

LONG Term Care; A Definite Misnomer

Presenter
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February 2021

Outline of Presentation

1. Long-Term Care (LTC) 101
2. Differences between Assisted Living and LTC
3. Differences between Acute Care and Long Term Care (LTC)
4. Medical Practice in LTC
5. Dementia
6. Palliative Approach in LTC
7. LTC & COVID-19

Long Term Care 101 – Victoria/South Island

1. 22% of the population are 65+ (88,000 seniors)
2. 93% of seniors live independently
3. 3 % live in Assisted Living
- 4. 4% live in Long Term Care**

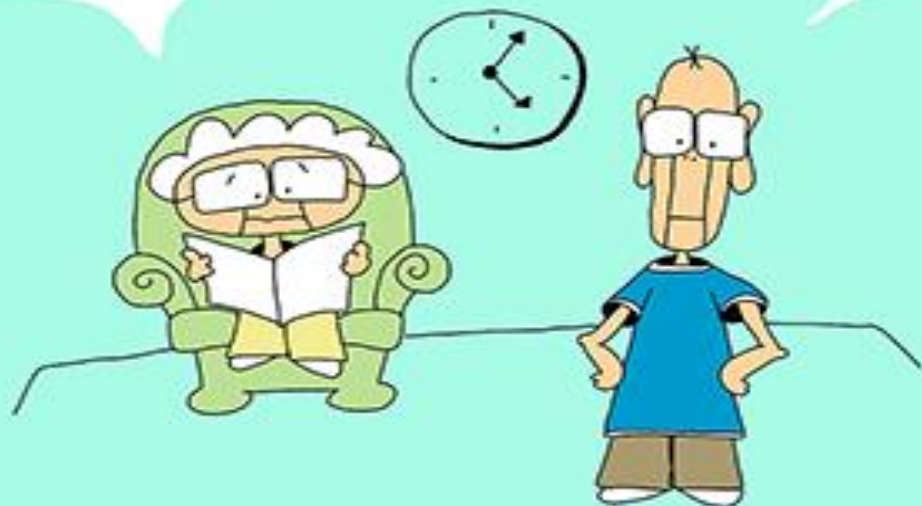
Long Term Care 101

Today's LTC Resident population:

- Frail elderly + younger & disabled (small %)
- Advanced dementia; end-stage chronic illnesses
- Median age at admission 84
- Avg Length of Stay (ALOS) 18 months; 30% die during 1st year, 95% die in the LTC home
- LTC home occupancy maintained at 98-99%
- High demand for public LTC beds in Island Health:
 - 901 on wait list, 78 days wait time
 - Private LTC– no wait list

It says the
average person lives
657,000 hours

Well, that would
have been nice to know
632,000 hours ago!



UNDER CARDIAC ARREST

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How does LTC differ from Assisted Living?

There are 2 care models for seniors who can no longer live independently and need some measure of care.

The differences are presented in the following slides

Assisted Living versus LTC Differences

	Assisted Living	Long-term Care
Staffing and Care	<ul style="list-style-type: none">• Hospitality model• Primarily non-health care staff• Planned and scheduled visits from Home Support Workers, Nurses or Case Managers	
Self-direction	<ul style="list-style-type: none">• Must be able to safely live in unit & self-direct own care	
Decision-making	<ul style="list-style-type: none">• Can make own decisions regarding personal safety/welfare	

Assisted Living versus LTC Differences

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Staffing and Care	<ul style="list-style-type: none">• Hospitality model• Primarily non-health care staff• Planned and scheduled visits from Home Support Workers, Nurses or Case Managers	<ul style="list-style-type: none">• Care model• Nursing, Health Care Assistants• 24/7 supervision/personal care• Other health disciplines (SW, PT, OT, Dietitian) available, may be full or part time
Self-direction	<ul style="list-style-type: none">• Must be able to safely live in unit & self-direct own care	<ul style="list-style-type: none">• Unable to self-direct
Decision-making	<ul style="list-style-type: none">• Can make own decisions regarding personal safety/welfare	<ul style="list-style-type: none">• Most often unable to make own decisions

Assisted Living versus LTC Differences

	Assisted Living	Long-term Care
Medical care	<ul style="list-style-type: none">• Assisted Living residents go out to the physician's community practice• No requirement for the physician to visit at AL residence	
Hospital transfers	<ul style="list-style-type: none">• Initiated by resident, family, or non-healthcare staff• Returns after "business" hours may be unsafe• Family are "middle-man"	

