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End-Of-Life Care Planning and Bereavement Practices Among Adult Day Services Centers, 2018

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Abstract

Introduction: This study describes the end-of-life (EOL) care planning and bereavement practices among adult day services centers (ADSC) when an ADSC participant is dying or has died.

Methods: Data are from the 2018 National Study of Long-term Care Providers' biennial survey of ADSCs. Respondents were asked about the following 4 practices: 1) honoring the deceased in some public way in this center; 2) offering bereavement services to staff and participants; 3) documenting in the care plan what is important to the individual at the end of life (EOL), such as the presence of family or religious or cultural practices; and 4) discussing spiritual needs at care planning conferences. ADSC characteristics included US Census region, metropolitan statistical area status, Medicaid authorization, electronic health records (EHR) use, for-profit status, employment of aides, services provision, and model type.

Results: About 50% to 30% of ADSCs offered the EOL care planning or bereavement services. Honoring the deceased was the most common practice (53%), followed by bereavement services (37%), discussing spiritual needs (29%), and documenting what is important at EOL (28%). Fewer ADSCs in the West had EOL practices relative to the other regions. The EOL planning and bereavement practices were offered more often in ADSCs that used EHRs, accepted Medicaid, employed an aide, provided nursing, hospice, and palliative care services, and were categorized as medical models, compared with ADSCs without these characteristics.

Conclusion: These results highlight the importance of understanding how ADSCs provide EOL and bereavement care to participants who are near EOL.

Keywords

end-of-life; adult day services centers; home- and community-based services; bereavement care; national study of long-term care providers; long-term care

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Declaration of Conflicting Interests

The authors declare that there are no conflicts of interest.

Disclaimer

The findings and conclusions in this paper are those of the authors and do not necessarily represent the official position of the National Center for Health Statistics, Centers for Disease Control and Prevention.

Introduction

Adult day services centers (ADSCs) are key home- and community-based services (HCBS) providers that offer services to adults with disabilities and chronic conditions to improve quality of life and reduce hospitalizations and institutionalization.[1] They serve over 251,000 participants, representing 2.6% of long-term care recipients.[2] ADSCs are not often thought of as serving adults near end of life (EOL), but previous research shows they provide advance care planning and hospice services.[2-4] End-of-life care planning involves decision-making among the individual, family, and care providers about their expectations for medical care and preferences for psychosocial, cultural, or spiritual support near EOL. Research in nursing homes has shown that having staff who engaged in discussions about palliative care and EOL preferences, improved well-being and satisfaction of residents.[5] Few studies have investigated EOL care practices within HCBSs, such as ADSCs.

Many ADSCs serve adults near EOL and participate in EOL planning. Almost 13% of ADSCs, either directly or through arrangement with other organizations, provide hospice services.[2] Approximately 80% of ADSCs provide information or document advance directives in participants' files and 41% of participants have an advance directive on file.[3,4] Further, 60% of ADSCs always/often provided participants and family members opportunities to express their EOL preferences.[6]

Little information exists about EOL practices beyond providing information and documenting advance directives. Spiritual, psychosocial, and bereavement care services are considered important aspects of quality EOL care.[7,8] Spiritual care is less commonly addressed by nurses and physicians providing EOL care, despite patients, family, and care providers expressing its importance at EOL.[9,10] The provision of bereavement services has been shown to be an important aspect of EOL care in 2 ways: by providing comfort to persons knowing there will be ongoing investment and support for their bereaved family and community members; and the opportunity for providers to assess patients' quality of care via bereaved family members' perspectives.[11] ADSCs focus on psychosocial, recreational, and social services for participants and serve a diverse population,[2,12,13] thus provide an environment for EOL care planning among adults who may otherwise not have access to EOL care in other settings.

The purpose of this study is to describe the prevalence of psychosocial and spiritual EOL care planning practices when an ADSC participant is dying and bereavement practices when a participant has died. This paper also examines whether these practices differed by key policy-relevant organizational characteristics of ADSCs, including US Census region, metropolitan statistical area status, Medicaid authorization, electronic health records (EHR) use, chain status, for-profit status, employment of aides, and provision of nursing, social work, hospice, and palliative care services.

