. Facilities at the bottom of the Medicaid load list spend 15 percent more per patient day on direct care than do those serving the highest Medicaid populations. (Figure 4) This smaller expenditure translates to either fewer staff or

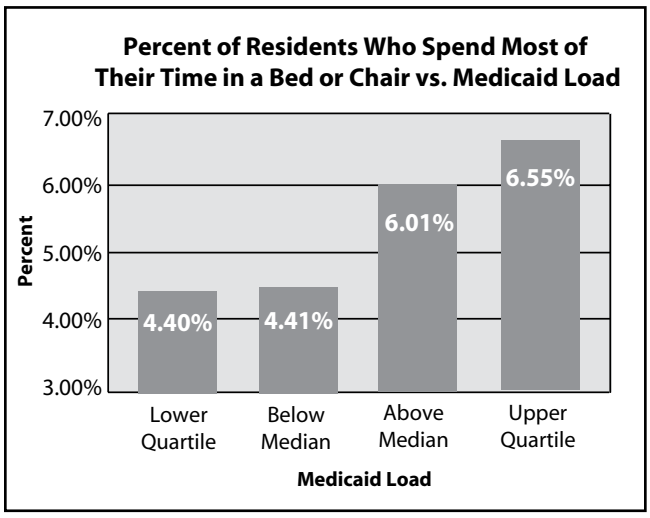


Figure 5: Facilities with higher Medicaid load have a greater percentage of residents spending most time in bed or in a chair.

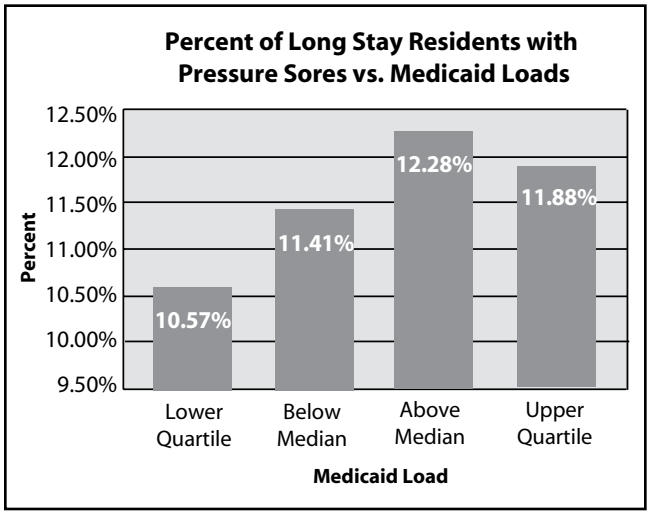


Figure 6: Facilities with higher Medicaid load have a greater percentage of with pressure sores.

lower salaries for staff. Either situation can have a negative impact on the quality of care.

Patients in High Medicaid Load Nursing Facilities Experience Lower Quality of Life

The Department of Health and Human Services maintains an ongoing quality control survey of skilled nursing facilities across the country.[6] The level of care at each facility can be measured against several assessments such as the percent of residents with pressure sores and percent of residents that spend most of their time in bed or in a chair.

The current results of this survey indicate the same conclusion that the 2005 cost reports reveal when it comes to care. As Medicaid load increases, the quality of care decreases. The percent of residents who experience bed sores, and the percent who spend most of their time in a bed or chair increase as Medicaid load increases (Figures 5, 6) This is another indication of the negative correlation between quality of care and Medicaid load.

Staffing Plays a Key Role in Ensuring Quality Care

Quality staffing in adequate numbers to serve the patient population has a major impact on the quality of care. A 2002 study released for the Centers for Medicaid and Medicare Services suggested that without 2.8 hours of care from nurse aides and 1.3 hours from licensed nurses, residents were more likely to experience poor outcomes--pressure sores and urinary incontinence, for example.

Average figures for nursing facilities in Washington indicate that most are able to offer the recommended hours of care from licensed nurses, but they do not on average offer adequate time from nurse's aides.