Assisted Living versus LTC Differences

	Assisted Living	Long-term Care
Medical care	<ul style="list-style-type: none">• Independent and AL residents go out to the physician's community practice• No requirement for the MRP to visit at AL residence	<ul style="list-style-type: none">• All residents must have a physician who is willing to visit at the LTC home and meet certain standards and Best Practice Expectations
Hospital transfers	<ul style="list-style-type: none">• Initiated by resident, family, or non-healthcare staff• Returns after "business" hours may be unsafe• Family are "middle-man"	<ul style="list-style-type: none">• Initiated after nursing assessment + call to after hours physician• Returns after hours OK with adequate communication

Assisted Living versus LTC Differences

	Assisted Living	Long-term Care
Number of Sites	40	38
Private vs Public Beds	<ul style="list-style-type: none">• 2100 private pay• 500 publicly funded	<ul style="list-style-type: none">• 600 private pay• 3300 publicly funded

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“Going to hospital is one thing - you are going there to get ‘fixed’, and then go home. Going to LTC is different – it means you can’t go home. This is a big loss, and a much higher level of grief is experienced.”

Victoria-based LTC Social Worker

Differences Between LTC & Acute Care

- Acute care:
 - Active, short-term treatment for an episode of illness or surgery
 - Restorative/curative approach
 - Get fixed and go home
- Long-term care:
 - When care at home is no longer safe or sustainable
 - Supportive care for chronic, complex illnesses that cannot be cured
 - Palliative approach (because residents are at end of life)

Differences Between LTC & Acute Care

- Staffing, programs and services:
 - LTC staff only 20-25% health professionals
 - Limited access to rehab/therapy
 - Limited access to specialist physicians, lab and diagnostic services
 - Contracted community pharmacy services, off-site
 - Behaviour management limitations: heavily regulated restraint use, no on-site security, no seclusion

Throughout our lives Acute Care is paid from MSP

Why is the cost of LTC not covered by MSP?

- ▶ Majority of acute care costs are covered by MSP
- ▶ LTC residents in subsidized beds pay a monthly fee based on income.
- ▶ These fees, in publicly funded LTC, include food & “lodging” as well as some prescribed medications, equipment and supplies.
- ▶ Publicly funded LTC fees are heavily subsidized compared with Private LTC

The Cost to the Resident of LTC

- Costs for public (subsidized) beds, based on income NOT assets:
 - **Monthly** fee up to 80% of after tax income
 - The current minimum is ~ \$1,200
 - The current maximum is ~ \$3,500
 - Private LTC is very expensive ~ \$10,000

Facts & Figures in LTC

50% of our medical costs to MSP are incurred in the last 6 months of our life.

LTC fees are quoted per month

Hospice fees are quoted per day.

DIRECT care hours: BC provincial guidelines 3.36 hours per day.

On entering any health care facility (Acute or LTC) Medical Orders for Scope of Treatment (MOST) are planned

PART 1: RESUSCITATION STATUS and MEDICAL TREATMENTS	
Check ONE designation. CPR is provided in accordance with the MOST policy and only with C2 designation	
<input type="checkbox"/> M1	Supportive care, symptom management and comfort measures only. Allow a natural death. <i>Transfer to higher level of care only if patient's comfort needs cannot be met in current location.</i>
<input type="checkbox"/> M2	Medical treatments within current location of care, <u>excluding critical care interventions</u>. <i>Transfer to higher level of care only if patient's comfort needs cannot be met in current location.</i>
<input type="checkbox"/> M3	Medical treatments including transfer to higher level of care, <u>excluding critical care interventions</u>. <i>Transfer to a higher level of care only if patient's medical treatment needs cannot be met in current location.</i>
<input type="checkbox"/> C0	Critical Care Interventions, <u>excluding</u> CPR and intubation. <i>Patient is accepting of any intervention from which they may benefit, excluding CPR and intubation.</i>
<input type="checkbox"/> C1	Critical Care Interventions, <u>excluding</u> CPR but including intubation. <i>Patient is accepting of any intervention from which they may benefit, excluding CPR.</i>
<input type="checkbox"/> C2	Critical Care Interventions, <u>including</u> CPR and intubation. <i>Patient is accepting of any intervention from which they may benefit.</i>

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The Changing Model of Medical Practice in LTC Homes

- Long-Term Care Initiative (LTCI) developed coordinated “CORE” and “TORCH” models of medical practice:
 - **CORE** - a group of family physicians who have agreed to attend the facility regularly and meet certain standards
 - **TORCH** - a group of physicians who attend an LTC home on specific days of the week

The Changing Model of Medical Practice in LTC Homes

- Upon admission, a new resident is assigned to a CORE/TORCH physician
- The most responsible physician (MRP) is usually determined the day before admission to the LTC home

Physician Best Practice Expectations

1. 24/7 availability and on-site attendance when required
2. Proactive visiting to residents
Ideally every 2 – 4 weeks:
3. Meaningful medication reviews with pharmacist
6 month intervals
4. Completed documentation
MOST/goals of care
5. Attendance at care conferences (meeting with family, physician, pharmacist, dietitian, social worker & nursing)
Annually
6. Participation in quality improvement process
Quarterly CORE Physician meetings & continuing medical education courses (CME)

A day in the life of a LTC Physician

1. Wake up to faxesyes faxes
2. Visit Care Home of the day
3. Attend Care Conferences with family and key staff eg. SW, Pharmacist, Dietitian, OT, RN, LPN
4. Return home to more faxes!
5. On call as per schedule. 24/7

Sending LTC Resident to Acute Care

Sending a resident to Acute Care is never taken lightly and usually results from an acute health change from resident's baseline.

