



The MetLife National Study of Adult Day Services

Providing Support to Individuals and Their Family Caregivers

October 2010

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National Adult Day Services Association

The National Adult Day Services Association (NADSA) is a membership organization developed for the purpose of advancing the success of its members through advocacy, education, technical assistance, research, and communication services. It serves as the leading voice for the diverse Adult Day Services community. www.nadsa.org

The Ohio State University College of Social Work

The Ohio State University is one of the largest and most comprehensive institutions of higher education and consistently ranks in the top 20 public universities in the U.S. First accredited in 1919, The Ohio State University College of Social Work is the oldest continuously accredited public social work program in the country. Dr. Holly Dabelko-Schoeny and Dr. Keith A. Anderson served as co-principal investigators for the study. Dr. Dabelko-Schoeny's practice and research interests focus on improving the delivery of community-based services for older adults and their caregivers through collaboration with community agencies. Dr. Anderson's practice and research centers on well-being and quality of life for older adults and their caregivers across the long-term care spectrum. csw.osu.edu

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Executive Summary

Adult day services (ADS) centers are a key provider of long-term care services in the United States. They provide a program of activities, health monitoring, socialization, and assistance with daily activities which allows individuals to continue to live in their homes and receive needed care in a supportive, professionally staffed, community-based setting.

Adult day services also benefit family caregivers by enabling them to remain in the workforce or receive needed respite and by providing them with direct services (e.g., educational programs, support groups). They provide cost-effective care, while supporting individual autonomy, allowing individuals to “age in place,” and enhancing the quality of life for both participants and family caregivers.

Adult day services provide health, social, and therapeutic activities in a supportive group environment for individuals with cognitive and/or functional impairments. Some are freestanding centers or programs; others are affiliated with a facility or organization such as a nursing home, assisted living community, senior center, or rehabilitation facility.

With the projected growth in the older population and resulting increase in the numbers of individuals who will require long-term care, the need for community-based providers such as adult day services centers will continue to grow. The passage of the Patient Protection and Affordable Care Act (the health care reform bill) and an increasing focus on managing chronic illness within the Medicare program speak to the importance of developing care models that will be able to meet these growing needs. Disability not only impacts the individual, but also the family members and friends who provide care and assistance. The costs of caregiving can include physical, emotional, and financial tolls that impact individuals, families, and society (e.g., lost productivity, premature nursing home placement).

Adult day services play an important role in meeting the care needs of today’s population and may hold the answer to the pressing question, “How can we meet our future care needs in a fiscally efficient and ethically responsible manner?”

The MetLife National Study of Adult Day Services, a collaborative partnership of the MetLife Mature Market Institute in conjunction with the National Adult Day Services Association (NADSA) and The Ohio State University College of Social Work, was conducted in 2010. Data was collected and analyzed from a representative sample of adult day services centers, focusing on the characteristics of adult day services (i.e., years of operation, physical spaces, sources of revenue), a profile of participants (i.e., age distribution, health status, living arrangements), and the range of services offered (i.e., care planning, health oversight, assistance

with activities of daily living, caregiver support). When possible the 2010 findings were compared with the findings from the first national study of adult day services conducted in 2002 by the Partners in Caregiving program and the Wake Forest University School of Medicine.

The study provides a picture of adult day services in the U.S. and offers a look to the future. It is anticipated that it will serve as a resource for public policymakers, service providers, researchers, and consumers, and can guide the development of adult day services to maintain and improve the quality of life for participants and family caregivers.

Today there are over 4,600 adult day services centers nationwide, which, at any given time, serve over 260,000 older persons and younger adults with disabilities.

Key Findings

Adult Day Services Are a Growing Source of Long-Term Care

- There are more than 4,600 adult day services centers across the U.S. — a 35% increase since 2002.
- More than 260,000 participants and family caregivers are serviced — an increase of over 100,000, or 63%, since 2002.

Adult Day Services Provide Comprehensive Skilled Health Care

- A full range of interdisciplinary professionals meet the physical, emotional, and social needs of participants and family caregivers.
- Nearly 80% of adult day services centers have a nursing professional on staff, nearly 50% have a social work professional on staff, and approximately 60% offer case management services.
- Approximately 50% provide physical, occupational, or speech therapy.
- There is one direct care worker for every six participants, facilitating individualized, person-centered care and enabling staff to care for increasingly complex needs.
- Adult day services centers serve as an emerging provider of transitional care and short-term rehabilitation following hospital discharge.

Adult Day Services Are a Preferred Platform for Chronic Disease Management

- There is an increase in disease-specific programs offered in centers to address chronic conditions.
- More than ever, adult day services participants have higher levels of chronic conditions and disease, such as hypertension (46%), physical disability (42%), cardiovascular disease (34%), diabetes (31%), mental illness (25%), and developmental disability (20%).
- There is a heightened focus on prevention and health maintenance — nearly 80% of centers offer physical activity programs to address cardiovascular disease and diabetes.

Adult Day Services Are Leaders in Community-Based Care for Individuals with Alzheimer’s Disease and Other Dementias

- Adult day services centers provide an interactive, safe, and secure environment.
- Nearly half of all participants have some level of dementia.
- Approximately 90% of centers offer cognitive stimulation programs, almost 80% provide memory training programs, and more than 75% offer educational programs.
- The care provided may allow these individuals to delay nursing home placement.

Adult Day Services Are an Essential Source of Support for Family Caregivers

- Adult day services provide a reliable source of support, restore balance in times of crisis, and enhance overall quality of life for caregivers.
- Adult day services provide respite to family caregivers.
- Over 80% of participants attend full days and 46% attend five days per week, enabling family caregivers to remain in the workforce.
- Most centers provide caregiver support programs, including educational programs (70%), caregiver support groups (58%), and individual counseling (40%).

Background

The first census of adult day programs was funded by the Robert Wood Johnson Foundation and conducted in 2002 by the Partners in Caregiving program and the Wake Forest University School of Medicine. Eight years later, the purpose of this study is to shed some light on the current state of the ADS industry in the U.S. by describing program priorities, operations, staffing, services, and consumers. Special emphasis has been put on identifying the specific services offered by ADS providers that have been associated with the improved health and well-being of older adults in previous studies. This study focuses on the following areas:

- Characteristics of ADS centers
- Characteristics of ADS participants
- Services offered by the ADS
- Present and future priorities and challenges for ADS
- Implications for consumers, providers, employers, policymakers, and researchers.

As the number of older adults and individuals with disabilities increases, the financial, social, and personal costs of caring for these persons will continue to grow. The number of adults age 65 and older in the U.S. is expected to rise from 40 million in 2010 to 55 million in 2020. Approximately 38% of older persons reported some type of disability in 2008, and this number will likely increase as more people live into older age.¹ Among older adults, cognitive disability is a growing concern, particularly Alzheimer's disease and other conditions that result in dementia.² Disability is not limited to older adults. In fact, 19% of people of all ages have some form and level of disability.³

Disability not only impacts the individual, but also the family members and friends who provide care and assistance. Caring for individuals with disabilities can be incredibly stressful and can result in problematic outcomes, including poor emotional and physical health.⁴ Adult day services are one care option that can support the needs of individuals with functional limitations as well as their caregivers. This study helps us to understand the current state of ADS as well as the future roles that they might play in response to new challenges and opportunities.

Adult day services support the health, nutritional, social, and daily living needs of adults in professionally staffed, group settings. Adult day services also benefit family caregivers by enabling them to remain in the workforce as well as providing them with direct services. Historically, ADS have been divided into three models of care: social, medical, or combined. Social models tended to focus on socialization and prevention services, while medical models included skilled assessment, treatment, and rehabilitation goals, and combined models covered all areas. The distinction among these models has become increasingly unclear as these models have evolved into a dynamic, comprehensive model of care.

As an alternative or supplement to home care and an alternative to moving to assisted living or a nursing home to receive care, ADS centers enable continued community-based living for individuals with physical and cognitive limitations and provide respite for their caregivers. In recent years, ADS have played an increasing role in providing long-term care services, as evidenced by the rapid growth in ADS programs from 2,000 in 1989 to over 4,600 in 2009.^{5,6} While this increase is partially due to the aging of our society, much of this growth can be attributed to the benefits offered through ADS. First, ADS allow individuals to remain in their home settings rather than an institutional setting, which is what the majority of caregivers and care recipients desire.⁷ ADS are also far less expensive than nursing home care. The national average daily rate for ADS was estimated at \$67 compared to \$198 for a semi-private room in a nursing home⁸ (note: the average daily rate for adult day services among respondents in this study was under \$62). Finally, new evidence from a case-controlled study suggests ADS can improve health-related quality of life for participants.⁹ In addition, ADS are effective in improving caregiver well-being and reducing burden, role overload, worry, anger, and depression.^{10,11,12,13,14}

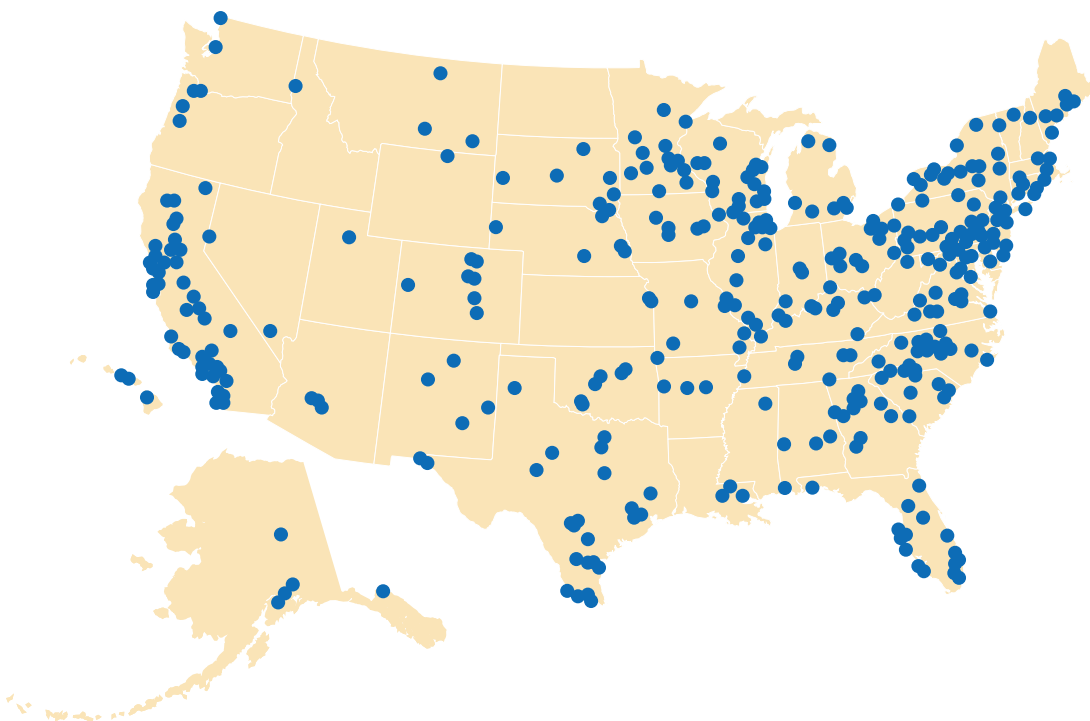
As lawmakers struggle to find ways to provide cost-efficient and high-quality long-term care services for our most vulnerable citizens, up-to-date information about ADS is urgently needed. The Patient Protection and Affordable Care Act provides potential new avenues of federal support for adult day services. This includes the Community First Choice program which adds 6% of additional federal funding to states for home- and community-based care. Pilot programs supporting Medicare funding for adult day services centers are also currently being evaluated.