Methods

Data Source

This study uses a nationally representative sample of ADSCs from the 2018 National Study of Long-term Care Providers (NSLTCP), the latest available data on this topic collected from July 2018 to February 2019.[14] To be eligible for the study, ADSCs had to 1) be licensed or certified by the state specifically to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), or authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care), or part of a Program of All-Inclusive Center for the Elderly (PACE); 2) have 1 or more average daily attendance of participants based on a typical week; and 3) have 1 or more participants enrolled at the ADSC at the location at the time of the survey. Data were collected via a mail, web, or telephone provider questionnaire. Of the 1367 eligible and presumed eligible ADSCs sampled, 672 completed the questionnaire, for a weighted response rate of 50%, after accounting for differential probabilities of selection, representing an estimated national total of 4200 ADSCs. More details on the 2018 NSLTCP questionnaire, survey methods, and public use files can be found here: https://www.cdc.gov/nchs/npals/questionnaires.htm.

Measures

EOL planning and bereavement practices items were adapted from the Palliative Care Survey,[15,16] designed to measure palliative care practices and knowledge among nursing home staff. The items ask respondents to indicate how often the ADSC engages in the following practices when a participant is dying or has died: 1) honor the deceased in some public way in this center; 2) offer bereavement services to staff and participants; 3) discuss spiritual needs at care planning conferences; and 4) document in the care plan what is important to the individual at the EOL, such as the presence of family or religious or cultural practices. The items had 5 response options including always, often, sometimes, rarely, and don’t know. These categories were collapsed into 3 categories: always and often, sometimes and rarely, and don’t know.

ADSC characteristics included US Census region (Northeast, Midwest, South, and West), metropolitan statistical area status, ADSC size (1-25, 26-100, 101 + enrolled participants), ownership type (for profit and nonprofit), chain status, use of electronic health records (EHRs), and Medicaid authorization. Selected services (skilled nursing, social work, hospice, and palliative care) were examined by how they were provided: by an ADSC employee or by arrangement with an outside provider, by referral only, or not provided at all. Aide staffing was measured by whether or not the ADSC had at least 1 full-time equivalent aide employee. Model type was measured by asking which best describes the needs that the services of the ADSC are designed to meet and categories were collapsed to indicate medical model ADSCs (equally social/recreational and health/medical; primarily health/medical; and only health/medical needs) and social model ADSCs (primarily social/recreational and only social/recreational).

Analyses

Data analyses were performed using both SAS version 9.3/SAS-callable SUDAAN version 11.0.0 statistical package[17] and StataSE 17.[18] Differences in each of the 4 practices by characteristics were evaluated using two-sided t-tests with $P < .05$ as the level of significance. The results section highlights only selected statistically significant findings on practices from Table 1, offering bereavement services and documenting what is important at EOL, because patterns of findings were similar across all 4 practices. Results for honoring the deceased and discussing spiritual needs are found in Table 2. Several estimates are suppressed to maintain confidentiality or because they are considered unreliable according to NCHS's guidelines for proportions.[19] Fewer than 5% of cases were missing data for any of the variables and were excluded from analyses on a variable-by-variable basis.

Results

EOL Planning and Bereavement Practices Overall

Honoring the deceased in a public way was the most common practice (38.0% always and 15.0% often), followed by offering bereavement services (26.0% always and 11.0% often), discussing spiritual needs at care planning conferences (18.8% always and 9.9% often), and documenting what is important at EOL (20.6% always and 7.5% often) (Figure 1. Tables 1 and 2). About 22% of ADSCs rarely honored the deceased, 33% rarely offered bereavement services, and about 40% rarely discussed spiritual needs or documented what is important at EOL. About 7% of ADSCs reported they did not know if the center honored a deceased participant, followed by 10% for offering bereavement services, 15% for discussing spiritual needs, and 16% for documenting what is important at EOL.