For example, a fall with suspected fracture - through the
“Hot Hip” Protocol

Sending LTC Resident to Acute Care

Steps taken when sending the resident:

- Nurse assessment
- Contact made with MRP or LTC physician on call
- Ideally MRP assesses resident
- MRP or nurse connects with resident and/or family member to decide, together, if the resident should go to the hospital
- If going to hospital, a “Pink Band” is put on the resident’s wrist. This identifies the resident is from LTC and provides ER staff with a phone number to reach the LTC.
- A “Pink Band” form is completed to be sent with the resident

Best Practices for Discharges from Acute to LTC

- A timely discharge summary is essential for a smooth transition!
- In general, does the patient have a plan of care that is realistic for LTC?
 - Hospitalists try to reduce the number of medications and frequency of administration in preparation for transfer to LTC
 - Helps to know when and why medications were changed during resident's hospital stay

Resident Return from Acute Care to LTC

When a resident is ready to be discharged from hospital back to the LTC home:

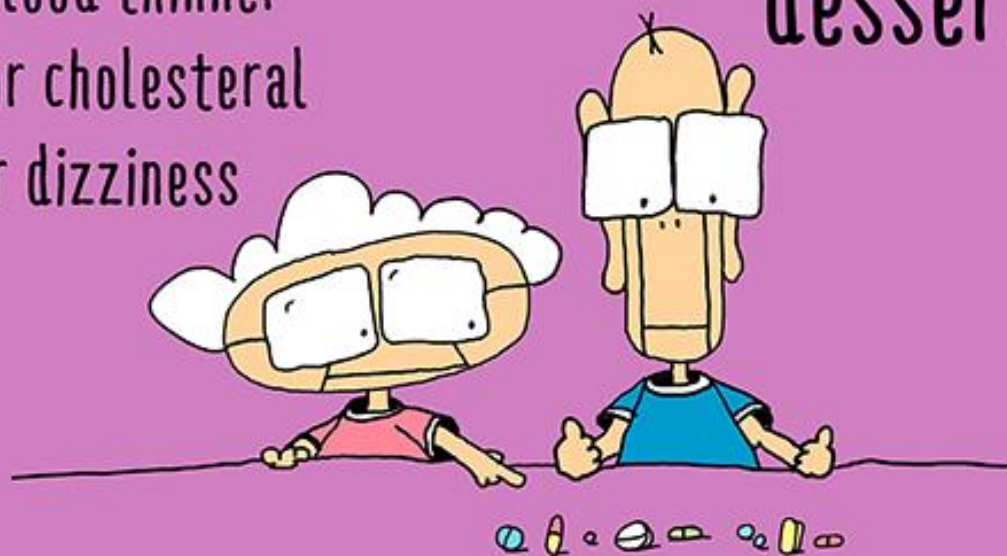
- Hospitalists call the home, as they need time to prepare. Nothing erodes trust like the ambulance just showing up with no warning!
- LTC homes do NOT, at present, have access to Powerchart - this is slowly changing though

Best Practices for Discharges to LTC Medication Orders

- Acute Care discharge medication orders cover the patient for the first week in LTC after their transfer.
- Community Pharmacies can then ask the LTC physician to review the medication orders without urgency.
- A 'Medication Reconciliation Report' is then prepared.

That pill is for your heart
that one is for your eyes
that one is for blood pressure
That's for diabetes
that's a blood thinner
That is for cholesterol
That's for dizziness

What's for
dessert?



UNDER CARDIAC ARREST

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Choosing Wisely Canada

- Recommendations for LTC
 - Reduce medications to essentials only
 - No unnecessary laboratory blood or diagnostic tests
 - Don't use antipsychotics as first choice to treat behavioural symptoms of Dementia

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Definition of Dementia

Canadian Government Dementia Statement

- “Dementia is a progressive and incurable disease for which a complete understanding of its pathophysiology and effective therapies to stop the progression are lacking.”

Dementia Types

- Alzheimers (70%)
- Vascular (15-20%)
- Lewy Body
- Frontotemporal
- Alcohol related
- Down Syndrome & Alzheimers

Dementia Research

Cognitive Health Initiative

- Patients want their disease to not be in vain
- Mobile monitoring of cognitive assessment tool eg. games at home similar to checking blood sugar
- Headbands measure brain waves and results sent to their iPhone.

