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Aging in (what) place?
'Holding the line' in residential long term care

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…and what do (and should) we do when we can no longer 'hold the line'?

An applied HSR program in elder care
(context → KT → outcomes)

Nursing home study (TREC)
Context, KT linked to RAI-MDS 2.0 outcomes: pain management, dementia behavior management, falls reduction, and other RAI-MDS 2.0 derived outcomes - in 36 NH's (AB, SK, MB)

Facilitating the Implementation of Research Evidence
Context, KT linked to uptake of continence guidelines in Nursing Homes in five European countries

OPTIC study (Transitions: NH-EMS-EDs in AB & BC)
Context, RAI-MDS 2.0 data linked to transitions (e.g., EMS, ED and return to nursing home times and transition outcomes)

SCOPE study (Quality & Safety in NHs: AB & BC)
Context, KT, change/facilitation/*SHN!* intervention targeting HCAs linked to RAI-MDS 2.0 outcomes (pain, behaviour, skin integrity)

Translating Research in Elder care

Phase II (2007-2012) of a multi-year (2002 to 2022) research program

Facility Based Elder Care (LTC)

Translating research in elder care (TREC)

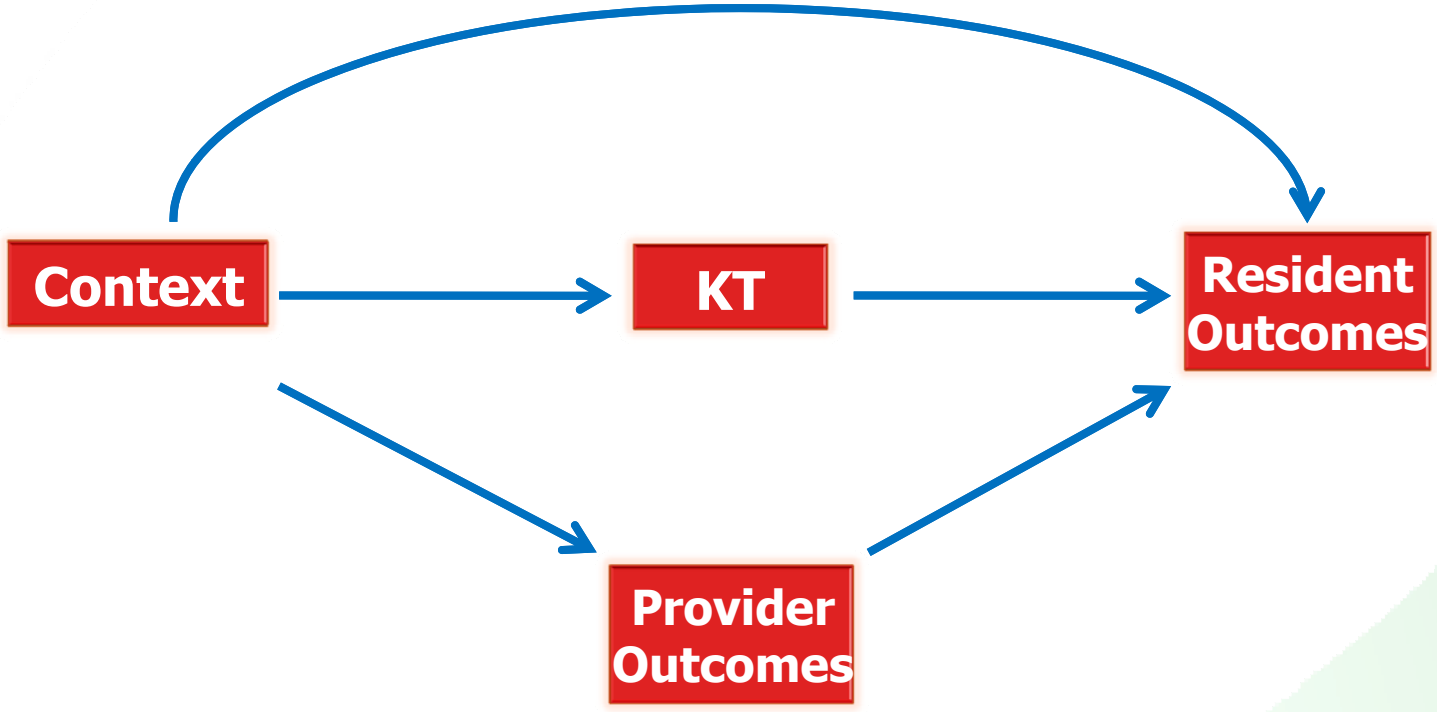
- Multi-method
- Multi-level
- Longitudinal (5 years)
- 3 major inter-related projects:
  - Organizational monitoring system (ACT)
  - Context case studies
  - Series of 3 pilot studies