Methodology

The MetLife National Study of Adult Day Services expands upon the 2002 study from the Partners in Caregiving Program and Wake Forest University School of Medicine by including program priorities, research-informed health and wellness practices, and more specific questions regarding staffing, referral sources, and financial information. Data were collected using a Web-based survey or a duplicate printed survey depending on provider preference. Simple random sampling of all ADS programs in the U.S. ($N = 4,601$) was used allowing for generalization to the entire industry at a lower cost, and with higher replicability.

Sampling was a multi-step process. In July 2009, NADSA identified 4,601 adult day centers across the 50 states. Researchers from the College of Social Work at The Ohio State University randomly selected 1,518 ADS centers from the 4,601 that were identified. Given the anticipated response rates for survey research, they anticipated that approximately 500 ADS centers would elect to complete the study. The data collection phase extended from January through June 2010. Of the 1,518 ADS centers contacted, 74 had closed and one reported that it had yet to open. From a total of 1,443 possible respondents, the final sample for the study consisted of 557 ($N = 557$) ADS centers representing 47,269 participants from across the country. Surveys received were predominately completed by center administrators (87%). The distribution of participating ADS centers is fairly representative of the overall distribution of centers across the country (see Figure A.1). The final participation rate for the study was almost 40%, which exceeds typical participation rates for similarly structured studies.

Figure A.1: Participating ADS Centers



A Profile of Adult Day Services (ADS) Centers

In this section, we examine the characteristics of the ADS centers in this study and when possible compare the current findings with the 2002 study, as well as other existing information.

The typical Adult Day Services program was initiated in 1992 as a single-site, stand-alone, private, non-profit service provider. The center is unaffiliated with any parent facility/organization, and is state-certified or licensed to provide its services.

Operating on a Monday–Friday schedule from 6:30 a.m. to 6 p.m. in a 1,000–5,000 square foot facility, the ADS center is administered by a professional in the Business/Health Care Administration, Nursing, or Social Work field. In addition, services are provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) available for at least 8 hours per day. Additionally, activity, recreational, and therapy professionals are on site and the center may have a social work professional available as well. There is also one direct service staff available for every six program participants.

The Adult Day Services collect a full day average fee of \$61.71, from a public source, including Medicaid waiver, Veterans Administration, State/local social services, or directly from a private-pay participant. However, the average daily costs of providing care to each participant is \$68.89. The ADS center makes up the shortfall through grants, fundraising activities, and donations.

The ADS center provides an unusually wide variety of services including care planning, assistance with activities of daily living, chronic health condition oversight and management, nursing, physical therapy, occupational therapy, meals, and transportation. Additional therapeutic services include psychosocial assessment, music/art/pet therapy, specialized dementia programs, and services for the intellectually and developmentally disabled. Aside from this wide swath of services provided directly to the participant, family caregivers receive support as well through education programs and center-sponsored caregiver support groups.

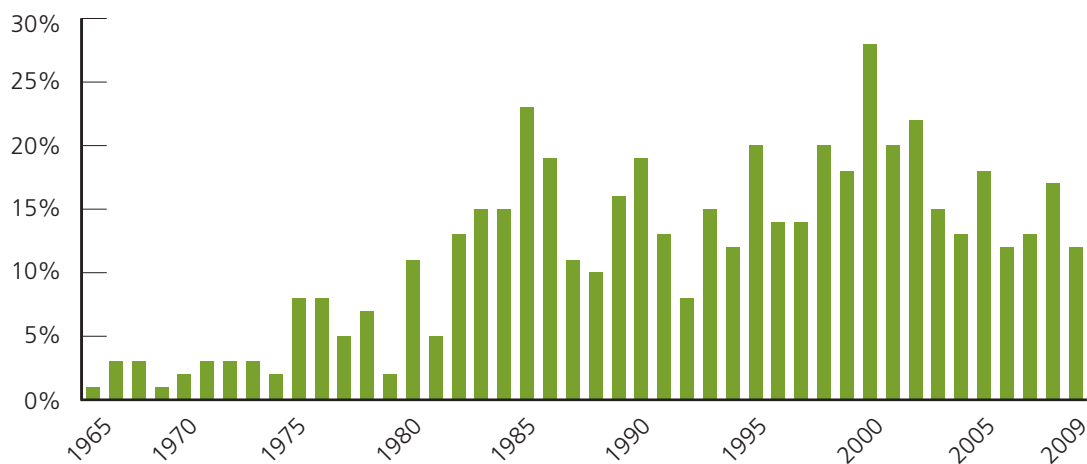
The ADS center provides over 8,500 combined participant days of service each year. Nationally, this accounts for more than 37,500,000 service days provided by adult day services centers annually.

In the coming years, the center will maintain and expand its focus on managing chronic illnesses, delaying/preventing institutionalization, and providing health-related services, socialization, dementia care, and caregiver support. It will continue to address revenue and reimbursement challenges in order to be able to serve its local community and the increasing national need for its services.

Years of Operation

The number of years ADS centers had been in business ranged from over 50 years to less than one year, with an average of 17 years of operation. There appeared to be two spikes within this range when a large number of centers opened, one occurring in 1985 and another occurring in 2000. These spikes likely correspond to public funding opportunities. The mid-1980s was a time when policymakers were increasingly aware of the growing costs of institutional care and many states sought Medicaid home- and community-based services waivers to keep individuals out of expensive nursing homes, providing a steady stream of public funding for ADS centers. The mid-1990s and early-2000s was a time of increased public awareness around caregiver issues and challenges, and funding for respite increased through programs such as the National Family Caregiver Support Program.

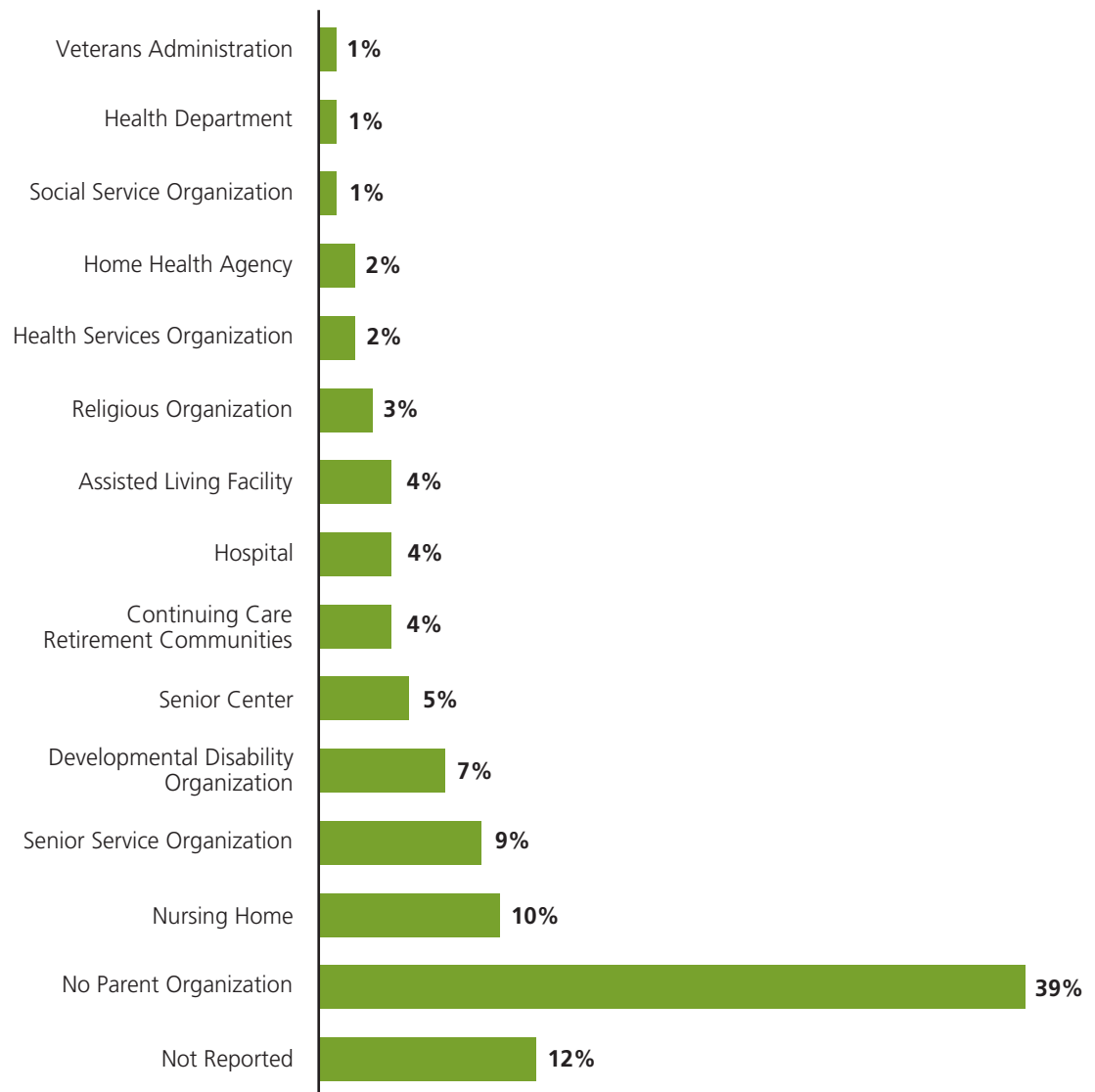
Figure 1.1: Dates ADS Centers Opened



Program Affiliation

About 39% of ADS centers were not affiliated with a parent organization, demonstrating an increase in freestanding centers from 30% in 2002. Thirty-three percent reported operating two or more centers, a decrease of 9% since the last national study in 2002. The industry may be focusing on larger, single-site centers as opposed to operating multiple sites.

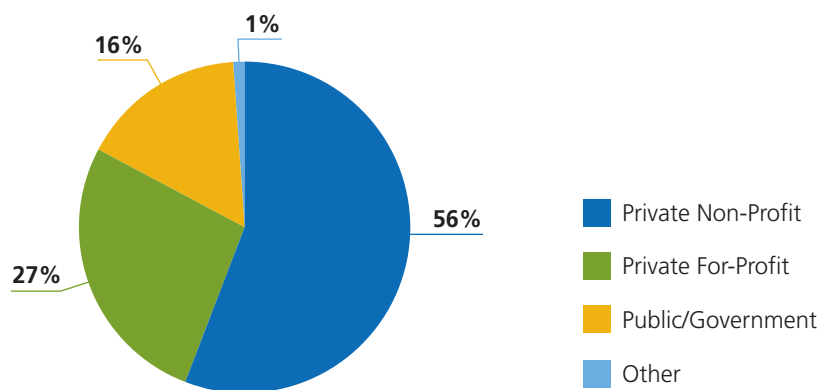
Figure 1.2: Affiliation with Parent Organization



Profit Status

There appeared to be an increase in the number of for-profit ADS centers compared to eight years ago. Twenty-seven percent of centers reported private for-profit status compared to 22% in 2002. Almost three-quarters of all centers (71%) in the current study reported to be private non-profit (56%) or affiliated with the public or government sector (16%). This increase in for-profit centers may be indicative of the financial health of the industry and an expected evolution as ADS centers become more sophisticated and focused on medical services.