Dementia Risk

- The most sensitive predictor of early Dementia is a change in gait.
- Hearing loss is a significant risk

Dementia Care

Memory Care Units/Centres

Locked units

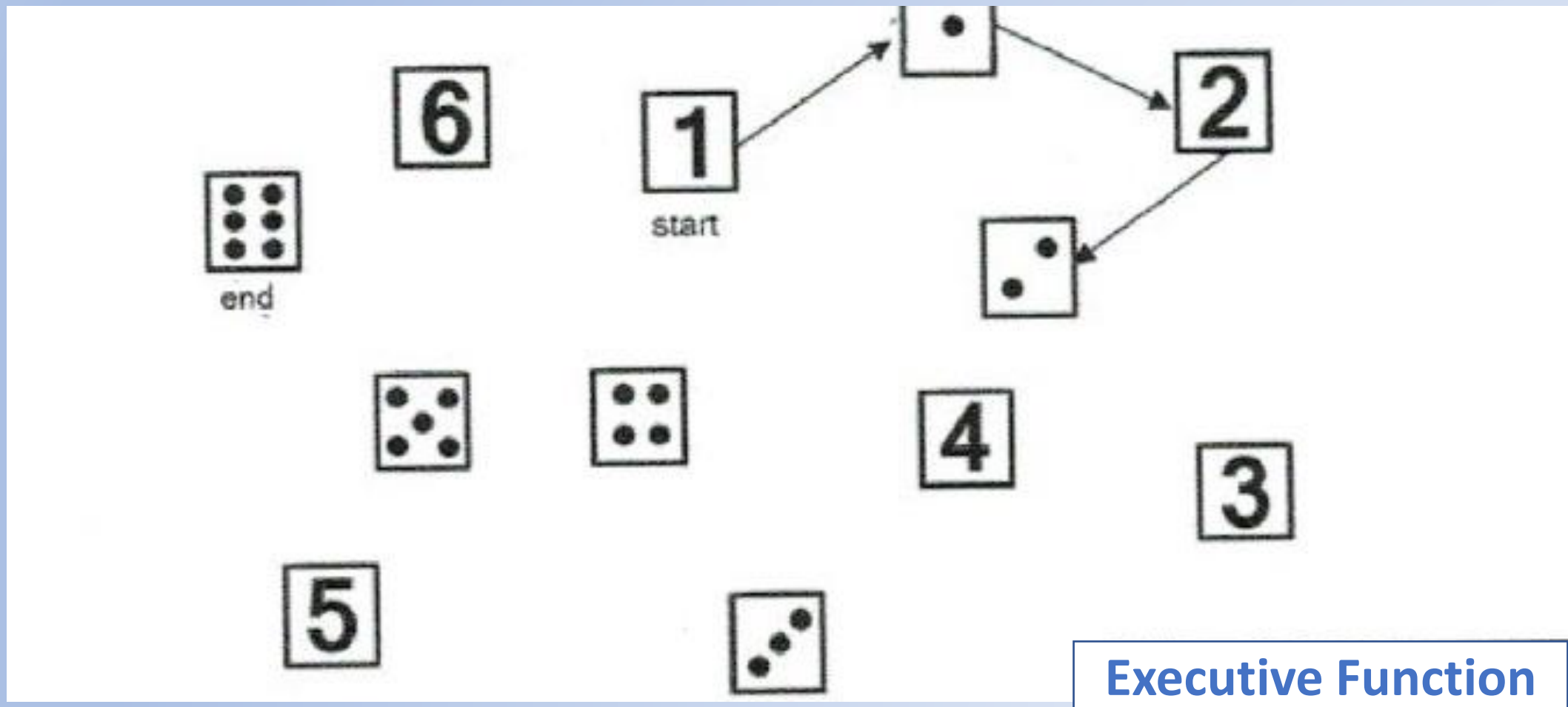
“It is better to have a fence at the top of the cliff than an ambulance at the bottom”

Dementia Trajectory Outline

Dr Trevor Janz

Teen	Having hobbies, driving a car, getting a job Planning and organizing tasks, preparing a meal, grocery shopping, laundry	Early Dementia
School age child	Able to be left unsupervised Simple math and managing money. Reading. Being able to understand & follow instructions	Middle Dementia
Preschool child	Grooming: Hair, teeth, shaving, makeup, dressing Toilet training: Continent bowels and bladder Talking: Able to express needs in words	Late Dementia
Baby	Walking (sitting up, crawling, standing, walking) Feeding (spoon fed, finger foods, spoon & fork) Rolling over, sitting up and looking at the world Sleeping and eating Swallowing	Actively Dying

Montreal Cognitive Assessment (MoCA)

