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Special Article

Prevention of Functional Decline by Reframing the Role of Nursing Homes?



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A B S T R A C T

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Institutionalization is generally a consequence of functional decline driven by physical limitations, cognitive impairments, and/or loss of social supports. At this stage, intervention to reverse functional losses is often too late. To be more effective, geriatric medicine must evolve to intervene at an earlier stage of the disability process. Could nursing homes (NHs) transform from settings in which many residents dwell to settings in which the NH residents and those living in neighboring communities benefit from staff expertise to enhance quality of life and maintain or slow functional decline? A task force of clinical researchers met in Toulouse on December 2, 2015, to address some of these challenges:

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how to prevent or slow functional decline and disabilities for NH residents and how NHs may promote the prevention of functional decline in community-dwelling frail elderly. The present article reports the main results of the Task Force discussions to generate a new paradigm.

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Worldwide, the number of dependent older adults is projected to rise from 350 million in 2010 to 488 million in 2030 and 614 million in 2050.¹ These increases are expected to influence the percentage of older adults residing in nursing homes (NHs), which in 2010 in the United States represented approximately 9% of people aged 85 or older² and 6% in 2011 in France.³

In 2011 in the United States, \$134 billion was dedicated to institutional care (ie, skilled nursing facilities, nursing homes, and nursing facilities located in continuing care retirement communities) or about 31% of long-term services and supports expenditures with an additional \$234 billion dedicated to informal care and \$58 billion to community-based care.² In 2012 in France, 8.3 billion euros were dedicated to health care for institutionalized people and increased each year.⁴ Similar increases are being observed throughout European nations.

Given rising costs in France, where 40% of dependent (defined as 2 or more activities of daily living [ADL] limitations) older adults are institutionalized,⁵ the National Assembly convened a panel of experts who estimated that an appropriate program organized in the community to prevent dependency would save a total of 10 billion euros in France.⁶ Such a recommendation to focus on prevention of disability has long been proposed as one potential strategy to respond to increasing levels of dependence and costs throughout the United States and Europe. Large randomized controlled trials have demonstrated an impact of primary prevention on morbidity.⁷ These observations mandate public health strategies and initiatives directed at prevention of disability.⁸ A shift toward prevention of disability would be consistent with trends in other medical disciplines such as oncology and cardiology that increasingly place an emphasis on proactive preventative approaches (eg, prevention of cancer or myocardial infarction) rather than reactive approaches after advanced disease has already developed.

Different pathways drive functional decline and development of disability with advanced age: loss of mobility, loss of cognitive function, loss of social support, iatrogenic events, and progression of disease. Earlier intervention to prevent decline and iatrogenic events may support geriatric medicine in meeting the challenge of slowing decline, and maintaining function and quality of life for as long as possible during aging.

Institutionalization is often a consequence of functional decline in older adults and is generally regarded as an outcome that signals failure of care systems to support elders effectively in the community.^{9–13} The expertise in NHs has long been questioned, but quality improvement is now reported in NH staff (eg, trained nurses and nurse aides, geriatricians, psychologists, dieticians, and physiotherapists). The NH staff could now shift NHs from a place of “dwelling” to a locus of activity both for current residents and for community-dwelling elderly at risk of functional loss.¹⁴ The goal would be to provide proactive, preventative approaches to delay disability and avoid iatrogenic events and loss of social supports modeled after other innovative community engagement initiatives such as the “Walk with a Doc” program that encourages physical activity by joining volunteer doctor in the community for a walk, many of which begin their walks at senior centers, assisted living facilities, and other locations where elders reside.¹⁵

A Task Force of Experts in NH care and research met on December 2, 2015, in Toulouse, France, during the 2nd Nursing Home Research International Working Group (NHRWIG2015) conference with the

support of the Office for Science and Technology of the Consulate General of France in Los Angeles, USA.

The aim of the workshop was to discuss intervention strategies to prevent disability and functional decline for NH residents. The second aim of the task force was to consider possible implementation strategies to prevent functional decline in community-dwelling frail elderly within the NH setting.

The Task Force was convened by the Global Aging Research Network (GARN), a network of the International Association of Gerontology and Geriatrics (IAGG).

How to Prevent Functional Decline and Disabilities for Nursing Home Residents?

Overview of the Nursing Home Health System in the United States

In the United States, 15,700 nursing homes cared for approximately 1.4 million residents on any given day¹⁶ in 2012 but the number of nursing homes has been steadily decreasing compared to a decade earlier when there were more than 16,000 beds. NH care is still viewed as something to be avoided if possible and NH admission reduction has been actively sought. The declining number of nursing homes has been attributed to availability of assisted living facilities and long-term supports and services such as home and community-based services. Occupancy has also declined slightly over the past decade from 86% in 2003 to 83% in 2012. The majority of nursing homes (68%) are for-profit, whereas only 25% are nonprofit and 7% are government-owned; the majority serve between 26 and 100 residents and approximately one-third serve more than 100 residents. NH staff are usually trained, but available time dedicated to resident care is limited. The vast majority of direct care is provided by nurse aides, who represent 65% of the total nursing full-time equivalents (FTEs), with an average of 2.46 hours of care per resident each day compared with 23% FTE and 0.85 hours of medical care for licensed practical nurses and only 12% FTE and 0.52 hours of medical care for registered nurses in nursing homes. Nearly all nursing home residents in the United States need assistance with bathing, dressing, and toileting, and more than half also require assistance with eating.

Overview of the Nursing Home Health System in Europe

Over the past 10 years, the growing number of patients who benefit from long-term care at home, especially in Sweden, France, and United Kingdom, generated a larger proportion of severely disabled residents living in NHs.¹⁷ In Europe, as in other regions of the world, NHs are more unique than similar.¹⁸ Since 2000, the number of NH beds has been increasing in Europe. In 2013 in Belgium, there were 72.1 NH beds per 1000 population aged 65 and older (59 in France, 18.9 in Italy).¹⁹ Similar trends of increasing numbers of long-term care beds were observed in Finland or Iceland between 2000 and 2013. During that same period, Spain reported one of the highest increase of NH beds by adding an average of 3.7 beds per 1000 population older 65 than years, each year in institutions.¹⁹

The Paradox of Nursing Home Funding

Although it was beyond the scope of our Task Force to comment on the complexities of NH funding, all countries face similar

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