EOL Planning and Bereavement Practices by ADSC Characteristics

EOL and bereavement practices among ADSCs varied by region (Table 1). A lower percentage of ADSCs in the West always or often honored deceased participants (42.7%), discussed spiritual needs (16.0%), and documented what is important at EOL (17.5%), than in other regions. A higher percentage of ADSCs in the Northeast always or often offered bereavement services (44.4%) than in the West (33.9%).

Overall, more ADSCs that were authorized to participate in Medicaid always or often had EOL and bereavement practices, compared with non-Medicaid authorized ADSCs (Table 1). For example, almost 50% of Medicaid-authorized ADSCs always or often offered bereavement services, compared with nearly 30% of non-Medicaid authorized ADSCs. Just over 30% of Medicaid-authorized ADSCs always or often documented what is important at EOL, compared with 20.3% of non-Medicaid authorized ADSCs. Similarly, a greater percentage of ADSCs that used EHRs always or often had EOL and bereavement practices, compared to ADSCs without EHRs. Almost 46% of ADSCs with EHRs always or often offered bereavement services, compared to 33.2% of ADSCs without EHRs. Just over 35% of ADSCs with EHRs always or often documented what is important at EOL, compared with nearly 25% of ADSCs without EHRs.

In terms of staffing, employing at least 1 aide was associated with always or often having the EOL and bereavement practices (Table 1). Just over 40% of ADSCs that employed aides always or often offered bereavement services, compared with 28.8% of ADSCs without aides. Just over 34% of ADSCs that employed aides always or often documented what is important at EOL, compared with 14.7% of ADSCs without aides. A higher percentage of ADSCs without aide employees did not know if their ADSC offered bereavement services (20.3%) and whether their ADSC documented what is important at EOL (32.2%) than ADSCs with aides (5.3% and 8.6%, respectively).

In general, ADSCs that provided nursing, social work, hospice, and palliative care services using employees or by arrangement, were more likely to offer the EOL practices, compared with ADSCs that referred only or did not provide these services (Table 1). For example, approximately 60% of ADSCs that provided hospice services using employees or by arrangement always or often offered bereavement services (57.2%) and always or often documented what is important at EOL (58.7%). However, when ADSCs referred to hospice, just over one-third always or often offered bereavement services (39.2%) and slightly less than one-third always or often documented what is important at EOL (31.2%).

Overall, a higher percentage of medical model ADSCs had the EOL and bereavement practices than social model ADSCs. Over 47% of medical model ADSCs always or often offered bereavement services, compared to 25.8% of social model ADSCs. Similarly, more medical model ADSCs always or often documented what is important at EOL (40.6%) than social model ADSCs (14.5%). A higher percentage of social model ADSCs did not know about their ADSC's bereavement (16.3%) and EOL (26.0%) practices than medical model ADSCs (4.9% and 7.8%, respectively).

Discussion

Quality EOL care includes addressing the spiritual, psychosocial, and bereavement needs of individuals and their loved ones, along with medical and health-related preferences, as outlined in clinical practice guidelines and previous research.[7,8] Many people who use HCBS, such as ADSCs, need EOL care and opportunities to discuss EOL preferences with their care providers. This study finds that EOL care planning and bereavement services are offered in ADSCs, ranging from 29% discussing spiritual needs to 53% honoring a deceased participant. Of note, however, the majority of ADSCs reported only sometimes or rarely engaging in 3 of the 4 practices. The 2 bereavement care practices were more common among ADSCs than the 2 EOL care planning practices.

A lower percentage of ADSCs in the West had EOL care planning practices relative to other regions. In general, Medicaid-authorization, EHR use, employing at least 1 aide, providing nursing, hospice, or palliative care services, and medical model ADSCs were associated with always or often having EOL practices. All of these characteristics were also found in previous research to be associated with ADSCs that serve participants with more medical and health needs.[10] Taken together, these findings suggest that ADSCs serving participants with greater medical needs may have these EOL practices. There were few statistically significant differences between ADSCs that had EOL planning and bereavement practices

and those that sometimes or rarely had such practices by chain and for-profit status, size, or by metropolitan statistical areas.