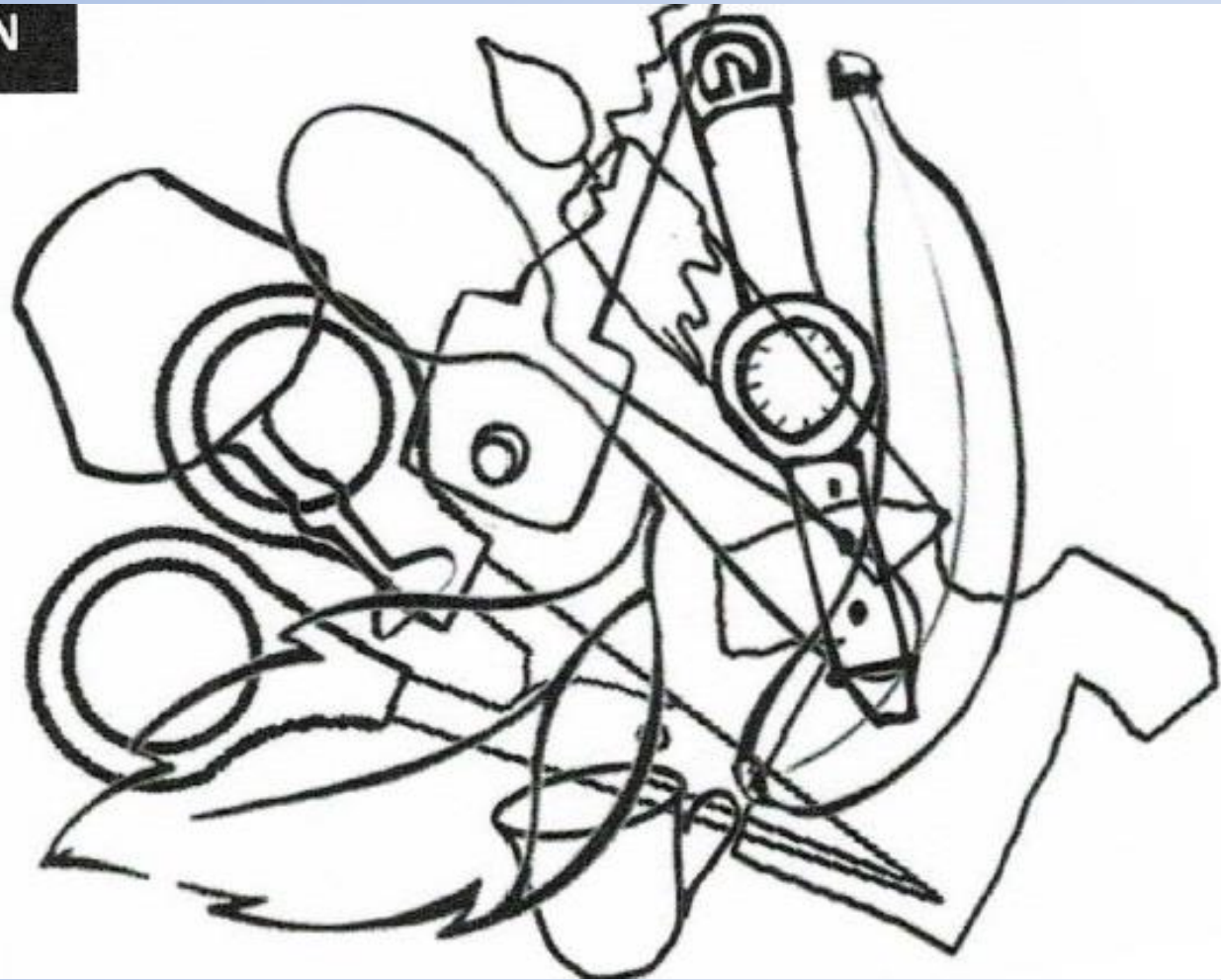


MoCA

IMMEDIATE RECALL		ROSE	CHAIR	HAND	BLUE	SPOON
Perform 2 trials even if 1 st trial is successful	1 st trial					
	2 nd trial					

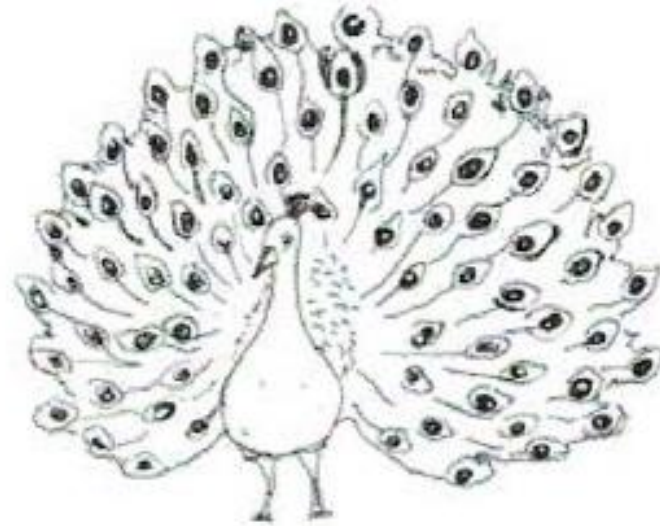
MoCA

VISUOPERCEPTION



MoCA

NAMING



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**“I’ve been telling you those things will
kill you for damn near eighty years!
When are you gonna listen?!”**