Not only do facilities not meet some CMS recommendations for contact time, this time decreases as Medicaid load increases. Nursing facilities with the lowest Medicaid load offer 10 percent less nurse's aide time per patient than facilities with the highest Medicaid load. This

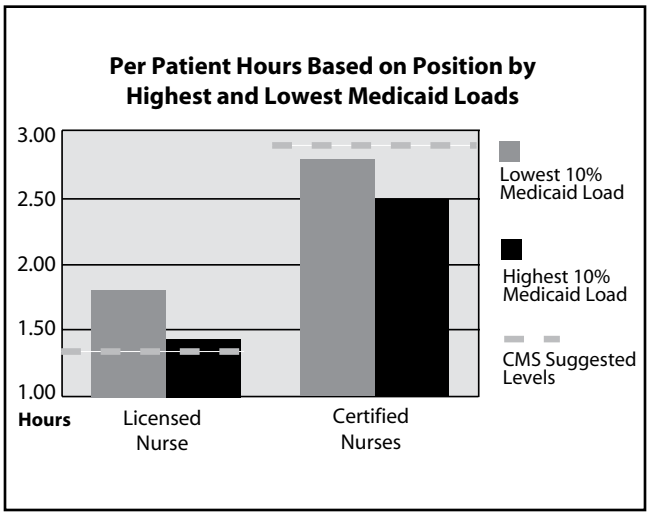


Figure 7: Direct care hours decrease as Medicaid load increases

difference rises to 20 percent when comparing licensed nurse daily contact time between the highest and lowest Medicaid load facilities. (Figure 7)

My name is Michelle Moulton. When my mother became ill, my father and I found ourselves having to navigate the nursing home system. For about one year, my mother was a resident of the Regency at Northpointe in Spokane, Washington. While she was there, my father and I spent as much time as we could with her to ensure that she got the best care possible. Because we were regulars, we got to know both workers and residents quite well. All in all, I found the staff to be caring people who did their best with what they had. But the sad reality is that short staffing and excessive workload have real consequences and can compromise the human dignity of residents.

One day I noticed my mother was rapidly putting on weight; her feet were swollen. I also noticed that she was having a difficult time breathing. Worried, I went to the nurse's station and told them that I thought my mother needed oxygen. The staff informed me that they needed a doctor's orders before they could give out oxygen. They told me that they would contact the doctor. An hour passed and still nothing. It was hard to watch my mother struggling, so I decided to call the doctor myself. Thankfully, I've known him for sometime and I had his number. About a half an hour later he arrived. We found out that my mother had gained 17 pounds in 2 days, and no one but my father and I noticed. The doctor prescribed the oxygen and a diuretic to reduce the swelling.

While at Regency, I noticed that staff took a long time to respond to call lights. It seemed to me that this was one tangible consequence of short staffing. There just weren't enough bodies on the floor to get to everyone's needs in a timely manner. After my mother started taking the diuretic, she had to urinate at least every ten minutes. She'd press the call light for bathroom assistance and it would take a while before anyone would come. Because I was there, I could either help her myself or put pressure on staff to attend to her needs. I often wonder what would have happened if I wasn't there. Would she just be forced to sit there soaked in her own urine?

My mother has since gone on to another nursing home. My father and I have learned valuable lessons on how to advocate for my mother. I do hope that there are changes in the way nursing homes function. One step in the right direction is having enough staff to get the job done. My father and I overheard many workers talking about working double shifts and we witnessed the how hard they worked. But, they need more tools and more staff to ensure that residents have a good quality of life, whether or not residents have family.

Michelle Moulton
Washington CAN member
Regency at Northpointe, 71 percent Medicaid load
Spokane, Washington

Consistent staffing is another way to measure the quality of care in a nursing facility. A patient that sees the same staff members day in and day out will form a relationship with him or her, improving both the efficiency and quality of care. Unfortunately, this is more difficult for patients in facilities with a high Medicaid population, as they have staff turnover ratios that are 10-11 percent higher than those with lower Medicaid loads.[7]

My name is Carl Reisbig. I am a Certified Nurse's Assistant (CNA) at the Clarkson Care Center in Clarkson, Washington. CNAs provide direct, hands on care. We are responsible for getting residents out of bed, cleaned, dressed, fed, and to scheduled activities throughout the day. Depending on the condition of the resident, CNAs help perform tasks most people wouldn't even think of, like reminding a person to chew, or, in some cases, actually feeding a resident. The levels of care vary from minimal to complete assist which includes lifting, feeding and toileting.

On the long-term care floor where I work, there are usually around 30 residents with three CNAs and two RNs. The residents are divided among the three CNAs, but we all work as a team and create a family environment. We all work hard to ensure that our residents have a good quality of life and get the best care.

Each day, I am responsible for 10-12 residents depending on staffing. I give the best care I can, but sometimes we are stretched too thin and the residents suffer. Short staffing and high turnover are the biggest problems. We just don't have enough CNAs to get the job done. In fact, when I started working here seven years ago, after six months on the job, I had the highest seniority level, a sign of high turnover. When a CNA calls in sick, we rarely have anyone that can come and fill in, which means a long and difficult day ahead.

