JAMDA 14 (2013) 626.e1–626.e7

JAMDA

journal homepage: www.jamda.com

Review

Conceptualization of a Toolkit to Evaluate Everyday Competence in Planning Transitions From Nursing Homes to the Community

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Keywords:
Everyday competence
person-environment fit
transitions
care planning

ABSTRACT

Living independently in the community is a primary goal for older adults, particularly for the estimated 10% to 20% of long-stay nursing home residents who have low care requirements. According to the model of person-environment fit, individuals with high levels of everyday competence have the ability to solve problems associated with everyday life. Nursing home residents with high levels of everyday competence and low care needs have poor person-environment fit, placing them at risk for declines in function, maladaptive behavior, and affective disorders. The goal of this article is to present a framework for the integration of everyday competence with standardized goal-setting and care-planning processes to enable the transition of appropriate nursing home residents back to the community. Barriers to community transitions exist across several Key Domains: rehabilitation, personal assistance and services, caregiver support, finances, housing, and transportation. We propose a research agenda to develop and implement a toolkit based on this framework that nursing home staff can use to overcome barriers to transition by (1) assessing residents' everyday competence, (2) developing personally meaningful goals that facilitate transition, and (3) conducting structured care planning to support resident goals around returning to the community. If successful, this toolkit has the potential to reduce costs associated with nursing home care and to improve functional health, psychological well-being, and quality of life for older adults. The proposed framework and toolkit complement national efforts focused on transitioning nursing home residents back into the community.

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Older adults prefer to remain independent in the community for as long as possible. Known home and neighborhood environments provide feelings of comfort, attachment, control, and independence.[1] However, living in the community is not always possible or appropriate, particularly if an older adult experiences significant declines in function.[1] According to the model of person-environment fit (P-E fit),[2] when the demands and resources available in the living environment are no longer in balance with the individual's everyday competence, older adults may be at risk for poor outcomes (Figure 1). Everyday competence can be simply defined as the ability to solve problems associated with everyday life.[3] Community-dwelling older adults with low levels of everyday competence and poor P-E fit because of little environmental support may be at risk for long term care placement or other negative outcomes. Conversely, older adults with higher levels of everyday competence may also experience declines in function if there is poor P-E fit because of an overly restrictive environment (eg, nursing home staff not providing opportunities for the person to contribute as able to activities of daily living [ADLs]).

Often transitions into long term care settings occur during a time of crisis (eg, acute hospital stay or loss of a spouse), leaving little opportunity to consider the individual's current and potential future level of everyday competence and all available options for receiving long term care services. Consequently, these individuals may be placed in environments that do not maximize P-E fit. It has been estimated that 10% to 20% of nursing home residents may not require skilled levels of care and could successfully reside in the community with appropriate rehabilitative services and supports in place.[4–8] However, many barriers exist to facilitating transitions to the community and no standardized process exists within nursing homes to assess

This work was supported with resources and use of the facilities at the Houston VA HSR&D Center of Excellence (HFP90-020), including the Advanced Post-Doctoral Fellowship in Health Services Research (Dr. Mills).

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1525-8610/$ - see front matter Published by Elsevier Inc. on behalf of the American Medical Directors Association, Inc.
http://dx.doi.org/10.1016/j.jamda.2013.05.010

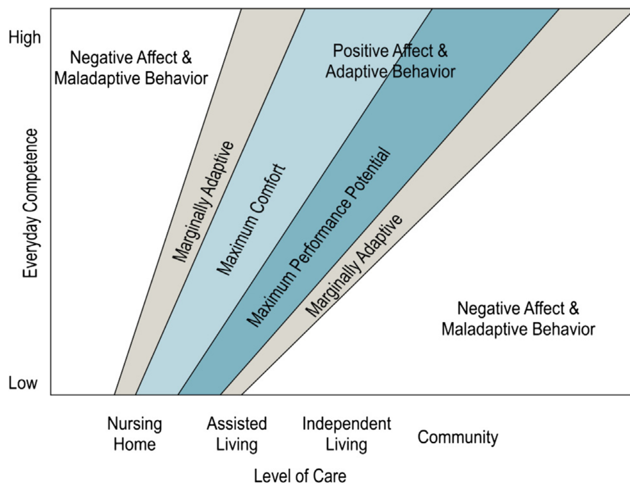

Fig. 1. Person-environment fit model adapted for the long term care continuum.

everyday competence, set resident-directed goals, and to develop care plans to transition older adults back into the community.