Comfort Not Cure

Physician's Mantra

- To cure sometimes
 - To relieve often
- To COMFORT always

A Palliative Approach in LTC

- The average length of stay in LTC home is **18** months
- 17% of residents die within 3 months of admission
- Residents admitted now are further along in their chronic life-limiting trajectories with multiple co-morbidities

What is a Palliative Approach

Some may think of it as..

- Final days or weeks of life
- Only cancer
- A place such as hospice
- An action
- Withdrawing treatment

A Palliative Approach is..

- May have months or years
- Any life-limiting illness
- A philosophy of care in LTC
- Action and process
- Active treatment to promote quality of life

A Palliative Approach in LTC.... WHY?

- Aligns treatment decisions better with goals and wishes
- Improves quality of life when preferences are known and respected
- Reduces inappropriate or futile treatments
- Gives team members permission to have conversations with the resident and family about serious illness
- Reduce emergency department use and hospitalizations of residents who are dying ...supporting dying in place

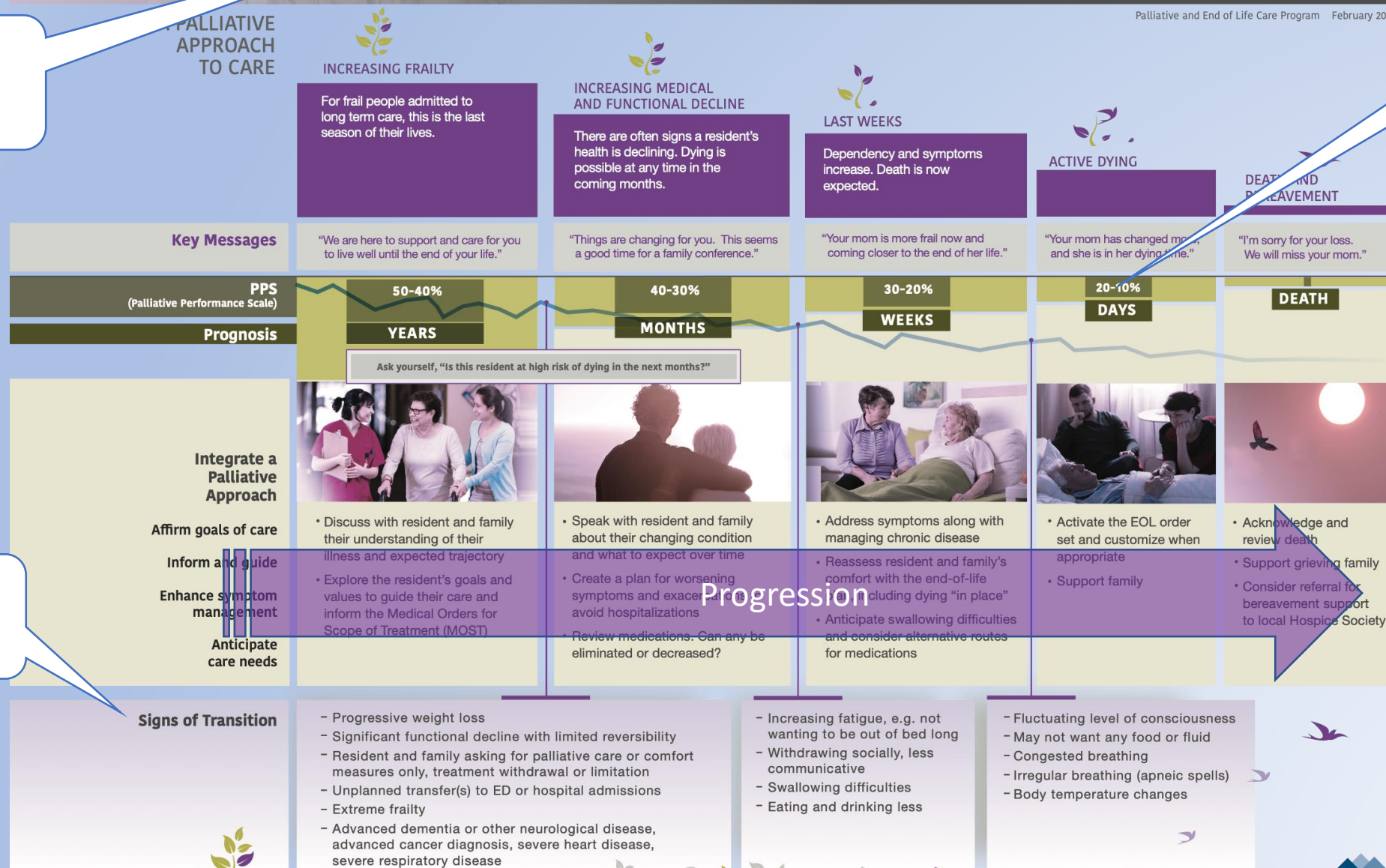
A Palliative Approach to care is not limited to last days. It is about providing comfort and quality care for all residents living with progressive life-limiting illness and their families.