Up until October 1, 2006 CNAs earned $7.90 per hour. The low wage is one of the biggest reasons Clarkson cannot keep or recruit good staff. The work we do is both physically and mentally challenging and the wages offered must be competitive to attract the best staff. When we voted for our first union contract, we were voting to make Clarkson a better facility. Now that we have a union, our wages have jumped to $9.00 with a wage scale to reward longevity.

The staffing issue isn't the only one that hurts patient care. I've heard that Clarkson is only reimbursed for 3 to 4 hours of skilled care a day. The reimbursement rates are too low and don't account for times in the middle of the night when a resident is incontinent and needs to be cleaned up. The constant budgetary worries limit our ability to do our best. Also, I often worry about the quality of food residents are given. I've been told that the dietary staff cannot exceed $4 per resident per day. Even little the things like food can impact a resident's quality of life.

All in all, I like working as a CNA. I can make a small difference in people's lives. I cherish getting a smile from a person who might otherwise not have anything to really smile about.

Carl Reisbig
Clarkston Care Center, 62% Medicaid load
Clarkston, Washington

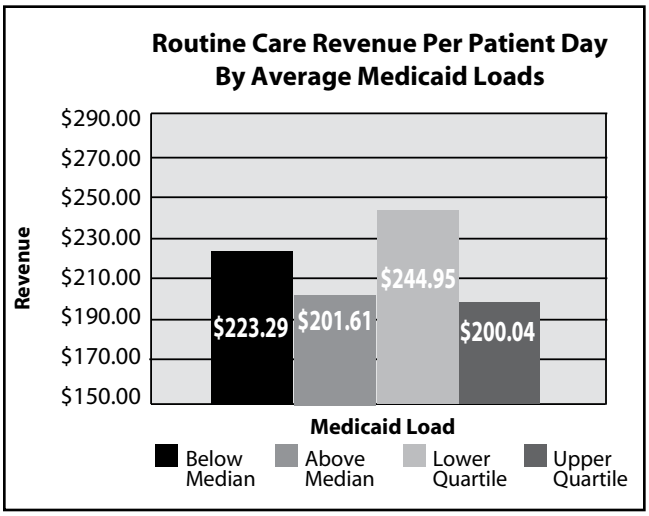


Figure 8: Facilities with high Medicaid loads receive lower revenue per patient day than those with low Medicaid loads

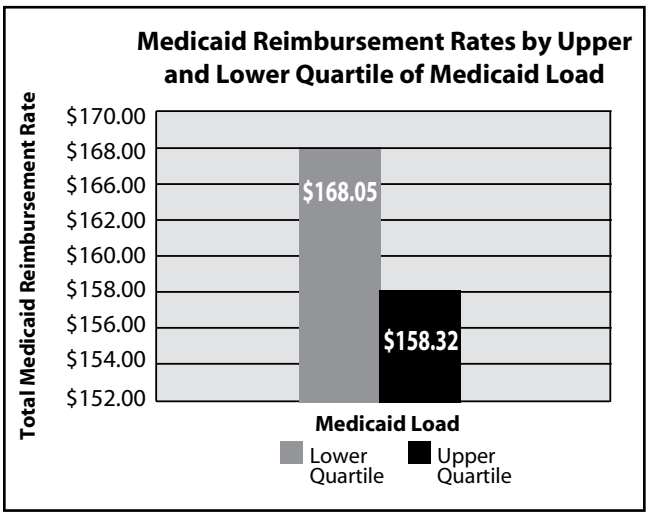


Figure 9: Reimbursement rates increase as Medicaid load decreases

Why Do Some Nursing Facilities Have More Money Than Others to Spend on Direct Care?

Overall, nursing facilities with relatively low Medicaid loads receive more revenue per patient day than do high Medicaid load facilities. Facilities with Medicaid loads above the median level average almost $25 (10 percent) less revenue per patient day then those under the median. Those in the upper quartile average almost $50 (18 percent) less revenue per patient day than do facilities in the bottom quartile. (Figure 8)

Of the over $1.4 billion in total revenue for all nursing facilities in Washington, 96 percent came from routine care revenue. This revenue comes from Medicaid and Medicare reimbursement, and private paying patients, i.e. patients paying out of pocket. In some homes, both the Medicaid reimbursement and private bed ratios are higher than others, resulting in more revenue to spend on quality care. Unfortunately, this quality care is not distributed equally among all seniors looking for skilled nursing home care.

