Understanding Satisfaction Among Older Adults Using Long-Term Services and Supports

by

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Paying for long-term services and supports (LTSS) continues to be one of the great financial risks facing Americans during retirement. Discussions regarding LTSS often center on the cost of services, both from the family’s perspective and the health care service delivery perspective. This is always an important issue and one that deserves focus. However, an issue of equal importance is how families and individuals experience and evaluate their satisfaction with these services, both at the outset of needing care and as they continue to use services over time.

There is an increased public policy focus on person-centered care and identifying the means for improving the quality of life and satisfaction for those needing and using LTSS. To develop effective strategies to meet these goals, it is important to understand what factors are associated with a feeling of satisfaction with LTSS. This brief will focus on whether or not people using LTSS are satisfied and remain so over time, as well as what independent factors are related to satisfaction. A better understanding of what is important to people using services will help providers focus on those elements of the total care experience that individuals and their families care about most.

Undoubtedly issues of cost and affordability of services are inextricably linked to levels of quality, hence, satisfaction. Thus, when people are constrained by cost in their choice of service provider, it confounds a true understanding of the factors associated with satisfaction at both a point in time and over time. To overcome this, we employed a unique dataset focused on the experience and opinions of private long-term care insurance policyholders at the time that they began using LTSS. Because these individuals were insured for these services and faced little to no cost, we are able to isolate what lies behind their sense of satisfaction by separating satisfaction from the ability to pay for services. These data were collected under the auspice of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy at the Department of Health and Human Services between 2004 and 2008. This brief is part of a larger paper that discusses satisfaction with LTSS across the continuum of care.

**Satisfaction is high at the outset of LTSS service use**

Individuals were asked how satisfied they were with their current provider/paid caregiver shortly after they made the decision to begin using care (within 4 months of paid LTSS use). Typically, this is a time when the need for services is most acute. For

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1 LTC insurance typically pays for 100% of home care and assisted living care and about 70% of nursing home care.
3 For a more detailed description of the larger study, please see the following resources: [http://www.thescanfoundation.org/lifeplans-satisfaction-long-term-services-and-supports-across-continuum-care](http://www.thescanfoundation.org/lifeplans-satisfaction-long-term-services-and-supports-across-continuum-care)
many, this was the first time that they were receiving paid services and many had been receiving family care for an extended period before accessing the formal LTSS system.

Figure 1: Satisfaction at the Beginning of Paid LTSS use

More than three-quarters of respondents stated that they were very satisfied with their current provider at the outset of their service use. When we looked at responses by service location, it showed that roughly four-in-five who were receiving paid LTSS at home and in assisted living reported that they were very satisfied, while a significantly lower proportion of new nursing home residents (62%) reported this level of satisfaction.

Satisfaction declines over time

Many older adults can expect to use LTSS for more than two years and one cannot assume that satisfaction remains constant over the course of service use. As people age, their needs and desires may change. The care that leads to high levels of satisfaction at the outset of service use may not be sufficient as time goes on. Our research shows that satisfaction levels with service providers do trend downward over time and that this trend holds true for all service locations. Each survey point represents roughly a 4-month time frame indicating that at the end of a 1-year period, those reporting that they are very satisfied with their LTSS care provider dropped to less than half.
What are the independent effects of different characteristics on satisfaction with LTSS?

Many things can influence whether or not someone is satisfied with care. Perhaps disability level influences satisfaction. In order to understand the independent effect of different characteristics that influence satisfaction, we use Generalized Estimating Equations (GEE) to analyze longitudinal data in which response variables are collected for the same subjects across time.\(^4\)

By definition, using LTSS is an on-going experience and very different from that of an acute care episode. Although it appears that satisfaction declines over time, we posited that this could be due to the worsening of an individual’s health situation and/or that their increased need was not being addressed adequately by the caregiver. The GEE analysis allows us to untangle these effects and capture the independent impact of each of the important characteristics of the individual and the nature of care on the probability of being satisfied. Table 1 shows the relationship between a variety of independent factors and the likelihood of being satisfied with LTSS with statistically significant variables bolded. For this model, we used a cut off of p=.10 for the significance test because we believe that understanding what at least 90% of the older adults in this sample associate with high satisfaction is sufficiently significant to warrant attention.