Palliative and End of Life Care Program February 2019

Main message

PPS & Prognosis

Signs of Transition



Earlier integration of a palliative approach enhances quality of living.

Early Identification Tool

“Would I be surprised if this resident died in the next 6 months”

Progressive weight loss

A PALLIATIVE APPROACH TO CARE

There are often signs that a resident's health is declining and that they are at higher risk of dying in the coming months. Ask yourself, “Would I be surprised if this resident died in the next 6 months?” Being attuned to these signs allows health care providers to better inform and guide residents and their families in this final season of their life.

Early Identification Tool

What factors support the care teams impression that the resident is in their last months of life? (check all that are relevant)

- ☐ Progressive weight loss (greater than 10% in 6 months)
- ☐ Progressive, irreversible functional decline
- ☐ Resident or family asking for palliative care or comfort measures only, treatment withdrawal or limitation
- ☐ Unplanned transfers to hospital
- ☐ Extreme frailty (e.g. persistent pressure ulcers, recurrent infections, delirium, persistent swallowing difficulties, falls)
- ☐ Advanced dementia or other neurological disease (e.g. full assistance needed with all activities of daily living, incontinence, unable to communicate effectively, poor oral intake, swallowing difficulties, recurrent UTIs, aspiration pneumonia)
- ☐ Advanced cancer diagnosis
- ☐ Severe heart disease (e.g. breathlessness or chest pain at rest or with minimal exertion)
- ☐ Severe respiratory disease (e.g. breathless at rest or with minimal exertion, on oxygen therapy in place, recurrent hospitalizations)
- ☐ Advanced illness of any cause with progressive function decline or poorly controlled symptoms

5 Key Features of a Palliative Approach

MOST IMPORTANT

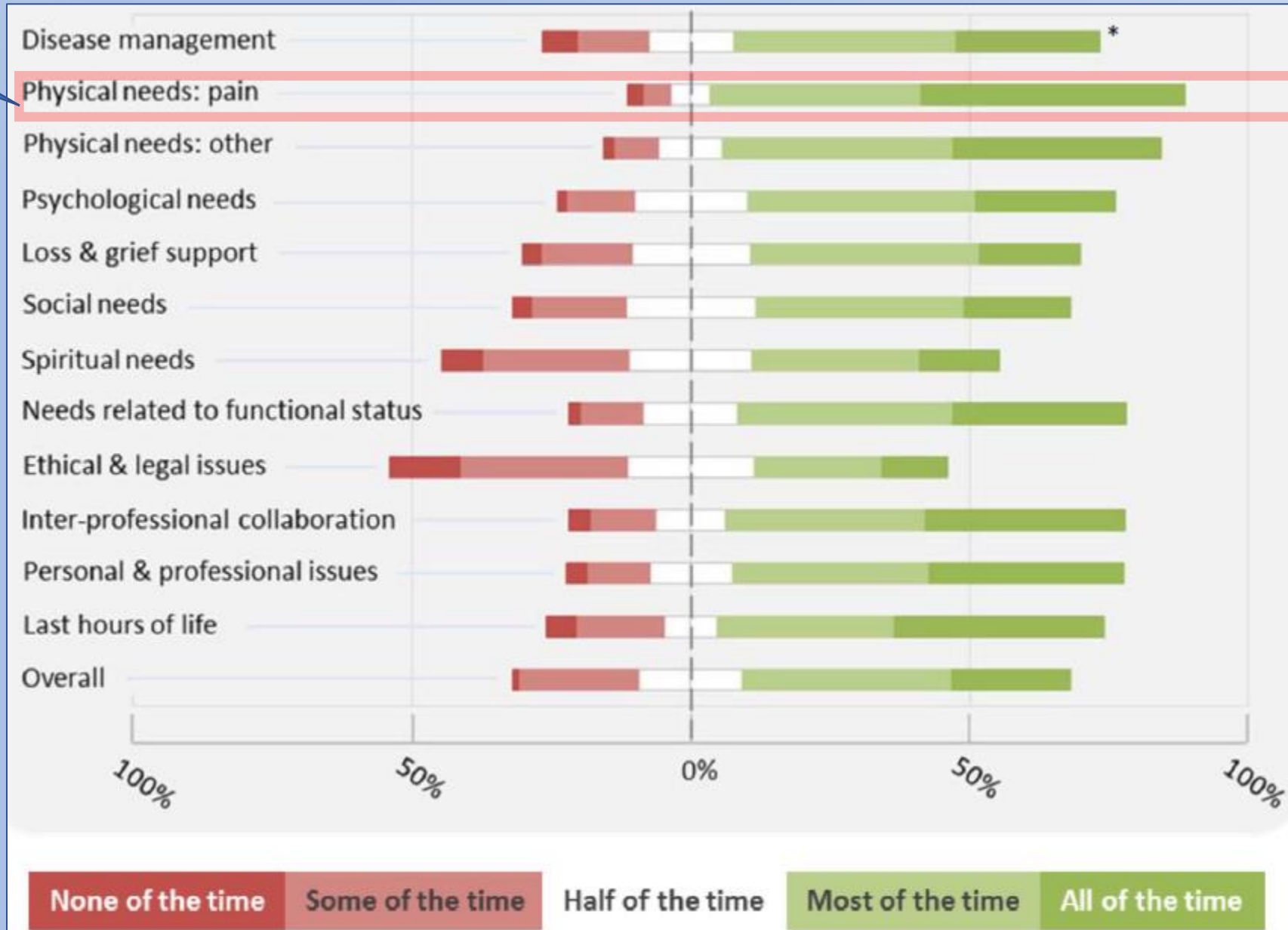
1. Involves life-limiting illnesses such as heart, lung and kidney disease, DEMENTIA, frailty and cancer
2. Understands where the Resident is in the course of their illness
3. Includes conversations about serious illness, personal preferences and goals of care
4. Orients care to their whole person and their family
5. Prepared for illness progression, while recognizing uncertain prognosis