Figure 1.3: Profit Status of Centers



Certification and Licensure

The majority of the ADS centers (86%) reported that they were state-certified or licensed, which is a 10% increase from 2002. This increase may be linked with state funding requirements.

Hours of Operation

Consistent with the 2002 findings, almost all ADS centers (98%) reported operating on Monday through Friday. Almost 15% of ADS centers are also open on Saturdays, and approximately 4% are open on both Saturday and Sunday. A small number of centers (less than 1%) reported providing 24-hour care. Most centers (88%) opened on weekdays between 6:30 a.m. and 8:30 a.m. and closed between 4 p.m. and 6 p.m. (73%). Between 3% to 4% of centers reported extended hours, opening before 6 a.m. or closing at 6:30 p.m. or later.

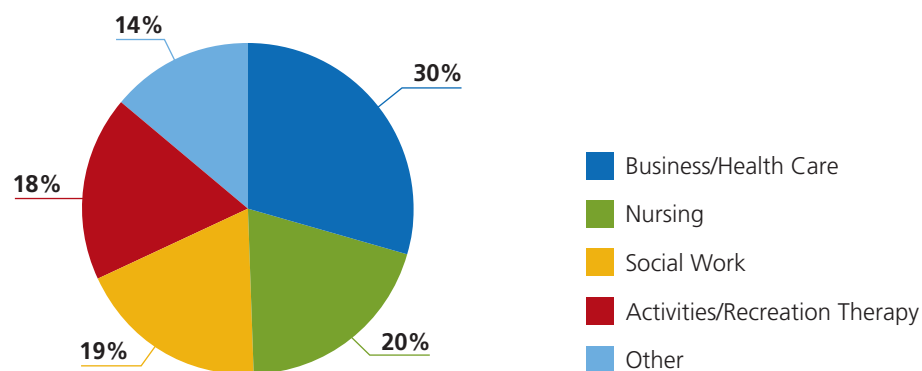
Physical Space

Indoor space used by participants (including bathrooms and kitchens) ranged from less than 500 square feet to more than 10,000 square feet (N = 426). The majority (58%) of ADS centers had programming space that was between 1,000–5,000 square feet. Average indoor square footage per participant was estimated to be approximately 194 square feet.

Center Administration

ADS center directors represented a wide variety of disciplines reflective of the interdisciplinary nature of the care provided by ADS centers. About a third of the center directors had business or health care administration backgrounds, while almost 60% came from practice disciplines including nursing, social work, and activities/recreation therapy. This distribution is in contrast to the typical directors of nursing homes or hospitals. Such institutions are predominantly run by individuals with business or health care administration backgrounds. The philosophy of care in ADS centers may reflect the training and beliefs of these helping professions and contribute to an atmosphere that promotes person-centered, holistic care.

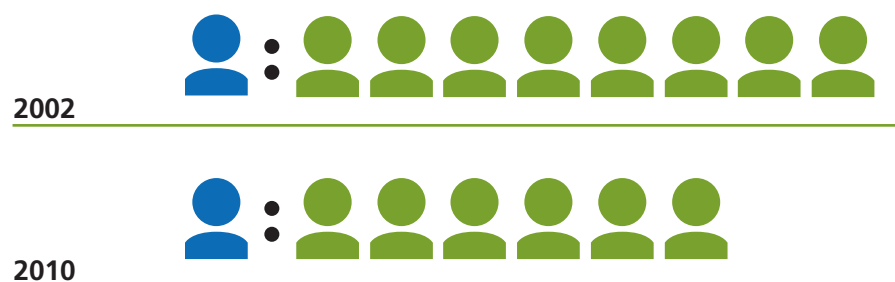
Figure 1.4: Primary Disciplines of ADS Center Directors



Staffing

Almost 80% of ADS centers had either a registered nurse (RN) or a licensed practical nurse (LPN) on staff. This includes over 65% that had at least one RN on staff and approximately 48% that had at least one LPN on staff. In 2002, only 53% of ADS centers reported having an RN on staff and only 33% reported having an LPN on staff. The increase in the number of nurses on site suggests an increase in the delivery of health care services in ADS centers. Most centers reported having direct care workers (99%) and activity professionals (92%). About half of all centers reported having social workers (48%).

Figure 1.5: Direct Care Worker-to-Participant Ratio



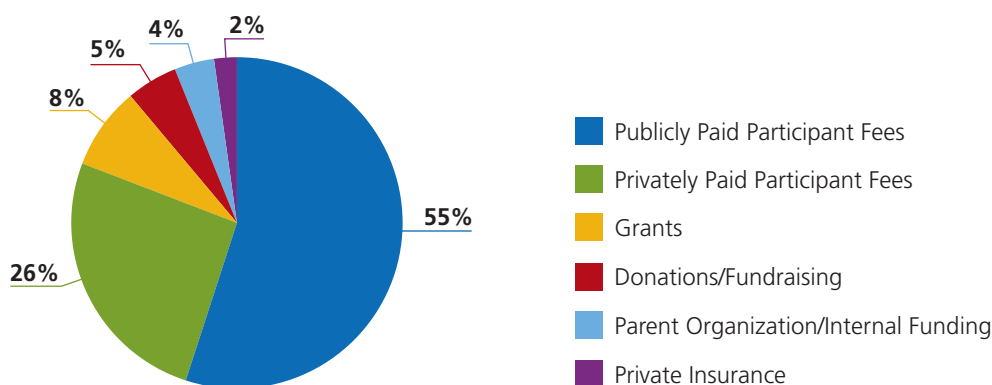
In calculating the direct care worker-to-participant ratio, direct care workers included certified nursing assistants (CNAs), personal care assistants, and health care aides. The average direct care worker-to-participant ratio was calculated in the current study at approximately one direct care worker for every six participants (1:6). In the 2002 study, the researchers calculated the average direct staff-to-participant ratio at 1:8. This improvement in direct care worker-to-participant ratio is significant and may allow for more individualized care and more hands-on care for participants with greater medical and mental health needs.

Often times, professional staff such as nurses and social workers provide “hands-on” care to participants of ADS. By aggregating direct care workers with professional nursing staff (e.g., LPNs and RNs), social workers, and activity professionals, the total staff-to-participant ratio in this year’s study is 1:4. On an average shift, 40% of providers had eight or more hours of registered nursing services provided by one or more nurses, 28% had eight or more hours of licensed practical nursing services delivered by one or more persons, and 26% had social work services for eight or more hours delivered by one or more persons.

Funding

Traditionally, ADS have been funded by multiple sources, often a patchwork of public and private funding. The 2010 results indicate that this is largely still the case. Over half (55%) of the funding reported came from publicly paid participant fees and one-quarter (26%) from privately paid participant fees. In 2002, it was reported that on average 35% of revenue came from privately paid participant fees. Public funding continues to pay for the vast majority of ADS services. Recent increases in public funding may be reflective of efforts aimed at augmenting funding for home- and community-based services including ADS. These statistics also suggest that ADS may be serving clients with fewer resources than in the past.

Figure 1.6: Sources of Revenue



Approximately 15% of ADS centers reported zero revenue from publicly funded participant fees and 20% of ADS centers reported zero revenue from privately paid participant fees. These statistics are of interest as they indicate a lack of diversity in funding for over one-third of ADS centers. This lack of diversity may leave these ADS centers particularly vulnerable to economic shifts and changes in public policy, in particular on the state level.

ADS centers identified the most common sources of public funding:

- Medicaid Home- and Community-Based Waiver Programs
- Veteran's Administration
- State and Local Funding

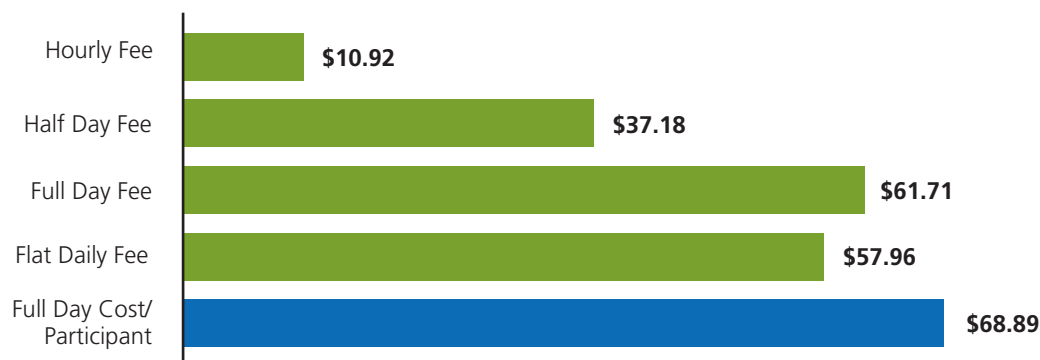
In the 2002 survey, Medicaid and state and local funding were listed as the top two sources of public funding, while the Veteran's Administration (VA) accounted for only 10% of total revenue. While there were measurement differences between the 2002 and 2010 surveys, the differences in the ranking of these public funding sources suggest that the VA may be a growing source of funding for ADS. This change reflects the VA's mandate to their medical centers to significantly increase their community-based services allocation.

Fee Structures and Costs

The fee structures of ADS centers tend to vary. The standard appeared to be full day (average of \$61.71) or flat daily fee (average of \$57.96) charged regardless of the number of hours a participant attended). Full day or flat day rates ranged from \$15–\$177.

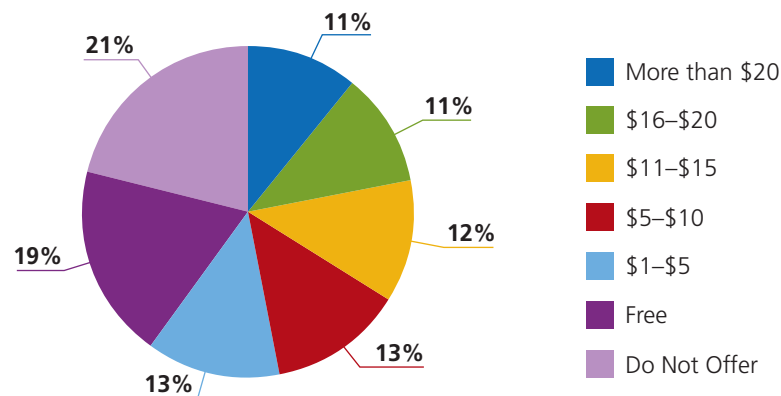
We also asked ADS centers to estimate the daily cost of providing care for one participant. There was a wide range in these estimates, from \$9–\$219 per day. The average daily cost of providing care to one participant was \$68.89.