Our analysis shows that even when controlling for a variety of variables that could influence satisfaction, LTSS satisfaction declines over time. Clearly, the decision to use paid LTSS is related to meeting a need that cannot be met with unpaid caregivers alone, if at all. The primary and most important role of a paid caregiver is to meet the needs of the individual. How the term “need” is thought of is typically in the curative sense -- what the doctor or provider thinks they must do to cure an illness. However, when it comes to LTSS, the concept of “need” is much broader and has much greater dimensionality. It is not confined to a definition of whether in a “technical sense” one believes that they are being “cured,” hence their needs are met. Instead, the term may be best understood from a person or family-centered perspective.

The concept of “need” can include feeling safe, having a say in schedules and decisions, having privacy when it is desired, feeling comfortable with and trusting the caregiver or service provider staff. When such needs are not met, this may lead to dissatisfaction with care – regardless of whether the care is technically proficient. In fact, when we included the self-reported measure of “needs being met” in our model, it turned out that it was the single most important explanatory variable related to the probability of being satisfied with a caregiver. In cases where there is no unmet need, individuals tend to be very satisfied with their caregiver.
Not surprisingly, older adults receiving care at home are more likely to be satisfied and remain satisfied with their caregivers compared to those residing in assisted living facilities – also a potentially home-like setting. Nursing home residents are less satisfied than assisted living facility residents – which empirically supports the notion that greater satisfaction is experienced in home and home-like settings.

When people begin using services, they may be trying to maximize certain preferences and values related to their service choices. As part of the study, we asked individuals to rank among a list of five value statements, which were most important to them. Along with the percentage of respondents that ranked a particular value as most important, the five items included:

1. Having someone available to assist me when I need them (53%);
2. Feeling safe where I am (28%);
3. Having control over my own schedule/daily routines (8%),
4. Maintaining personal privacy (7%); and;
5. Being around peers and acquaintances (4%).

We included an individual’s ranking of these values as one of the characteristics in the analysis and only one of them was related to a person’s satisfaction. Having someone nearby to help when needed was related to being satisfied, but only for the sub-sample of individuals with cognitive impairment. When this is the most important value, there is an increased chance of being very satisfied with the service provider. Given that cognitively impaired individuals are more likely to require stand-by and queuing assistance -- rather than actual physical assistance for ADL loss – this is expected. For the cognitively intact, the mere presence of a caregiver is not as important as having someone actually providing the care, and this is reflected in the findings.

The extent to which the individual was involved in the actual decision-making about the specific provider had no subsequent effect on whether or not they were satisfied with the provision of care. This is true even in cases where the care setting was not the first choice of the individual. As well, whether or not the individual went to the effort of obtaining information on the caregiver, compared costs among different providers, or even interviewed caregivers did not affect their ultimate evaluation of the care provider. This suggests that the factors associated with how the decision around provider setting and choice is made do not meaningfully influence the evaluation of care once it commences.


6 Cognitively impaired individuals were not interviewed directly, but questions were asked of family members.
However, when cost was an important consideration in the decision to use paid care, it had a negative impact on the probability of being satisfied. At the time of these interviews, the average monthly costs of care nationally were $5,561 for nursing home care, $2,653 for assisted living and $3,601 for home care. When cost is an important consideration in the choice of care, individuals are less likely to be satisfied, which suggests that they are evaluating satisfaction in a relative not absolute sense. That is, they are not asking the question “…am I satisfied or not” but rather, “…am I satisfied relative to what I am paying?” This is a qualitatively different evaluation and the findings presented here suggest that the cost-conscious are less satisfied, even in the presence of significant private insurance coverage for care in these alternative settings (A typical long-term care insurance policy will cover 100% of home care and assisted living costs and about 70% of nursing home costs.) The fact that these individuals may be more conscious about cost may have led them to choose lower cost providers. To the extent that lower cost is associated with lower quality, this may have resulted in lower levels of satisfaction.