Prior evidence shows that ADSCs are serving participants who are near EOL by offering information about and documenting advance directives and by providing or referring for hospice and palliative care services.[2,4,5] This study further demonstrates that about one-third typically engage in psychosocial, spiritual, and bereavement care for participants at EOL, with variation by region, organizational characteristics, and services. These results highlight the importance of understanding how ADSCs are providing EOL care and the prevalence of participants who are near EOL with access to these practices.

Limitations

Some respondents reported they did not know about the EOL or bereavement practices in their ADSCs (ranging from 7.2 to 16.4%, as shown in Figure 1), and it is difficult to interpret this response. While NSLTCP intends to administer the questionnaire to the director/owner or administrator, some ADSCs may opt to have a proxy staff member complete the survey who may not be knowledgeable about their center's EOL practices. This study uses a nationally representative sample of ADSCs and complex survey weights to adjust for non-response bias; however, some nonresponse biases may not be accounted for. The survey is provider-focused and does not describe the prevalence of participants near EOL or the impact of these practices on quality of EOL care. Finally, this is a cross-sectional study and associations did not control for confounding variables or examine temporal changes, thus inferences about causality should not be drawn.

Conclusions

In 2018, approximately 1 third of ADSCs always or often provided psychosocial and spiritual EOL care planning and offered bereavement services, while 53% honored deceased participant in some way. However, as many as 16% reported they did not know if their ADSC had the practices. ADSCs that were Medicaid authorized, used EHRs, employed at least 1 aide, and provided nursing, hospice, and palliative care services were more likely to always or often have the EOL and bereavement practices than ADSCs without the above characteristics. In addition, compared to social model ADSCs, more medical model ADSCs provided the EOL and bereavement practices.

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Data Availability Statement

Data used in this research article may be accessed by contacting the Research Data Center: https://www.cdc.gov/rdc/index.htm

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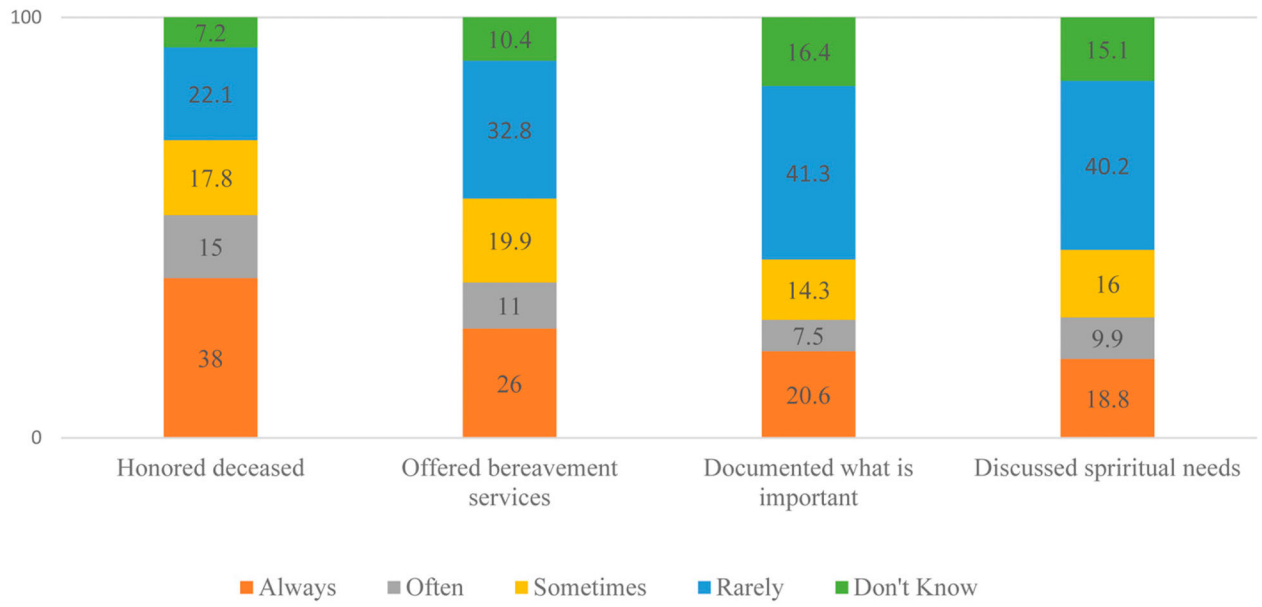

Figure 1.