Figure 1.7: Participant Fees and Costs of Providing Care



Approximately 80% of ADS centers offer transportation with fees ranging from no cost to \$20 per round trip. This wide range may be related to geographic location and distance. Figure 1.8 below shows the distribution of costs for transportation.

Figure 1.8: Daily Round-Trip Transportation Fees



General financial health was calculated by examining the difference between reported revenue and costs. The majority of ADS centers (70%) appear to be operating with a balanced budget, 17% reported an annual deficit, and 13% reported an annual profit.

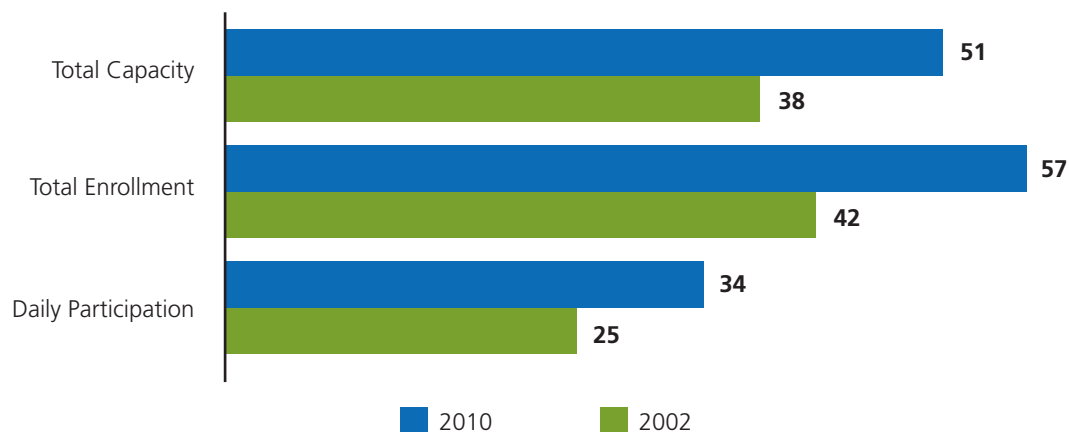
Shortfalls between fee-based revenue and costs are often addressed through grants, fundraising, and internal funding to maintain breakeven financial status.

Participation and Enrollment

ADS centers have grown in size since the 2002 survey. The average maximum capacity grew from 38 participants in 2002 to 51 in 2010. Enrollment grew from 42 participants in 2002 to 57 in 2010. This equates to over 260,000 participants served compared with approximately 150,000 in 2002. The average number of participants served per day was 34 compared to 25 in 2002, indicating a significant growth in daily utilization. This equates to over 150,000 participants per day compared to 85,000 per day in 2002. It should be noted that enrollment is typically larger than the number of participants per day, as some participants do not attend every day of the week.

Centers that serve a larger number of people are able to spread fixed costs such as staffing, purchasing, technology, and facilities over a larger client base. Serving more people daily at one site not only provides a cost-effective way to deliver services, but creates a larger congregation of often hard to reach populations for chronic disease treatment and management.

Figure 1.9: Center Capacity, Enrollment, and Participation



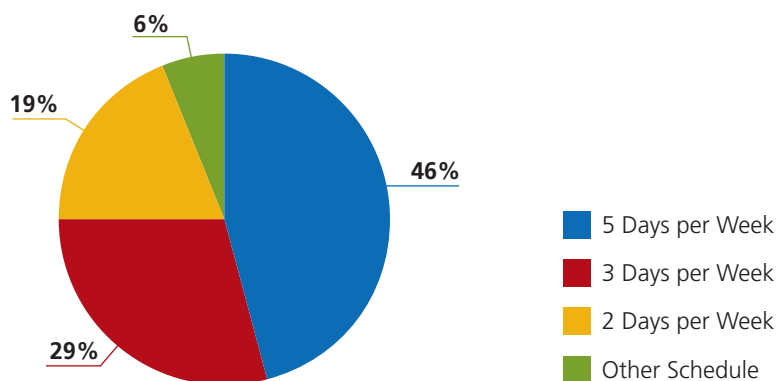
We also asked ADS centers to report whether they had a waiting list and, if so, the number of individuals on the list. Approximately 29% of centers reported having a wait list compared to 22% in 2002. The increase of individuals on waiting lists may be the result of an increase in awareness of ADS as an important community-based services option.

The average length of participant enrollment was approximately 32 months. This is considerably higher than the 2002 study in which the average length of enrollment was reported as approximately 24 months. In comparing the two data sets, the range for length of enrollment was much broader in 2010 (1–360 months in 2010; 1–96 months in 2002), likely due to services for individuals with intellectual and developmental disabilities. Given the extreme values reported in the 2010 data (360 months = 30 years), it might be prudent to examine the most commonly reported length of enrollment which was 24 months — equal to the average length of enrollment reported in 2002.

Schedules of Attendance

The vast majority (81%) of participants attended full days (at least five hours per day). There was some variability in the schedules of attendance. As presented in Figure 1.10, approximately 46% of participants attended on a five days per week schedule, while 29% and 19% attended three days per week and two days per week, respectively. It is likely that many caregivers are utilizing adult day services five days per week so they can maintain full-time employment.

Figure 1.10: Schedules of Attendance



A Profile of Adult Day Center Participants

To construct an accurate profile of ADS participants, individual-level statistics were computed based upon the enrollment figures for each center and the percentage of participants identified as part of a particular group in that center. This technique yields a more accurate estimate than reporting percentages of percentages. The 2002 study did not use this strategy, so comparisons between those findings and the findings from the current study should be done with caution.

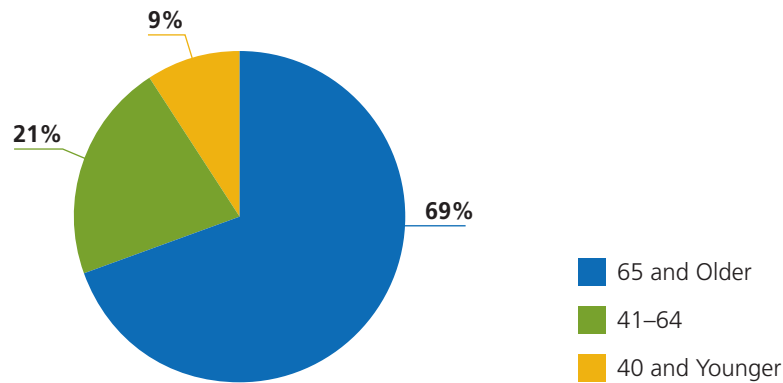
The “average” participant is a 65-plus-year-old, white female with dementia, hypertension, or physical disability requiring assistance with toileting or other activity of daily living (ADL) and medication management. While she may live with her adult child, spouse, or live alone, she typically receives care primarily from her adult child. She is joined in her program by 33 other daily participants of the total of 57 enrolled, who also attend the center’s full day program (five or more hours per day), five days per week. She and her fellow center participants are enrolled in the program for an average of 24 months after being referred through her local Area Agency on Aging, family or friends, physician’s office, or self-referral.

She was enrolled in the program due to increased care needs or behavior problems, the need of her caregiver for respite from the stress of caregiving, and reduced capacity of the family caregiver — often employed — to provide daily care. After her average 24-month enrollment in the program she will leave the program due to nursing home placement, a significant health decline, or death.

Age Distribution of Participants

The majority of participants were women (58%). In terms of age distribution, 69% of participants were age 65 and older, 21% of participants were age 41 to 64, and 9% of participants were age 40 and younger. This is reflective of the wide range of ages served by ADS as well as the dominant focus of ADS on the older adult population. While average age might appear to be a convenient statistic to generate, the wide distribution in ages makes such figures rather misleading. For this reason, the age distribution figures present a more accurate picture.

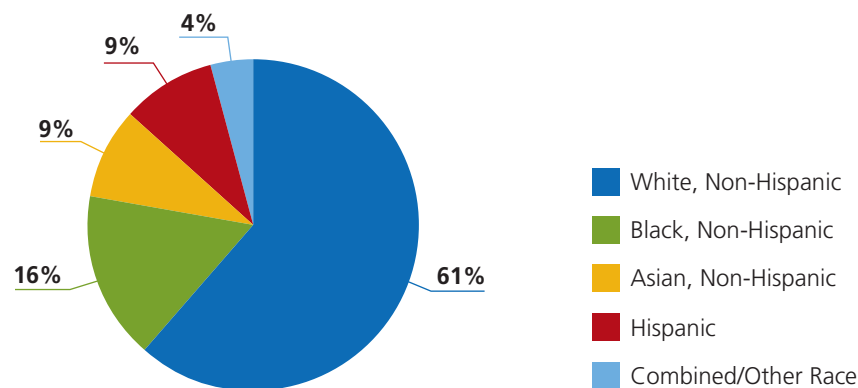
Figure 2.1: Age Distribution of Participants



Race and Ethnicity of Participants

In terms of race and ethnicity, ADS centers reported that approximately 61% of participants were White, 16% were Black, 9% were Hispanic, and 9% were Asian. It is difficult to compare the statistics on race and ethnicity to the 2002 data, as their calculations were based on facility-level data rather than on participant-level data. We can, however, compare these data with population estimates. The U.S. Census Bureau's 2009 American Community Survey estimates that approximately 75% of the population are White, 12% are Black, 16% are Hispanic, and 4% are Asian.

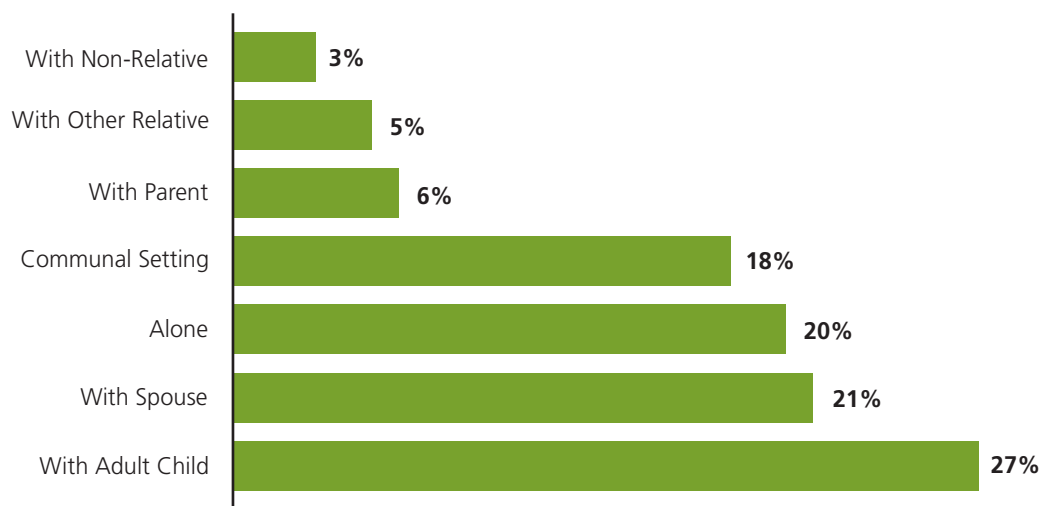
Figure 2.2: Race/Ethnicity of Participants



Living Arrangements

The most common living arrangement of ADS participants was with an adult child (27%), followed by living with a spouse (21%), alone (20%), or in a communal setting (18%). The number of participants living with adult children has decreased (estimated at 35% in 2002) and the number living alone has increased (estimated at 11% in 2002). In effect ADS may be a collaborative partner with in-home services or congregate housing (i.e., group homes) to enable people to live as independently as possible.