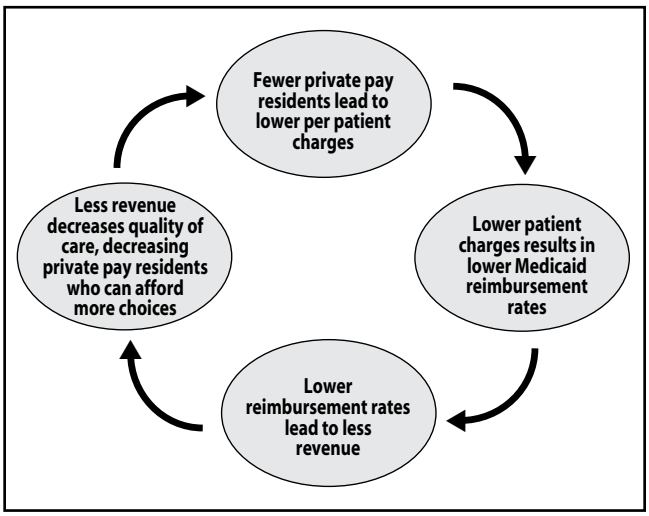


Figure 10: Fewer private pay patients leads to lower Medicaid reimbursement, limiting revenue, resulting in worse care.

Private Pay Patients Generate More Revenue Than Do Medicaid Patients

Patients not covered by Medicaid or Medicare pay private fees for their stay at a nursing home. These fees are generally greater than Medicaid and Medicare reimbursement. It follows that a facility serving a high population of low- and middle- income seniors with fewer private pay

patients generate less revenue than does one with more private pay patients.

It is not surprising that as Medicaid load increases, private paying patient load decreases. This can limit revenue in two ways. First, Medicaid reimbursement levels are generally lower than market driven private pay rates. Secondly, since Medicaid reimbursement rates are set based on facilities' costs, lower private patient spending drives down reimbursement rates. (Figure 10)

The reimbursement rates released in October, 2006 from Washington's Department of Health and Human Services indicate this trend, as low Medicaid load facilities have higher reimbursement rates than facilities with high Medicaid load. (Figure 9) Total reimbursement rates for the upper quartile of nursing homes are 6 percent lower than reimbursement rates for the lower quartile of nursing homes.

CONCLUSION

When it comes time for seniors and their families to make the difficult decisions about end of life care, the quality of a nursing facility is a top priority. However, as has been well documented in the press as recently as August 2006,[8] not all nursing facilities offer the same standard of care. Differences in hours spent on direct care, expenditures on direct care, staffing ratios and turnover, and routine care revenue allow some nursing facilities to offer better care than others.

With annual private pay costs averaging almost $20,000 more than Washington's median household annual income,[9] many low-income and even middle-income seniors turn to Medicaid to help them cover costs. However, the inverse correlation between quality of care and Medicaid load revealed in this report means that these seniors could see their own nursing facility struggle to provide top quality care. Wealthy seniors paying costs out of pocket, on the other hand, will experience higher levels of care since those low Medicaid load facilities are able to generate more revenue.

This economic discrimination does not only mean that low- and middle-income seniors will not be able to have the highest quality of care. As the results of the U.S. Department of Health and Human Services quality survey indicate, poor quality nursing homes can actually reduce the quality of life for residents. Increased chances for pressure sores and lack of movement directly affect both the physical and mental well-being of seniors.

RECOMMENDATIONS

In order to guarantee a more equal level of care for all seniors looking for long term nursing care, skilled nursing facilities need to be able to generate more revenue. A major step in this direction is to break the cycle of low costs leading to lower reimbursement rates. (Figure 10) This cycle puts downward pressure on reimbursement rates for facilities that serve lower income residents and thus have higher Medicaid loads. This pressure decreases revenue, and limits a facilities ability to offer high quality care.

All skilled nursing facilities should receive Medicaid reimbursement rates adequate to offer the highest possible care without depending on wealthy private pay seniors. This will mean an increase in reimbursement rates for many facilities serving a high Medicaid population.

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In Search of Quality Low-Income Care
Seniors Left Behind

About the organizations releasing this report

Northwest Federation of Community Organizations (NWFCO) is a regional federation of four statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Citizen Action (WCA). Collectively, these organizations engage in community organizing and coalition buiding in 14 rural and major metropolitan areas, included the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Oregon. 1265 South Main Street Suite #304, Seattle, WA 98144, Voice: (206) 568-5400, Fax: (206) 568-5444, Web: http://www.nwfco.org

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