Percentage of adult day services centers that engaged in end-of-life care and bereavement practices: United States, 2018.

SOURCE: National Center for Health Statistics, National Study of Long-term Care Providers, 2018.

Table 1.

Bereavement Services and Document End-of-Life Care Plan among Adult Day Services Centers, by Center Characteristics, 2018.

	Offer Bereavement Services						Document End-of-Life Care Plan					
	Always or Often		Sometimes or Rarely		Don't Know		Always or Often		Sometimes or Rarely		Don't Know	
	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE
All adult day services centers	37.0	1.8	52.6	1.9	10.4	1.2	28.1	1.7	55.6	1.9	16.4	1.4
US Census region												
Northeast	44.4*	2.9	51.1	2.9	^	^	34.0*	2.8	56.7	2.9	9.2	1.7
Midwest	36.1	4.8	55.6	5.0	^	^	35.6*	4.9	56.2	5.1	^	^
South	36.0	3.5	56.2	3.6	7.9	2.0	31.1*	3.4	56.3	3.7	12.7	2.4
West (referent)	33.9	3.3	48.6	3.5	17.5	2.6	17.5	2.7	53.8	3.5	28.6	3.2
Metropolitan statistical area												
Metropolitan (referent)	36.3	2.0	53.7	2.1	10.0	1.3	26.7	1.8	57.0	2.0	16.3	1.5
Not metropolitan	40.9	5.0	46.5	5.1	12.6	3.2	36.0	5.0	47.1	5.1	16.9	3.7
Size												
1-25 participants (referent)	32.6	3.7	56.5	3.9	10.9	2.5	23.7	3.4	59.2	3.9	17.0	2.9
26-100 participants	38.2	2.4	51.8	2.5	9.9	1.5	31.2	2.3	53.6	2.5	15.2	1.8
101+ participants	38.6	4.3	50.4	4.4	11.0	2.8	23.5	3.6	57.0	4.4	19.4	3.6
Electronic health records												
Used (referent)	45.6	3.4	47.8	3.5	6.7	1.8	35.4	3.3	50.0	3.5	14.6	2.5
Did not use	33.2*	2.2	55.0	2.3	11.8*	1.5	24.7*	2.0	58.2	2.3	17.1	1.7
Ownership status												
For profit (referent)	36.8	2.9	52.9	3.0	10.2	1.9	29.1	2.8	55.4	3.0	15.5	2.2
Nonprofit	37.3	2.4	52.1	2.5	10.5	1.5	27.5	2.2	55.4	2.5	17.2	1.9
Chain status												
Chain (referent)	38.5	2.8	48.4	2.9	13.1	2.0	30.4	2.6	50.1	2.9	19.6	2.3
Not a chain	36.2	2.4	55.5	2.5	8.4	1.4	26.5	2.2	59.4*	2.5	14.2	1.8
Medicaid authorization												
Medicaid authorized (referent)	39.3	2.1	52.1	2.2	8.6	1.2	30.5	2.0	56.7	2.2	12.8	1.5
Not medicaid authorized	29.8*	3.6	54.3	3.9	15.9*	2.9	20.3*	3.2	52.1	4.0	27.6*	3.5