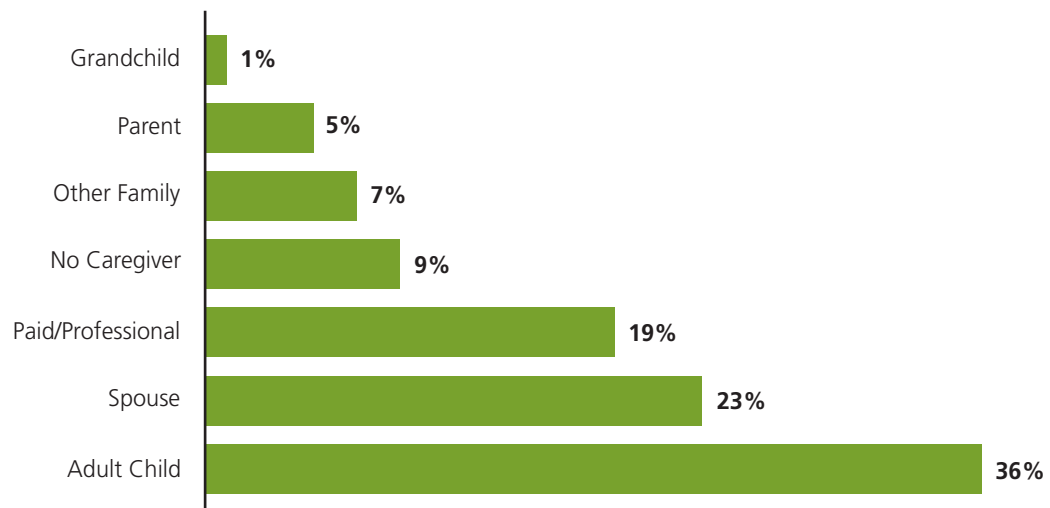
Figure 2.3: Living Arrangements



Primary Caregivers

Caregivers were primarily adult children (36%), spouses (23%), and paid/professionals (19%). Data on primary caregivers were not collected in the 2002 study, so it is difficult to determine whether changes have occurred in the caregiving situations of ADS participants.

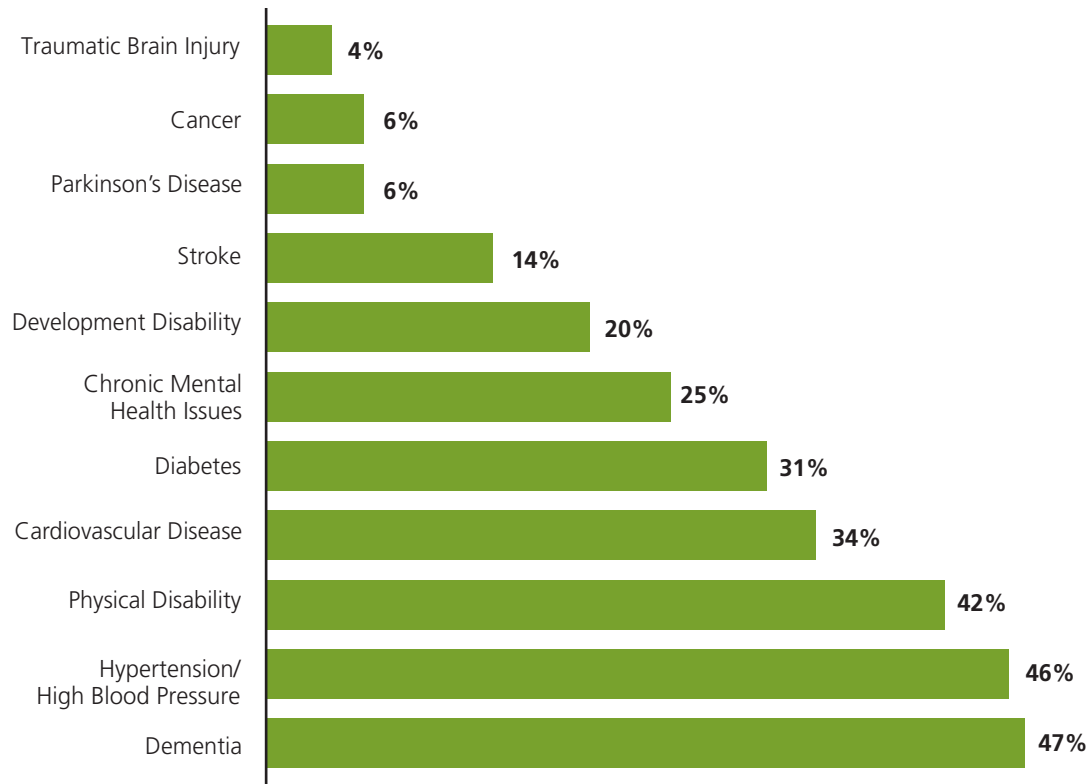
Figure 2.4: Primary Caregivers to Participants



Health Status of Participants

The three most prevalent conditions experienced by ADS participants were dementia (47%), hypertension/high blood pressure (46%), and physical disability (42%). About a third of participants experienced cardiovascular disease (34%) and diabetes (31%). Chronic mental health issues were experienced by 25% of participants and 20% had a developmental disability. In comparing these to the 2002 estimates, it appears that levels of dementia and developmental disability have remained relatively static; however, physical disability (23% in 2002; 42% in 2010) and chronic mental health issues (14% in 2002; 25% in 2010) have increased dramatically, suggesting that the needs of participants have increased.

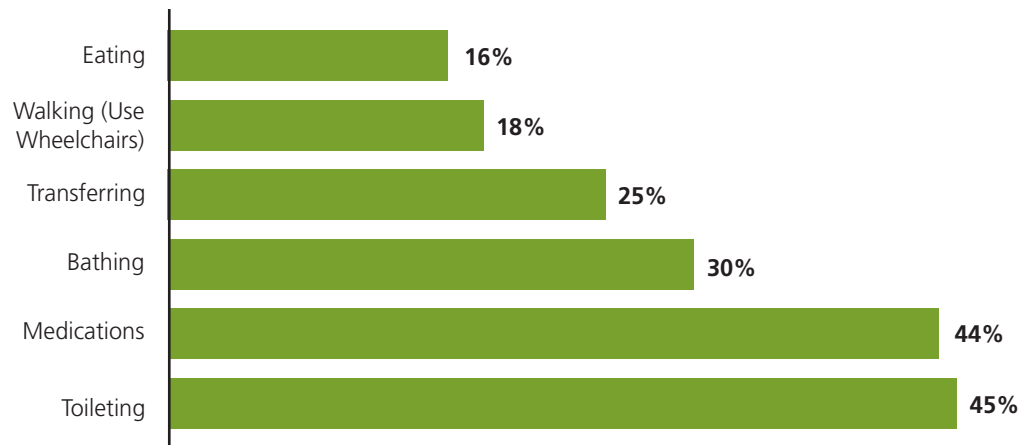
Figure 2.5: Health Status of Participants



Care Needs of Participants

In terms of assistance with care needs and activities of daily living (ADLs), just under half of all ADS participants needed assistance with toileting (45%) and medication management (44%) and about one-third needed assistance with bathing (30%). One-quarter needed assistance with transferring (25%) and less than 20% needed assistance with eating. Given the increase in the number of individuals with physical disabilities, it is likely that participants require more assistance than in 2002.

Figure 2.6: Assistance with Care Needs



Transitional Care and Short-Term Rehabilitation

Transitional care and short-term rehabilitation have become increasingly common for older adults who need assistance following illness, accident, or surgery. In the current study, centers reported that 13% of participants receive short-term rehabilitation services. Of this group, approximately 39% become long-term participants demonstrating ADS centers' emerging ability to provide both acute and long-term care services. ADS centers are well-positioned to provide important "step-down" medical care such as nursing, rehabilitation, and transitional support after a hospital stay. Cost for this type of support is likely lower than institutional care.

Referral Sources

ADS centers reported and ranked the sources that referred potential participants. The most common referral sources reported by ADS centers included:

1. Area Agencies on Aging
2. Family/Friends
3. Self-Referral
4. Medical Doctors

One group that is missing from this list is hospital discharge planners. ADS centers may consider exploring how to outreach to hospitals and other medical facilities to educate them about their service capacity, and to develop a streamlined enrollment process to respond to the often short timelines hospital personnel have to place people in aftercare settings.

Reasons for Enrollment and Disenrollment

The same formula used in ranking the sources of referral was used to determine the ranking of reasons for enrollment and disenrollment. The most common reasons for enrollment into ADS centers included (there was a tie for third place):

1. Increased Functional Needs of the Participant
2. Caregiver Respite
3. Declines in Caregiver Ability
3. Increased Behavior Problems in the Participant

The common reasons for enrollment in ADS could be viewed as indicators of family caregivers in crisis. In particular, the imbalance between care recipient needs and caregivers' sustained ability to meet those needs. The three most common reasons for disenrollment included:

1. Placement into a Nursing Home
2. Death of the Participant
3. Services No Longer Matched the Needs of the Participant (Health Decline)

These reasons come as no surprise as there are limitations to the amount of care that can be provided in ADS centers. The fact that death continues to be one of the top reasons for disenrollment suggests that ADS may allow individuals to not only age in place, but to maintain community-based living until the end of life.

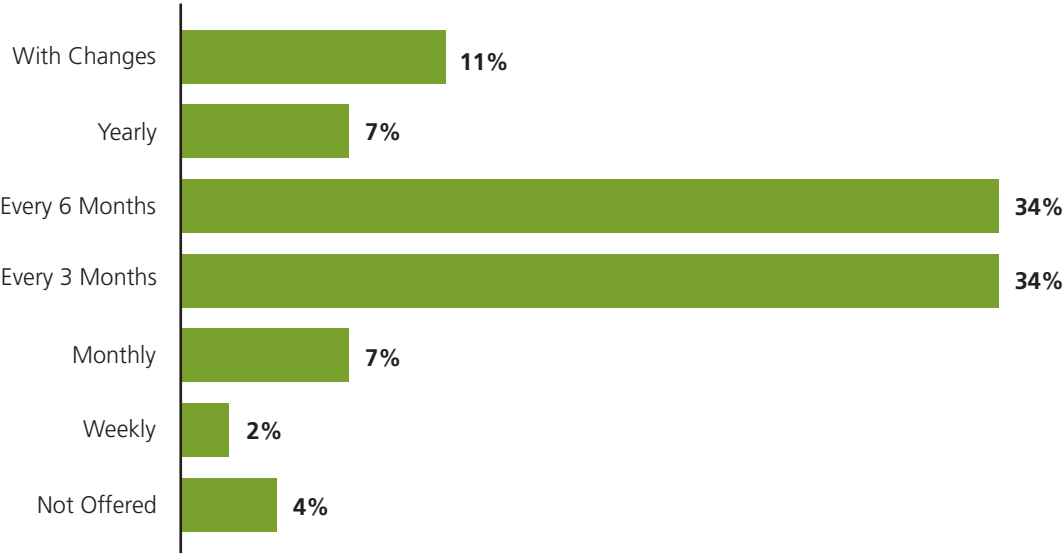
Services Offered in Adult Day Centers

As anticipated, ADS centers offered a wide array of services to address the range of conditions and needs presented by participants and their caregivers. Most ADS centers included these services and programs at no extra charge, while certain specialized services (e.g., podiatry services) were offered for an extra fee. Several of the most important of these categories are presented in Figures 3.1 through 3.8 and help to visualize trends since the last national survey.

