Elder care: We can do better

Modern medicine, good nutrition, and sanitary conditions have resulted in life expectancy reaching a record high in the developed world. Many more people are now surviving illnesses that were previously fatal, but they are left with chronic health conditions that impair their functional independence and quality of life. As well, many Canadians are now living long enough to develop neurodegenerative diseases that were not common in the past, when death at a younger age was the norm. Over the next 20 years, the population of Canadians over 65 will double. Consequently, the percentage of the population with chronic illnesses will also grow. These elderly patients increase pressure on an already stressed health care system. Although the percentage of Canadians over 65 hovers around 14%, they are overrepresented in acute care beds, accounting for 40% of inpatient days.

In-hospital care

Our health care system is designed to prevent and treat episodic, curable, single-system disease. It does not necessarily serve the needs of a growing population of aging patients with multiple complex comorbidities. Elderly people in hospital are at high risk not only for functional decline, but also mobility failure, falls, pressure ulcers, and delirium. Early intervention starting before the acute event has been resolved has been shown to decrease functional decline. A 2012 meta-analysis of 13 randomized and quasi-experimental trials of hospital units providing acute care to elderly patients demonstrated that this type of care was associated with fewer falls, less delirium and functional decline, fewer discharges to nursing homes, more discharges to home, and lower costs.

Components of acute care to the elderly include a purpose-built environment, comprehensive medical review, early mobilization with involvement of rehabilitation staff, patient-centred elder-friendly care, and early discharge planning. Elder-friendly care consists of:

- Avoiding/minimizing the use of psychotropic drugs and restraints
- Using non-drug techniques (reorientation, reassurance, redirection) to manage behavioral issues
- Early discontinuation of IVs
- Using Foley catheters
- Discouraging bed rest
- Encouraging toileting (instead of using bedpans or commodes) as soon as possible

There is also close attention paid to falls risk, cognitive changes, nutrition, hydration, and skin care.[1-3]

All these activities are very time consuming and require ongoing training as well as interest in care of the elderly. Staffing and financial issues often necessitate the creation of special units designed to provide care for the elderly, but the ideal situation would be to have entirely elder-friendly institutions.

Care in the community

There are currently approximately 740 000 Canadians living with dementia. This number is expected to quadruple to 1.4 million by 2031, according to the Alzheimer Society of Canada. The burden of dementia care drastically affects families and friends of the sufferers, who provide the bulk of care in the community. Along with providing assistance with household chores and personal care, these family members—often elderly themselves—have to deal with behavioral challenges including wandering, inappropriate and unsafe behaviors, mood disturbances, and occasionally verbal and physical aggression. Society at large is impacted in terms of costs and lost productivity. Each year $33 billion is spent in formal and informal care costs in Canada. There are also about 440 million hours ($11 billion) lost due to time taken off work by families and friends caring for dementia patients. Worldwide it is estimated that dementia care costs have reached $650 billion, or 1% of the world's GDP. These costs are expected to triple by 2040. It must be acknowledged that the current system is not sustainable. Caregiver stress can lead to physical and emotional illness[4] and burnout, as well as hospitalization and institutionalization for the patient. Hospitals are designed to care for acutely ill patients, but often they are the last resort for dementia patients who no longer can be managed at home or in long-term care facilities because of behavioral issues.

The recent G8 conference in Great Britain was dedicated to the eradication of dementia and improved care of dementia patients. There are 13 countries with a national dementia plan, but Canada is currently not one of them. Many agencies involved with care of the elderly, including the Alzheimer Society, have called for such a plan to be developed in support of research, caregiver support and education, an integrated care model, and education for health care professionals. The G8 dementia summit promised a cure by 2025, but what to do in the meantime?