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	Offer Bereavement Services						Document End-of-Life Care Plan					
	Always or Often		Sometimes or Rarely		Don't Know		Always or Often		Sometimes or Rarely		Don't Know	
	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE
Employs at least 1 aide												
Yes (referent)	41.0	2.3	53.7	2.3	5.3	1.0	34.4	2.2	56.9	2.3	8.6	1.3
No	28.8*	3.1	50.9	3.4	20.3*	2.8	14.7*	2.4	53.1	3.5	32.2*	3.2
Nursing services												
By employee or arrangement (referent)	43.9	2.4	47.9	2.4	8.2	1.4	35.4	2.3	53.6	2.4	11.0	1.5
Referral only	^	^	^	^	^	^	^	^	^	^	^	^
Does not provide	23.4*	3.1	59.1*	3.6	17.5*	2.8	10.5*	2.3	57.7	3.7	31.8*	3.4
Social work services												
By employee or arrangement (referent)	44.4	2.6	48.9	2.6	6.7	1.3	37.3	2.5	51.5	2.6	11.2	1.7
Referral only	29.7*	3.9	62.6*	4.1	7.7	2.2	20.3*	3.4	64.3*	4.1	15.4	3.0
Does not provide	29.3*	3.3	51.6	3.7	19.1*	2.9	17.2*	2.8	56.1	3.7	26.8*	3.2
Hospice services												
By employee or arrangement (referent)	57.2	5.1	35.6	4.9	7.2	2.7	60.5	5.0	33.0	4.8	^	^
Referral only	39.2*	3.0	56.0*	3.1	4.8	1.4	31.2*	2.9	58.7*	3.1	10.1*	1.9
Does not provide	29.9*	2.5	54.6*	2.7	15.5*	2.0	17.0*	2.1	59.1*	2.7	23.9*	2.3
Palliative care services												
By employee or arrangement (referent)	50.3	3.0	41.3	2.9	8.4	1.7	42.3	3.0	46.1	3.0	11.6	2.0
Referral only	35.3*	3.9	58.6*	4.0	6.0	1.9	29.7*	3.7	62.5*	4.0	7.8	2.2
Does not provide	24.5*	2.7	60.7*	3.0	14.8*	2.2	12.6*	2.1	61.2*	3.1	26.2*	2.7
Model type												
Social model (referent)	25.8	2.4	57.8	2.7	16.3	2.1	14.5	2.0	59.6	2.7	26.0	2.4
Medical model	47.5*	2.6	47.5*	2.6	4.9*	1.2	40.6*	2.6	51.6	2.6	7.8*	1.5

SE = standard error. *Difference between this characteristic and the referent characteristic is statistically significant at P < .05. ^Estimate is not presented because it does not meet National Center for Health Statistics standards for confidentiality or reliability of proportions. SOURCE: National Center for Health Statistics, National Study of Long-term Care Providers, 2018.

Table 2.

Honoring Deceased and Discussing Spiritual Needs among Adult Day Services Centers, by Center Characteristics, 2018.

	Honor Deceased						Discuss Spiritual Needs					
	Always or Often		Sometimes or Rarely		Don't Know		Always or Often		Sometimes or Rarely		Don't Know	
	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE
All adult day services centers	53.0	1.9	39.9	1.9	7.2	1.0	28.7	1.7	56.2	1.9	15.1	1.3
US Census region												
Northeast	54.5*	2.9	41.7	2.9	^	^	33.5*	2.8	58.3	2.9	8.2	1.6
Midwest	58.4*	5.0	37.9	4.9	^	^	34.6*	4.9	58.6	5.0	^	^
South	59.5*	3.6	36.9	3.5	^	^	35.3*	3.5	54.0	3.7	10.7	2.3
West (referent)	42.7	3.5	42.7	3.5	^	^	16.0	2.6	56.2	3.5	27.9	3.1
Metropolitan statistical area												
Metropolitan (referent)	52.6	2.0	40.1	2.0	7.3	1.1	28.0	1.8	57.0	2.0	15.0	1.5
Not metropolitan	55.5	5.0	38.4	4.9	^	^	32.7	4.9	51.5	5.1	15.8	3.6
Size												
1-25 participants (referent)	47.2	3.9	45.7	3.9	7.1	2.0	24.6	3.4	59.3	3.9	16.1	2.9
26-100 participants	54.8	2.5	39.1	2.4	6.1	1.2	31.6	2.3	54.3	2.5	14.1	1.7
101+ participants	54.5	4.4	35.0	4.3	10.4	2.7	24.6	3.8	58.5	4.4	17.0	3.4
Electronic health records												
Used (referent)	61.6	3.4	30.8	3.2	7.6	1.9	35.1	3.3	50.6	3.5	14.3	2.5
Did not use	49.2*	2.3	44.0*	2.3	6.8	1.2	25.7*	2.0	58.9*	2.3	15.4	1.7
Ownership status												
For profit (referent)	58.0	3.0	35.4	2.9	6.6	1.5	29.1	2.8	57.3	3.0	13.6	2.1
Nonprofit	49.8*	2.5	42.7	2.5	7.6	1.3	28.2	2.2	55.5	2.5	16.3	1.8
Chain status												
Chain (referent)	53.4	2.9	37.3	2.8	9.3	1.7	26.0	2.5	57.1	2.9	16.9	2.2
Not a chain	53.0	2.5	41.4	2.5	5.6	1.2	30.2	2.3	56.0	2.5	13.8	1.8
Medicaid authorization												
Medicaid authorized (referent)	56.2	2.2	38.4	2.1	5.4	1.0	31.1	2.0	57.6	2.2	11.3	1.4
Not medicaid authorized	42.9*	3.9	44.5	3.9	12.6*	2.7	21.2*	3.2	52.2	4.0	26.7*	3.5