Care Planning

Care plans serve as important guides for staff in ADS and typically include information on medical conditions and diagnoses, treatment plans, medications, activities, and progress to date. Care plans are also evidence of “person-centered care”—the concept or belief that care should be tailored to the needs and desires of each person. The vast majority (96%) of ADS centers sampled offered care planning for their participants. As indicated, most ADS centers updated participants care plans every three to six months (68%).

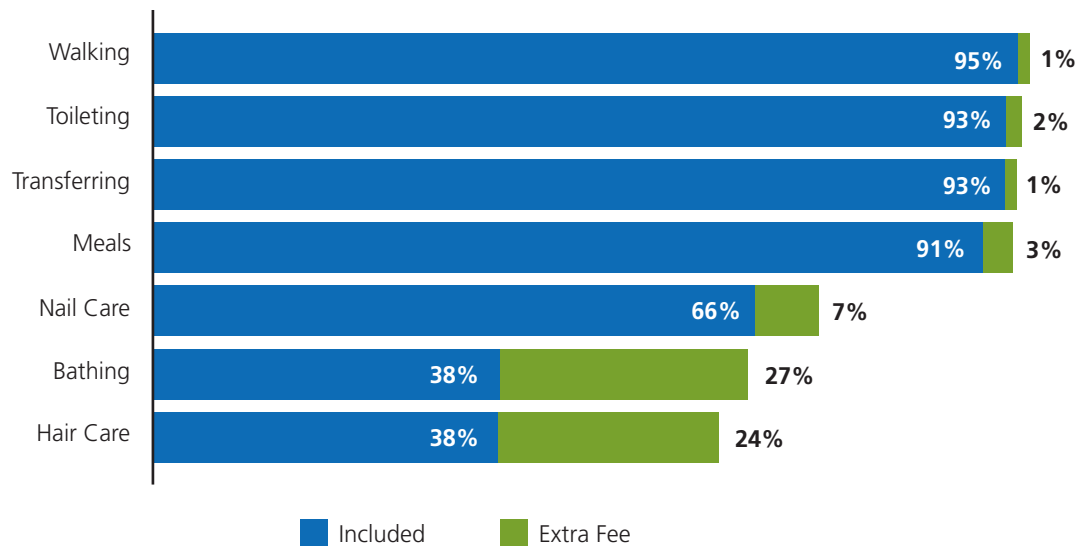
Figure 3.1: Care Planning



Assistance with Activities of Daily Living

Assistance with activities of daily living (ADLs) is also a primary function of ADS. As previously mentioned, ADLs include activities such as walking, toileting, and bathing. As indicated, assistance with ADLs is offered by the vast majority of centers at no extra fee.

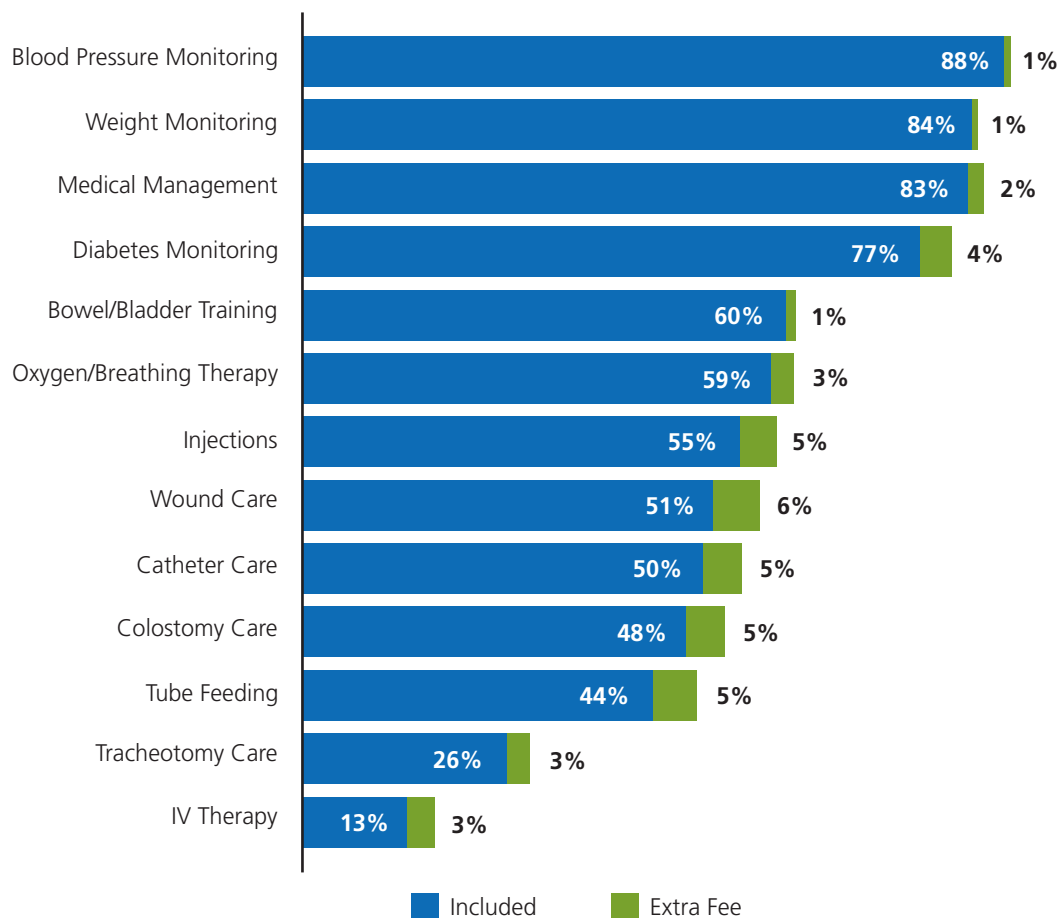
Figure 3.2: Assistance with Activities of Daily Living



Nursing and Other Health-Related Services

Nursing services and health-related services are also an integral offering in ADS. Figure 3.3 illustrates the wide range and the high prevalence of such services. Again, these findings suggest that ADS centers have the potential to provide comprehensive care across a variety of care needs, some of which can be quite complex (e.g., catheter care, tube feeding). One notable change since 2002 was in the percentage of centers offering medication management (70% in 2002; 85% in 2010). There was also an increase in the percentage of centers offering diabetes monitoring (68% in 2002; 81% in 2010). This may speak to a number of factors, including the increased presence of chronic illnesses and the medications associated with those illnesses, as well as an increased ability or capacity of ADS centers to treat chronic illness.

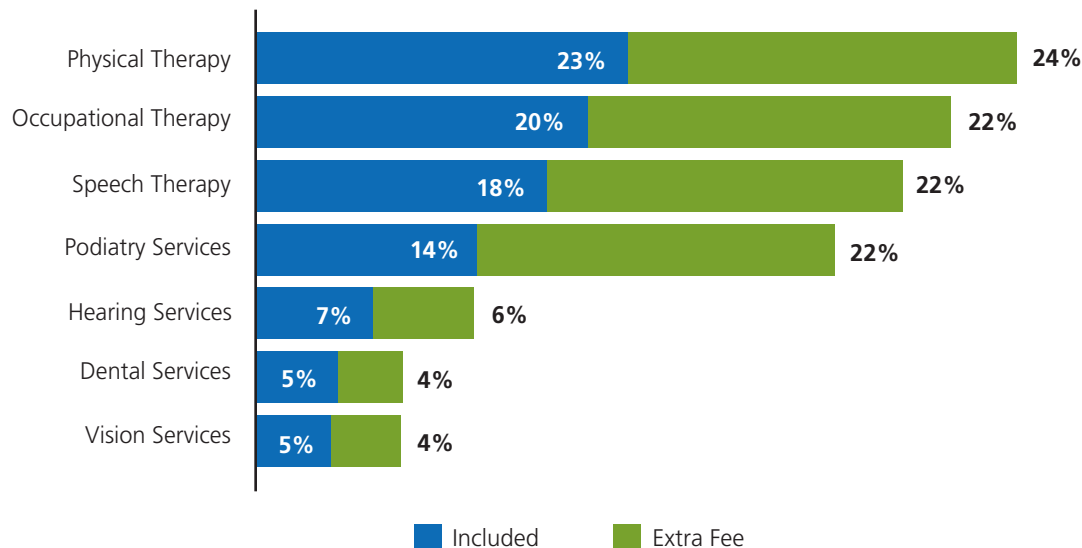
Figure 3.3: Nursing and Other Health-Related Services



Therapeutic and Medical Services

Some of the most notable changes appear to be clustered around the percentage of ADS centers offering therapeutic services at no extra fee. In 2002, far fewer centers offered occupational therapy (13% in 2002; 20% in 2010), physical therapy (10% in 2002; 23% in 2010), and speech therapy (12% in 2002; 18% in 2010) at no extra fee. The overall availability of podiatry services has also risen from 20% in 2002 to 36% in 2010. Again, this may point toward the increased presence of illnesses such as diabetes as well as the enhanced capacity of ADS centers to monitor and control such chronic illnesses. It should be noted that services may be offered in the centers, but not by the centers.

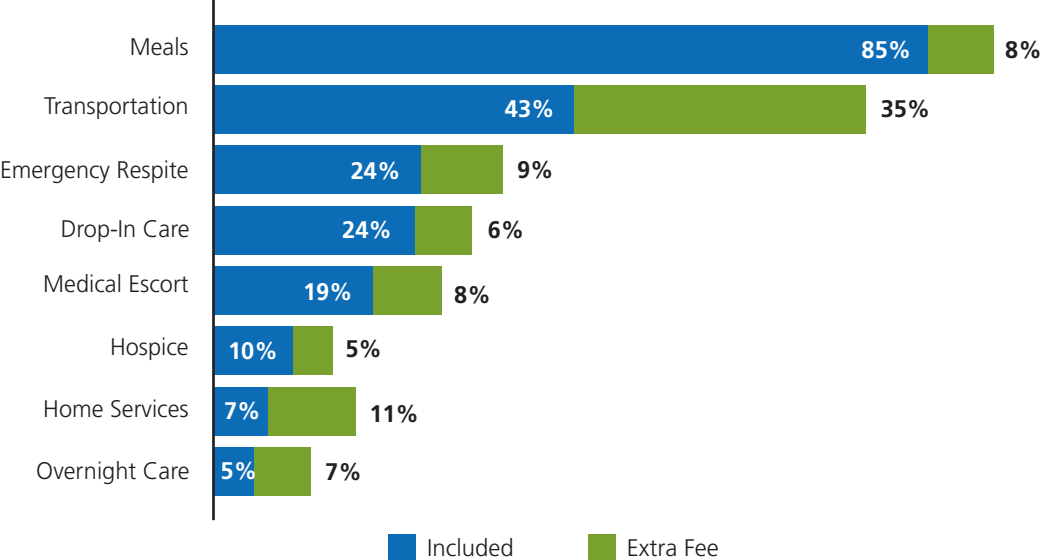
Figure 3.4: Therapeutic and Medical Services



Meals, Transportation, and Specialized Services

Meals and transportation continue to be offered at a high rate and have seen little change in fee structure (included or at an extra fee) since the 2002 survey. Other general services appear to be slightly increasing, including the provision of hospice care (up 7% overall). In-home services were offered by over one in eight of the centers — an emerging trend that may be indicative of the possibilities of the ADS as a comprehensive service delivery platform.