The purpose of this article was to present a framework for the integration of everyday competence with a standardized goal-setting and care-planning process. We begin the discussion with the barriers to transition faced by nursing home residents and highlight existing programs to transition nursing home residents to the community. We then examine the conceptual foundation of everyday competence and present an integrated model of goal setting and care planning around transitioning nursing home residents to the community. We conclude by proposing a research agenda that will further refine the proposed model and explore its use in additional contexts.

Background

Nursing Home Residents Face Many Barriers to Transitioning to the Community

Although the nature of the physical and cognitive impairments suffered by many nursing home residents would preclude them from ever gaining the everyday competence necessary to return to the community, there are indications that a significant proportion of nursing home residents could regain the ability to do so. The most recent version of the Minimum Data Set (MDS 3.0) was released in October 2010 and included an improved Section Q (resident participation in assessment and goal setting regarding desire to transition back to the community).[9] A recent study of national MDS data reported that up to 12% of nursing home residents were candidates for return to the community given their "low care" requirements,[8] where low care status was defined as a resident not requiring physical assistance with any of the 4 late-loss ADLs (bed mobility, transferring, toileting, and feeding) and not classified in the "Special Rehabilitation" or "Clinically Complex" Resource Utilization Groups in the MDS. Given the enormous costs per day associated with nursing home care, the potential savings for returning 12% of the nursing home population to the community would be substantial and would profoundly impact quality of life for these individuals. Furthermore, it is possible that the 12% figure is an under estimate because it was based on MDS data collected by nursing home staff members typically not trained to recognize and maximize residents' potential for rehabilitation and transition to the community.

Residents face many challenges in their efforts to return to the community. Despite federal regulations that require certified nursing homes to initiate care planning and make referrals to community integration agencies, nursing homes have little incentive to discharge residents back to the community because of the potential impacts on facility census and revenue.[10] The nursing home care planning team would ideally need to be able to appropriately assess a resident's everyday competence and then ensure P-E fit in the new environment to arrange a successful transition. However, the feasibility of returning to the community for this population of "transition-capable" nursing home residents is hampered by a number of pragmatic barriers in several Key Domains: rehabilitation, personal assistance and services, caregiver support, finances, housing, and transportation (Figure 2).

Rehabilitation

The nursing home environment is not one historically recognized for supporting autonomy and independence, which can negatively affect the confidence necessary for a resident to initiate and successfully complete a transition into the community.[11] In addition to medical and functional rehabilitation needs, residents who have lived in the nursing home environment for an extended period of time often become "institutionalized," meaning that beliefs and attitudes about their own capabilities are informed by how they are treated by the staff, resulting in decreased self-efficacy and feelings of hopelessness and dependence.[12–15] Furthermore, many older adults are placed into the nursing home as a result of a precipitating health status change, which may have resulted in functional decline that may not be recovered. Rehabilitation services offered before and after the transition must directly address medical, functional, and psychological issues if transition back to the community is to be achieved.

Personal assistance and services

Nursing home residents and family members may be reluctant to initiate transitions because of concerns that the resident's functional and complex care needs will not be adequately addressed through

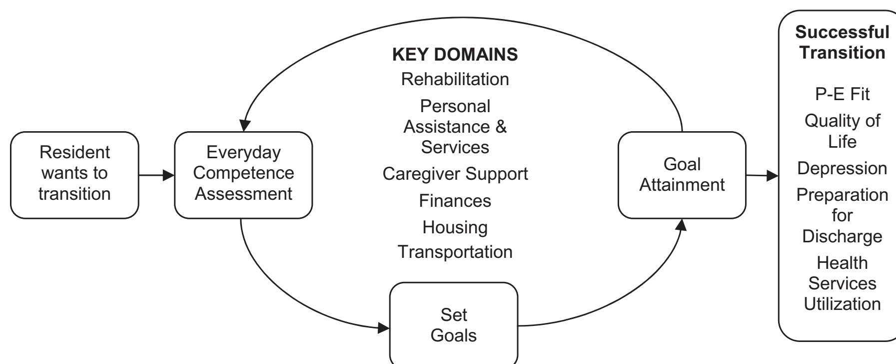

Fig. 2. Conceptual model of ECAP-CT process.

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