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	Honor Deceased						Discuss Spiritual Needs					
	Always or Often		Sometimes or Rarely		Don't Know		Always or Often		Sometimes or Rarely		Don't Know	
	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE
Employs at least 1 aide												
Yes (referent)	56.6	2.3	40.2	2.2	3.2	0.8	35.2	2.2	55.9	2.3	8.9	1.3
No	45.8*	3.4	39.4	3.4	14.8*	2.4	15.3*	2.5	57.3	3.4	27.4*	3.0
Nursing services												
By employee or arrangement (referent)	59.3	2.3	35.6	2.3	5.1	1.1	38.0	2.3	52.1	2.4	9.8	1.5
Referral only	^	^	^	^	^	^	^	^	^	^	^	^
Does not provide	39.7*	3.6	47.3*	3.7	13.1*	2.5	8.1*	2.0	63.0*	3.6	28.9*	3.3
Social work services												
By employee or arrangement (referent)	59.7	2.6	34.9	2.5	5.4	1.2	38.9	2.6	50.6	2.6	10.4	1.6
Referral only	43.3*	4.2	50.5*	4.2	^	^	20.6*	3.4	66.3*	4.0	13.1	2.8
Does not provide	48.4*	3.7	40.5	3.6	11.1*	2.4	16.4*	2.8	58.4	3.7	25.2*	3.2
Hospice services												
By employee or arrangement (referent)	^	^	^	^	^	^	52.4	5.1	40.9	5.1	^	^
Referral only	54.2	3.1	42.3	3.1	^	^	35.6*	3.0	55.5*	3.1	8.9	1.8
Does not provide	44.9	2.7	44.2	2.7	10.9	1.7	17.0*	2.1	60.9*	2.7	22.1	2.2
Palliative care services												
By employee or arrangement (referent)	65.8	2.8	27.5	2.7	6.7	1.6	43.0	3.0	46.2	3.0	10.7	1.9
Referral only	^	^	^	^	^	^	33.8	3.9	61.2*	4.0	^	^
Does not provide	40.4*	3.1	48.4*	3.1	11.3	2.0	11.2*	2.0	63.6*	3.0	25.2*	2.7
Model type												
Social model (referent)	42.2	2.8	46.4	2.8	11.4	1.8	14.5	2	61.2	2.7	24.3	2.4
Medical model	63.2*	2.5	33.5*	2.5	3.3*	0.9	40.8*	2.6	52.3*	2.6	6.9*	1.4

SE = standard error. *Difference between this characteristic and the referent characteristic is statistically significant at P < .05. ^Estimate is not presented because it does not meet National Center for Health Statistics standards for confidentiality or reliability of proportions. SOURCE: National Center for Health Statistics, National Study of Long-term Care Providers, 2018.