Purpose: To address the influence of context on the use of best practices and the subsequent influence on resident outcomes (as well as provider and system outcomes)

Data sources:

- Nursing Homes
- Units (microsystem) within NH's
- Care providers (professional, managerial, unregulated)
- Residents (MDS-RAI 2.0)

Hypotheses



Organizational context on QI

- Leadership
- Organizational culture
- Data infrastructure, information systems
- Physician engagement
- Microsystem motivation and leadership
- Resources

Kaplan et al, MBQ, 2010


NASA-S-62-893

Airplanes are flying nursing homes!

What is the problem?

Population aging …

- **January 2011 – the first Canadian baby boomer turned 65**
- **January 2021 – the first boomer is 75**
- **December 31, 2031 the last Canadian boomer will turn 65**

Age related dementia

- With increased longevity comes a dramatic impact on the number of Canadians with Alzheimer's and other age-related dementias (ARD)
- One in three Canadians over 85 now has an age-related dementia
- *Rising Tide* (2009) estimates 1,125,000M people will have an age related dementia by 2038.
- The UK Alzheimer's Trust (2010) reports spending £27,647 per person per year on dementia compared to £5,999 on cancer, £3,455 on heart disease, per person per year
- The 2010 World Alzheimer's report puts it this way:
  - if dementia were a country it would be the world's 18th largest economy
  - if dementia were a company, it would be the world's largest by annual revenues (>$600B) exceeding Wal-Mart ($414B) and Exxon Mobil ($311B)

Age related dementia and LTC

- With longer life + an increase in people with dementia come dramatically increased requirements for residential long-term care (nursing home) and other supportive living environments
- Dementia diagnoses account for up to 80% of admissions to nursing homes
- 70% of all individuals diagnosed with dementia will die in a nursing home
- The current projected increase in care beds inadequate to meet the demand and but we have an ill-designed, fragmented system with which to provide effective and efficient care for these frail older adults

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What is long term care & how are we doing there?

Continuing care system

1. Home care
2. Community support services
3. Supportive/assisted living arrangements
4. Facility-based long term care
    - accommodation
    - hospitality services
    - health services

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Overview

- Canada had 2,216 residences for the aged, which served 205,442 residents and generated approximately $13.1 billion in revenue, at the end of 2008-2009 (StatsCan 2010)

- Conservative projections suggest by 2041 Canada will need 320,000 beds (McGregor & Roland, 2011)

- Other estimates suggest more dramatic increases may be needed, e.g., upwards of 690,000 beds by 2038 (Rising Tide, 2009)

Some features of Canadian LTC

- Facility-based LTC encompasses different services in each province and territory of Canada
- It is not a publicly-insured service under the *Canada Health Act* but is partially insured as extended health care services
- Facility-based LTC is not a fully insured health service in any jurisdiction
- Broad mix of public and private funding, ownership and administration of homes across Canada, includes not-for-profit lay and faith-based homes, government operated homes, and proprietary for-profit operations

- **accommodation rates and comfort allowances vary across Canada, in some provinces, residents pay for more than their accommodation; they also incur personal care expenses**

- **Provincial residency requirements for admission to LTC present obstacles to some in placing frail seniors near their relatives**

- **Inadequate staffing numbers and inappropriate staff mix continue to be a problem in facility-based long term care**

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Despite advances in staff training, organizational culture change and increasing attention on respect for individual dignity – quality of care remains under scrutiny in Canadian LTC facilities