Palliative terms/phrases

- “He/she is not DYING because they are not EATING, they are not EATING because they are DYING.”
- “The INTENT is to kill the pain, not the patient.”
- “The goal is COMFORT, neither to hasten or prolong death.”

Most
Important

Application of a Palliative Approach



Placebo Effect

- Placebo effect - caused by a person's expectations.
- 30% of effectiveness of medications
- Happens even if patient aware that it is not the real pill
- **No** placebo effect in patients with Dementia

Opioid Treatment

- **No** placebo affect, so higher dose of analgesic (pain relief) is needed
- Effective both short acting and long acting
- Reduces pill burden

Opioid Treatment

- Dependence is NOT addiction
- Physical dependence is because of ongoing pain.
- Psychological dependence/addiction is drug seeking behaviour.

Opioid Medication

- Narcotic naive – No experience of opioids so 'go low and go slow'
- Never given without pain assessment and review of effectiveness

Palliative Care...Beginnings

- Hospice care started in 11th century with religious orders
 - Dame Cecily Saunders in England in 1950s
 - The 1st palliative care unit in Canada was in 1974 in Winnipeg
-
- In the Brompton Chest Hospital in England in 1840s, they used the Brompton cocktail by Dr Herbert Snow... Heroin/cocaine/gin or vodka

*“You matter because you are you,
And you matter to the end of your life.
We will do all we can not only to help you die peacefully,
But also to live until you die.”*

Dame Cicely Saunders

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COVID challenges in LTC

1. Extreme frailty of residents
2. Nursing Home size, the larger the number of residents the higher the risk
3. The vast majority of infections occur from care staff to the resident
4. Pre-symptomatic transmission
5. Inability to effectively isolate residents
6. High frequency/long duration tasks eg. personal care for bowel incontinence
7. COVID presentation in LTC is atypical Fatigue, Anorexia and Delirium.

COVID-19 Quarantine Rules for LTC

- Residents are isolated for 2 weeks after transfer to LTC from Hospital, with contact/droplet precautions.
- Residents can attend ESSENTIAL medical appointments without isolation on their return if they use approved transportation eg. Medivan
- Cohort isolation in 16 bed unit at 'The Summit' for Residents moving from the Community to LTC

COVID Challenges in LTC

Early in the pandemic, BC was quick to:

- Announce single LTC work policy
- Deploy specialized health teams to LTC homes with outbreaks
- Direct the use of universal masking

COVID Challenges in LTC

All Residents and staff have received their Covid vaccinations

Scottish blessing

“May you always keep hale and hearty

‘Til you’re old enough to die”

“May a mouse never leave your pantry

With a teardrop in his eye”



THANK YOU!

**“LONG-Term Care;
A Definite Misnomer”**

???