Fewer than one-in-five individuals used a care manager to assist in organizing services. However, for those who did, there are two surprising results. First, when a care manager is used, there appears to be a lower likelihood of being satisfied with services. On the other hand, when this variable is interacted with time, there is a positive and significant relationship. This suggests that when people use a care manager, they may start out being less satisfied with services, but over time the chance of being satisfied increases. At the time of service initiation, there is often a general reluctance to have to rely on formal (paid) caregivers to assist with daily activities. The job of a care manager is to actually get services in place as quickly as possible to assure that the acute physical and medical needs of the individual are met. Thus, there may be an associated negative sense about both the care manager and the initiation of services that dissipates over time, especially as the care manager takes on a continued advocacy role for the individual and becomes more familiar with what is important to them on a personal level.

The nurses conducting the interviews were asked in the interview protocol to give their assessment as to whether the individual was expected to improve, stay the same or deteriorate. We hypothesized that here too there would be an impact on whether people


are ultimately satisfied with their service providers. In fact, the variable is significantly related to the probability of being very satisfied, but not in the way one would have expected. Individuals whose health is predicted to worsen are more likely to be satisfied with their service providers than are those who are predicted to improve or stay the same. A possible explanation for this is that during a period of general decline, for which there is a diminishing chance of recovery, people are less likely to hold their caregivers to the same standard as might be the case when there is a chance of real improvement. That is, there may be a different standard in place when care is more palliative or maintenance-oriented rather than curative. It also may reflect that fact that the worse someone becomes, the more care they receive and the more attention is paid to their emotional needs as well as physical comfort. Individuals who are expected to deteriorate (and, in fact, prior analysis shows that there is a high rate of mortality for this group so many might be experiencing end-of-life care) may receive more emotional care in addition to physical assistance, meaning there may be more focus on other dimensions of care that results in a higher prevalence of satisfaction.

Lastly, we focused on whether or not the presence of unpaid and paid caregivers working in concert would have an effect on satisfaction with the latter. Our analysis showed that when there are unpaid caregivers, there is a lower likelihood of satisfaction with the paid caregiver. For the most part, unpaid caregivers are spouses, children, or other relatives. Given the highly personal nature of the services that are provided – assistance with personal care activities, companionship and assistance with other daily activities such as shopping and paying bills – perhaps it is expected that care receivers would be less satisfied with paid caregivers, in a relative sense. That is, the comparison being made is with family caregivers. We suggest that this finding supports the importance of focusing on the dimensions of quality from the individual and family perspective. Family caregivers are more likely to listen, focus on the individual’s emotional needs, and have a level of trust and comfort with the individual – none of which are necessarily related to providing physical assistance. While it is important that the paid caregivers are trained and able to meet the daily physical needs of an individual, the result here would indicate that those who also have their interpersonal needs met experience greater satisfaction.

**Conclusion**

Understanding the concept of satisfaction with LTSS is a complicated undertaking. Not only are there many different ways to measure satisfaction, but there are many diverse dimensions to understanding what makes the care that someone receives satisfactory. Through the use of this unique longitudinal dataset we have shown that while people tend to be very satisfied with their LTSS providers when they commence their care, this satisfaction decreases over time. Moreover, this pattern occurs regardless of where one receives care. While one might assume that health status, age, marital status and other socio-demographic factors would be important to understanding whether one is satisfied with paid caregivers, such is not the case. In fact, the presence of unmet need,
receiving care at home (compared to assisted living), cost consciousness, use of a care manager, and the expected trajectory of decline or recovery are most important to understanding why some people are satisfied with their caregivers and others are not.

Knowing that across all LTSS settings satisfaction with providers tends to decrease over time, what are the actions that could be taken to counteract this decline? One strategy is to conduct more frequent reassessment of the care receiver’s needs, both technical and emotional. This would ensure the appropriate level and type of care is being provided and would guard against unmet need by helping the provider and care receiver understand changes not only in disability status or medical condition, but also changes in expectations about other dimensions related to care that lead to satisfaction.

While the concept of satisfaction is multi-faceted, our analysis indicates that in broad terms what people are focused on in the evaluation of caregiver satisfaction are not only the technical skills of the caregiver, but also the nature of the relationship formed with the provider. In a companion brief, entitled “Understanding the Dimensions of Satisfaction with Long Term Services and Supports,” we continue the discussion of the dimensions of satisfaction from the perspective of older adults using LTSS.

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