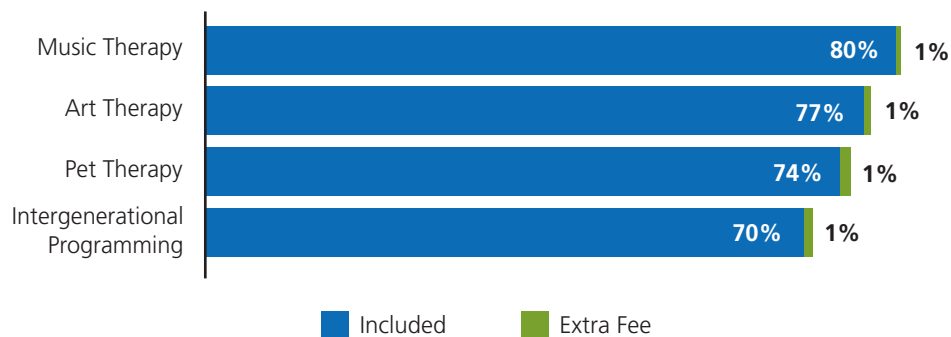
Figure 3.5: Meals, Transportation, and Specialized Services



Psychosocial Services, Therapeutic Activities, and Targeted Programs

Psychosocial services, therapeutic activities, and targeted programs continue to be offered with a high prevalence in ADS. For example, over 60% of ADS centers offered psychosocial assessments. More than 70% of ADS centers offered music, art, and pet therapies (see Figure 3.6) and 50% offered programs specifically designed for persons diagnosed with Alzheimer’s disease and other dementias.

Figure 3.6: Therapeutic Activities



A proportional number of ADS centers serve individuals with intellectual and developmental disabilities. Traditionally, ADS have been an important support service for this population.

Wellness Practices and Disease-Specific Programs

The current study differs from previous work in asking whether ADS centers had services and programs directed at specific health conditions, diseases, and needs. These areas were selected based upon prevalence in the general population and in the ADS population, as well as national priorities set forth by leading public health agencies, including the Centers for Disease Control (CDC) and the National Institutes of Health (NIH). We asked centers whether they offered specific services and programs that might help to address these problems. It should be noted that many programs offered in ADS centers can simultaneously address multiple problems and conditions, for instance exercise and diet programs may help to address both cardiovascular health and diabetes.

In looking at commonalities across diseases and conditions, a considerable proportion of ADS centers reported that they offered disease-specific educational programs, physical activities, diet programs, medication management, and referrals. Other centers reported having programs that have not traditionally been offered in ADS centers such as smoking cessation programs (offered in approximately 12% of centers). Other services were offered in a moderate percentage of facilities but could be offered in the vast majority of centers, primarily those services directed at obesity, diabetes, and depression (e.g., weight control programs, blood sugar screening, depression screening). This represents unrealized capacity to address chronic health care issues and conditions. Nonetheless, the data indicate that ADS centers can and do offer a wide array of services and programs that address some of the most problematic conditions currently facing older adults, such as cardiovascular disease and dementia.

Figures 3.7 through 3.9 illustrate the availability of several selected disease-specific services.

Figure 3.7: Cardiovascular Disease-Specific Programs and Interventions

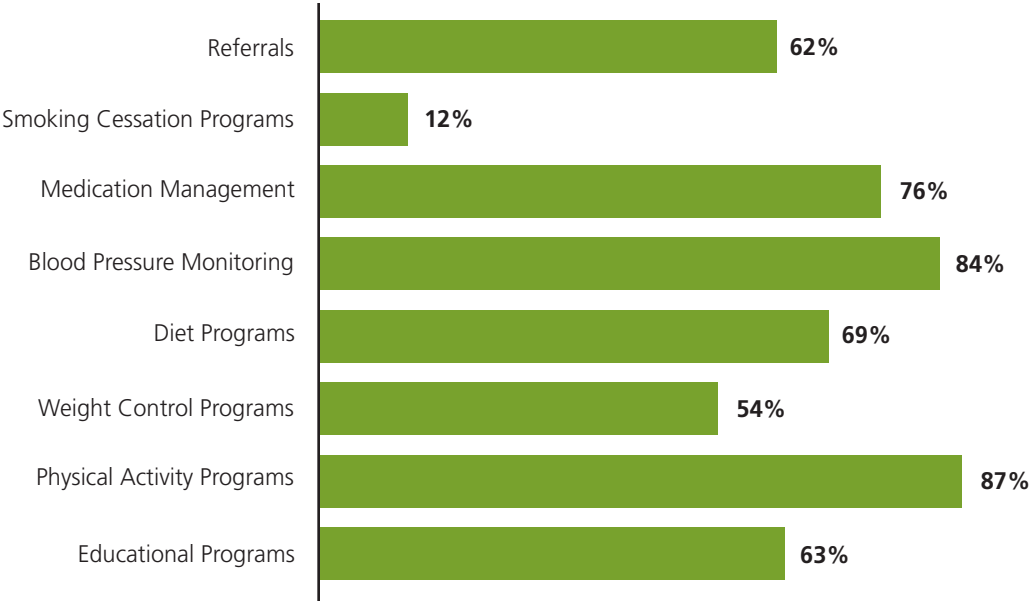


Figure 3.8: Diabetes-Specific Programs and Interventions

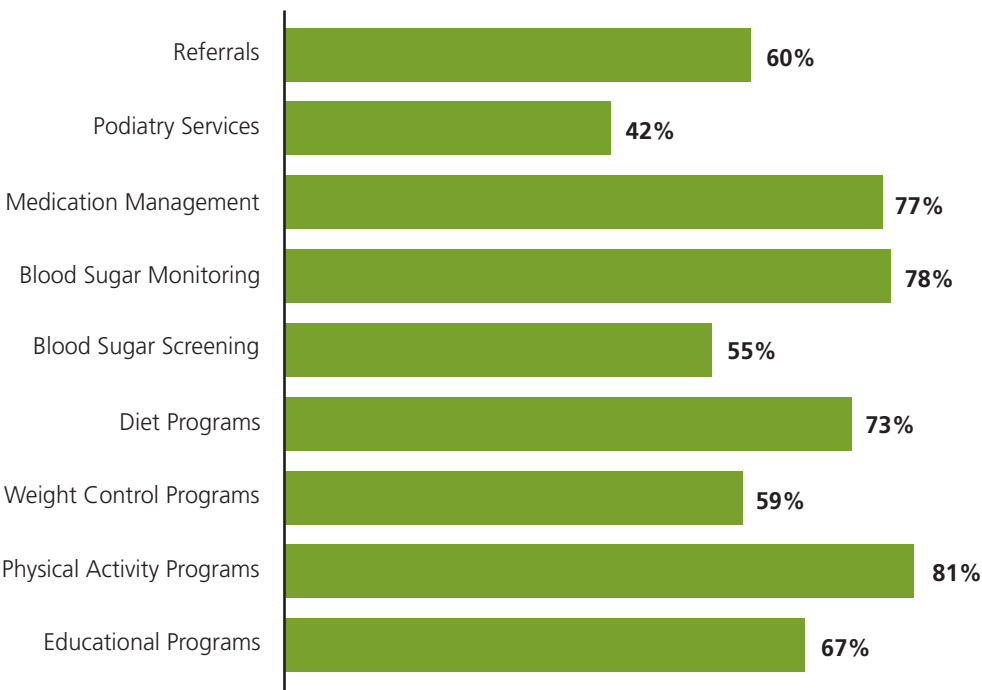
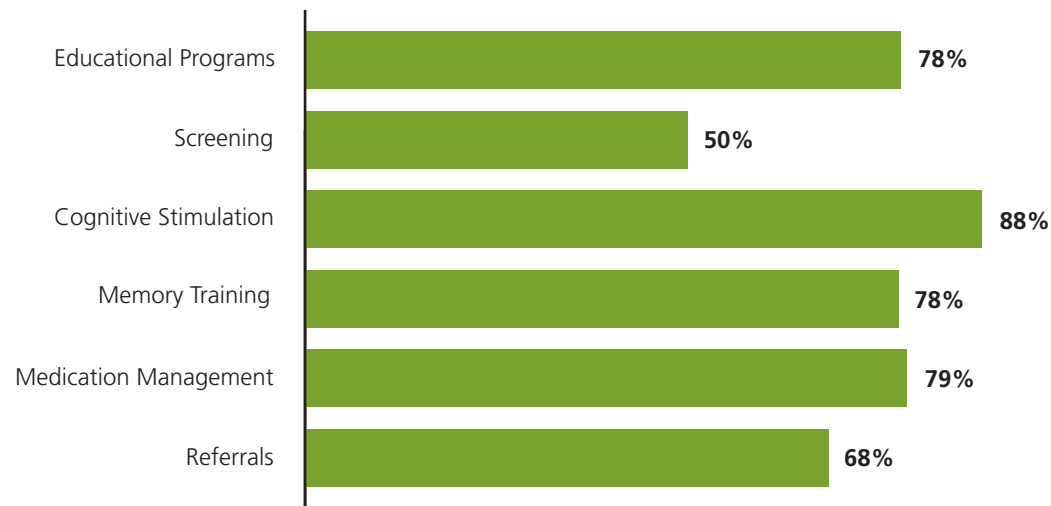


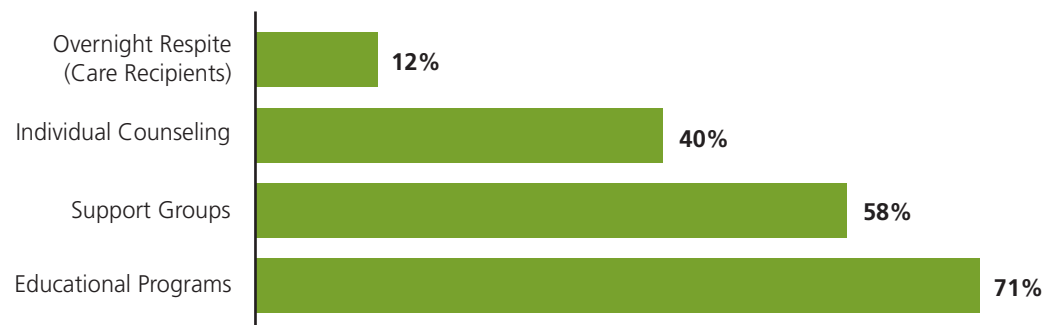
Figure 3.9: Dementia-Specific Programs and Interventions



Caregiver Well-Being and Support

Caregivers are also an important focus for adult day services and a number of centers provide specific services to support caregivers. Figure 3.10 demonstrates some of the key components offered specifically to assist family caregivers of center participants.