Who lives in LTC* – the Residents

- predominantly women
- lower income
- much older when admitted than previously
- ~80% have a form of dementia
- admitted later in their trajectories
  - and are thus more medically complex and more frail when admitted
  - thus have heavier and more complex personal and care requirements
  - stay much shorter periods of time (many 12 months or less)

*residential care for the elderly

Services – what is and isn't there

- 24/7 hospitality, personal (ADL, social), health related services
- There are trends in some jurisdictions to reduce professional nursing, and other allied care services (e.g., recreational therapists and aides, physiotherapist and PT aides) largely due to costs
- Variable and often limited or no access to some services, e.g., oral health, audiology, ophthalmology, mental health
- Most medical care provided by family physicians using a number of models, for the most part none of them ideal
- Geriatrician, geriatric psychiatry and mental health services limited – despite what we know about prevalence and the importance of appropriate care in these areas

Who provides the direct 24/7 care for the residents

- ~80% of direct care is provided by unregulated care aides*
- We do not know how many care aides there are, we think about 200,000
- There are no (few) mandatory registries and only recently emerging voluntary ones
- Training standards are highly variable across the country and in many cases significantly limited
- The care aide group is:
  - older
  - predominantly women
  - as many as 50% in urban areas are immigrant women
  - as many as 50% in urban areas do not speak English as first language**
  - often working two jobs
  - working for wages that vary from minimum to ~15/hr
  - at the bottom of a rigid hierarchy

*multiple terms are used – PCA, PSW, HCA, NA, etc
**a different issue than is there anyone in the NH who speaks the resident's language

So how are we doing?

AUDITOR GENERAL Alberta

Report of the Auditor General on Seniors Care and Programs (2005)

Auditor General of British Columbia

In Sickness and in Health: Healthy Workplaces for British Columbia's Health Care Workers (2004)

- **Numerous reports …**
- **Many papers …**
- **General consensus that we can and need to do better in the areas of …**
  - **Quality of care**
  - **Quality of work life**
  - **Quality of Life**
  - **Quality of end of life**

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Quality of care areas

- **Preventable adverse events** (e.g., injury falls, pressure ulcers, untreated pain, inappropriate hospitalization….)
- **Undiagnosed and/or inadequately treated mental health conditions**
- **Inappropriate medication practices**
- **Excess disability** (e.g., moving, eating, hearing…)
- **Cultural (in)competence** (Ethnic, religious, gender, sexual orientation, …)
- **Spirituality and end of life care**

The need and the right to move
preventing excess disability
(or "holding the line")

We know that …

- 90% of LTC residents have some type of mobility limitation
- 40% of residents with dementia lose their ability to walk each year
- immobility leads to a loss of ADL's, e.g., toileting and ↑ the risk of serious problems, e.g., pressure ulcers
- when a resident loses the ability to stand up from a chair, the bed, or a toilet, the time and cost for care escalate

We know that …

- extra time required for a transfer often translates to fewer transfers and significant delays in toileting, if toileted at all
- There should be a multi-disciplinary consultation but that requires a functioning system to enable it

Preventing excess disability
a major "know-do gap"

We have known about …

- **the adverse consequences of immobility and bed rest for many years**

- **still however, elderly NH residents commonly sit or lie in bed for long periods of time, in many cases for most of their waking hours**

What solutions have been proposed…

- **Regulation, inspection, public reporting**
- **Health human resource planning at all levels** (recruitment and retention of professionals and unregulated providers, curriculum standards, focus on geriatricians and professional nursing, etc.)
- **Minimum standards for staffing across Canada** (e.g., in US they have identified 4.1 hours of care as a “threshold” level below which quality is affected)
- **Quality improvement programs** (implies needs for data availability, EHR, etc.)
- **Team approaches, engagement of direct care providers**
- **System integration**

… but is something missing?

a sustained and sometimes difficult public conversation about choices, values, priorities, resource allocation and ultimately conversations about the choices that we should ensure that older Canadians (us) have about how it is that we will live the end of life and how it is that we will die at the end of that life

Tolson et al, 2011. IAGG: A global agenda for clinical research and quality of care, JAMDA

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