In 2004 the BCMA Council on

Continued on page 47

This article is the opinion of the Council on Health Promotion and has not been peer reviewed by the BCMJ *Editorial Board.*

Continued from page 12

of the responses:

- Reminiscing with my wife and family.
- Having a glass of beer.
- Not knowing how and when it happens.
- No nasty symptoms.
- In my sleep (three responses).
- Shot by a jealous husband.
- In my bed at home.
- Quickly.
- Instantly, no pain or suffering.
- Quickly and with dignity.
- In any fashion that would not inconvenience my family.
- Quietly with all my marbles.
- Skiing at Whistler.
- Reading Cicero.
- After a cigar, a glass of Bordeaux, and in my sleep.
- Suddenly.

There is a theme to these comments. Prominent doctors who have answered the Proust questionnaire all want to die quickly and painlessly after having enjoyed a full and complete life and perhaps while enjoying their favorite pastimes. What I find fascinating is that doctors frequently see exactly the opposite types of death, marked by lingering symptoms, dementia, ongoing pain, and misery. My sense is that there is more of the latter than the former available to us as we approach our end.

I was most dismayed when the CMA at the General Council 2013 voted not to even debate the end-of-life issues when it came to physician-assisted death. I find this appalling, given what we know and knowing how we would like to have our own lives end.

I would like the BCMA to take a leadership role on this issue and deliver on some of the wishes of the prominent physicians who answered the Proust questionnaire.

—Derryck H. Smith, MD
Vancouver

Continued from page 28

Health Promotion released a paper entitled "Building Bridges: A call for a coordinated dementia strategy in BC."[5] The paper called for BC to develop a multifocal, coordinated dementia strategy, not just support research into prevention and treatment.

The province of BC released its Dementia Action Plan[6] in 2012, developed with the help of clinical, research, and policy experts with the goal of improving the care of patients with dementia during all stages of illness, through health care and service redesign. Components would include preventive and health promotion strategies, augmented primary care, high-quality hospital care when needed, and improved delivery of health services. It was recognized that improving dementia care at all stages of illness could decrease the need for hospitalization and institutional care.

An engaged, able, and active caregiver was recognized as a vital component in improving the life of a patient with dementia. Those without one are more likely to be placed at an earlier stage of their illness.[7] Services such as First Link, provided through the Alzheimer Society, offer support and education for patients and their caregivers at the earliest stages of the disease, when the patient has just been diagnosed. It is currently not available in all areas of BC.

It may be tempting to yield to financial pressures and cut back on funding for services directed toward care of the elderly in BC. However, this action will not only severely impact the elderly and their caregivers, but in the long run it will be detrimental to the health care system as well. Education for caregivers, including assistance with advanced care planning, support, accessible primary care, and respite care, could help them succeed in their goal of supporting their loved ones at home, reducing the need for placement or prolonged hospitalization. In acute care, up-front provision of appropriate, evidence-based management of elderly patients who have been hospitalized can also succeed in both increasing patient quality of life and decreasing overall care costs.

—Maria Chung, MD
Geriatrics and Palliative Care Committee

References

1. Fox MT, Persaud M, Maimets I, et al. Effectiveness of acute geriatric unit care using acute care for elderly components: A systemic review and meta-analysis. J Am Geriatr Soc 2012 60:2237-2243.
2. Wong RY. Discharge outcomes of older medical in-patients in a specialized acute care for the elders unit compared to non-specialized units. Can J Geriatr 2006;9:96-101.
3. Rockwood K. Commentary: What does the ACE unit trump? Can J Geriatr 2006; 9:102-103.
4. Lovell B, Wetherell MA. The cost of caregiving: Endocrine and immune implications in elderly and non-elderly caregivers. Neurosci Biobehav Rev 2011;35:1342-1352.
5. BC Medical Association. Council on Health Promotion. Building Bridges: A call for a coordinated dementia strategy in British Columbia. Accessed 6 January 2014. www.bcma.org/files/Dementia_Building_Bridges.pdf.
6. Government of British Columbia. Ministry of Health. The Provincial Dementia Action Plan for British Columbia. Accessed 6 January 2014. www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf
7. Mittleman MS, Ferris SH, Shulman E, et al. A family intervention to delay nursing home placement of patients with Alzheimer disease. A randomized controlled trial. JAMA 1996;276:1725-1731.