Figure 3.10: Caregiver Well-Being Programs and Interventions

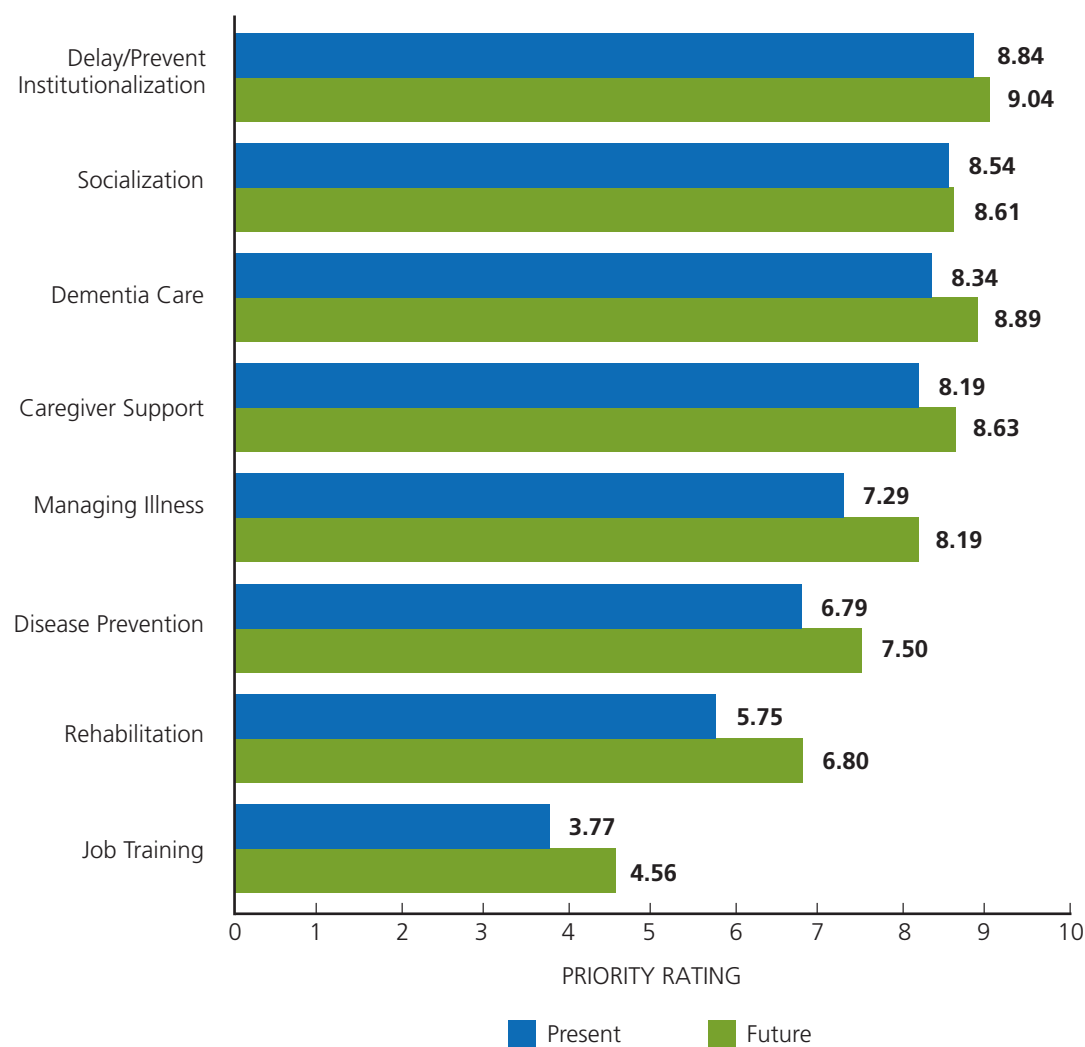


The Present and Future of Adult Day Services

Priorities and Roles

In an effort to understand the perceived priorities and roles of ADS, we asked ADS centers to select and rank items from a list including the following: managing chronic illness, dementia care, socialization, caregiver support, delaying/preventing institutionalization, job training, rehabilitation, and disease/illness prevention. We asked them to rate these priorities and roles in terms of their importance at the present time and to project the importance of such priorities and roles 10 years from now.

Figure 4.1: Present and Future Priorities in ADS



Delaying and/or preventing institutionalization was ranked as the top priority and role of ADS. While this is certainly a potentially important priority and role in ADS, researchers have yet to conclusively show that ADS have this impact. Given the participants' level of need and the most common reason for disenrollment being nursing home placement, a more accurate description of the role ADS centers play may be delaying institutionalization, not preventing it. Socialization was listed as the second highest priority and role. As a congregate care model of service delivery, ADS provide opportunities for socialization. Clearly, ADS centers continue to see this as a priority, both today and in the future. Dementia care was third on both lists. This is clearly in line with both the needs of older adults with dementia today and the projected number of older adults who will face dementia in the near future. Caregiver support was the fourth highest priority. Again, this role has always been a primary concern for ADS and the importance of this role will, in all likelihood, not diminish in the coming years. Job training ranked at the bottom of the lists of priorities and roles. This is most likely due to the fact that a fraction of ADS centers in this study served individuals under the age of 65, the population that would most likely be targeted for job training programs.

There were some slight disparities in the mean levels of importance among the present and future priorities and roles. There was a noted increase in the projected importance of managing chronic illness/conditions, disease prevention, and rehabilitation in the future. This may indicate an increased awareness or urgency on the part of ADS centers in response to the approaching challenges of caring for the Baby Boomer generation.

Challenges

To gauge the challenges facing ADS, we used open-ended questions to allow participants to voice their most pressing present challenges and to forecast what they see as their most pressing challenges 10 years from now. The responses were categorized by themes and quantified. The following themes were most common in terms of present challenges:

- Funding/Financial Concerns
- Maintaining/Increasing Number of Participants
- Marketing Adult Day Services to the Community

Funding/financial concerns were by far the most frequently identified challenge for ADS centers. As our findings and those of other studies indicate, most ADS centers are operating on a break-even basis, but many are struggling to remain afloat in the current economic environment. Maintaining the number of participants and marketing were also frequently mentioned as challenges for ADS centers. This may be indicative of the fact that ADS continue to struggle with educating the public as well as other health and social service professionals about who they are and what services they provide. In 2002, ADS centers identified many of the same concerns. However, concerns about recruiting, training, and retaining qualified staff seems to have decreased since that time. ADS may be doing a better job at staff recruitment and retention. The following future challenges for ADS were identified:

- Funding/Financial Concerns
- Meeting the Projected Needs of Future Participants
- Facilities and Physical Space of the Center

Funding/financial concerns were projected to be the most significant concern to ADS providers in the next 10 years. As with any business providing health and social services, these concerns are rational. Providers seemed optimistic about the number of individuals they will be serving as the Baby Boomers move into old age. However, they also appear to be concerned about the acuity and case mix of participants and the limitations of their facilities and physical space.

Implications

The findings from the MetLife National Study of Adult Day Services provide a wealth of up-to-date information for consumers, adult day services providers, policymakers, and researchers. By comparing the data in this study to that collected in 2002, we can begin to understand and project trends in ADS. This information is critical as the Baby Boomer generation ages and we continue to look for cost-effective mechanisms to support independent living for individuals with functional limitations. Projected trends in service need and use enable us to plan for the future and to ensure that ADS are properly positioned to meet the needs of a changing society.

Adult Day Services Consumers — Individuals and Family Caregivers

- ADS can help maintain independent living through the provision of cost-effective, community-based care that includes a full day of health services and supervision, assistance with daily living, and stimulating activity.
- Participants and their families can expect person-centered, individualized care in an interactive group setting.
- ADS allow working caregivers to attend to job responsibilities with the comfort of knowing their family member is in a professionally staffed, supportive group program.
- Caregivers are provided with respite — a break from caregiving responsibilities — and support and education from professionally trained staff.
- For individuals who have long-term care insurance policies that cover ADS, it can serve as a less costly solution that will help to efficiently use the maximum benefits available under their plan.

Adult Day Services Providers

- It is essential for ADS providers to understand the dynamic evolution of ADS — larger centers, higher levels of staff training, shifts in organizational structure, dynamic nature of funding — in order to effectively respond to the changing needs of society.
- Higher levels of acuity and chronic illness in ADS participants will require additional and more sophisticated health care services to meet complex care needs.
- To maintain economic viability, it is critical for ADS providers to understand and to advocate for new funding sources as community-based care evolves with health care reform. Diversification in funding is also an important goal, as unpredictability persists in ADS funding, particularly on the state level.
- There is a continued need to market ADS services to the community and to other key players in the long-term care network, such as hospital discharge planners.
- ADS providers must prepare for and anticipate trends in service usage with the aging of the Baby Boomer generation — a time of great opportunity and challenge.

Employers

- ADS can benefit employees who are caregivers with a viable work/life solution that can result in a more productive and satisfied workforce.

Policymakers

- There is a pressing need to educate the public and decision-makers on the function of ADS and the potential that ADS have in delivering cost-effective health and long-term care services.
- With changes in the funding for Home- and Community-Based Services (HCBS), ADS need to be recognized as a major provider of care and included in the options available to individuals and their families.
- The Centers for Medicare and Medicaid Innovations Center should explore the role of ADS as it charts out its recommendations for the future of Medicare and Medicaid.

- ADS can serve as a “preferred service platform” for community-based care for conditions such as Alzheimer’s disease and for transitional care and short-term rehabilitation following hospitalization.
- ADS organizations would benefit from increasing and improving policy efforts on the state and national levels. This includes establishing and strengthening partnerships with other groups (e.g., AARP, The Council on Developmental Disabilities) in an effort to market and promote the capabilities of ADS.
- A recognition of the support ADS provide to family caregivers and its relationship to the goals of National Family Caregiver Support program should be considered as part of the 2011 Older Americans Act renewal.

Researchers

- Research that compares long-term care services, such as assisted living and home health care, needs to be developed to understand the cost-effectiveness of ADS within the spectrum of long-term care options.
- There is a critical need for outcome-based research to establish the effectiveness and efficacy of ADS in supporting quality of life for individuals and families. For instance, research that examines the impact of ADS on delaying nursing home placement and the effectiveness of ADS in providing transitional care following hospitalization.
- Evaluative studies on the programs and interventions offered in ADS are needed to provide a foundation of evidence-based “best practices” in areas such as diabetes care and dementia — diseases and conditions that are costly for individuals, families, and our society. It is important that best practices and successful interventions are documented, disseminated, and instituted across centers.
- Researchers need to give ADS providers accurate projections of future needs as the Baby Boomer generation matures. Anticipating the future will allow ADS to position and retool itself as the needs, expectations, and desires of our society change with time.

Endnotes

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