A Good Life in Old Age?

Monitoring and Improving Quality in Long-Term Care

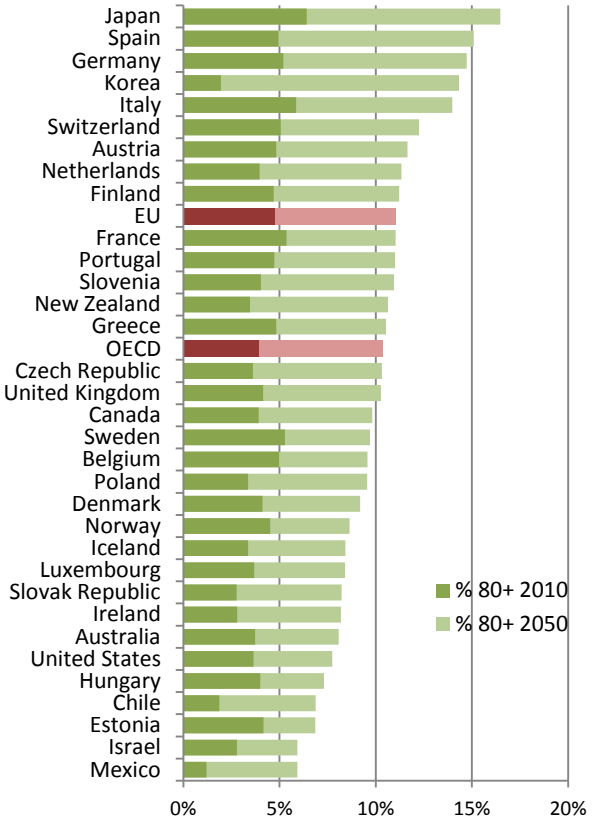
While the number of elderly people in need of care is projected to at least double, governments are struggling to deliver high-quality care to people facing reduced functional and cognitive capabilities. Based on a recent OECD and EC report, this policy brief looks at data and policies to measure quality in long-term care and drive standards of care up

Delivering quality long-term care services must be a priority

There will be more than twice as many old people aged over 80 years old in 2050 than there are now (Figure 1). The share in the population will rise from 3.9% in 2010 to 10% in 2050 across OECD countries; and from 4.7%to 11.3% across 27 EU Member States. Between one quarter and one half of them will need help in their daily lives. Yet governments are struggling to deliver high-quality care to those facing reduced functional and cognitive capabilities.

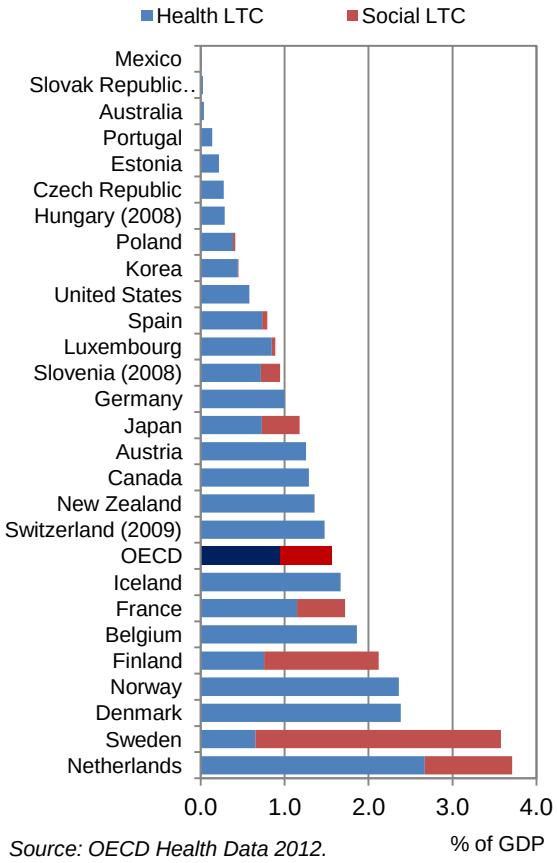
Quality of long-term care (see definitions in Box 1) is important for three reasons. First, users of care services demand more voice and control over their lives. Second, as the cost of care services keeps on growing from 1.6% of GDP across the OECD (Figure 2) to at least double this figure by 2050, LTC services are under pressure to improve their accountability. Third, governments have the responsibility to protect vulnerable older people from potential abuse.

Figure 1. Rapidly increasing share of the population aged over 80 years



Source: *OECD Labour Force and Demographic Database, 2013*

Figure 2. Long-term care expenditure, as a share of GDP
(2010 or nearest year)



Source: OECD Health Data 2012.

Box 1. What is long-term care quality?

Good quality of LTC maintains or, when feasible, improves the functional and health outcomes of frail, the chronically ill and the physically disabled old people. Three aspects are generally accepted as critical to quality of care: effectiveness and safety, patient-centredness and responsiveness, and care co-ordination. LTC includes a range personal care services to help disabled people with basic activities of daily living (ADL), as well as basic medical services, nursing care, prevention, rehabilitation or palliative care. It can also include domestic help and help with administrative tasks.

LTC quality measurement lags behind comparable efforts in heath

Indicators of LTC quality are useful for government regulatory oversight, help providers identify problems and point to adverse events in the provision of care, and can help users make informed choices. Yet, whereas all countries are keen to measure indicators such as 30-days case fatality for stroke and heart attack, few countries systematically measure whether LTC is safe, effective, and centred around the needs of care recipients.

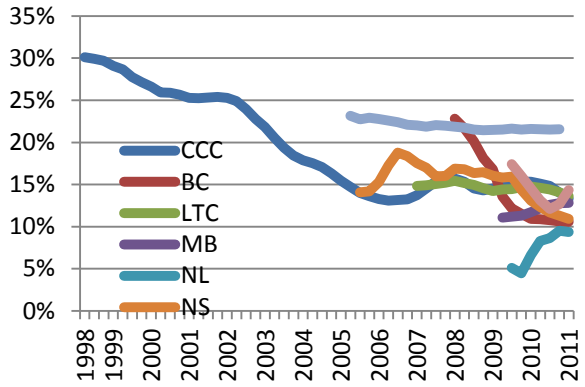
Lessons from the development of quality of health care indicators suggest that indicators should focus on quality outcomes, not processes; be constructed from administrative data using standardised coding systems; and be built on a single item, not on a multi-item scale. See Box 3 for examples of monitoring and improving quality in a few OECD and EU countries.

Clinical quality

Measures of elderly falls and related fractures are only collected in about a third of OECD countries. Even fewer have indicators on bed-sores, medication use, or weight loss, and only a minority such as Finland, Iceland, the Netherlands and the United States have measures of depression among old dependent people, despite this being a very common condition.

Standardised need-assessment tools used by providers to monitor quality have sometimes been employed to generate quality indicators, and provide useful indication of trends (see Figure 3 which shows big differences in the use of physical restraints in nursing homes both across Canadian provinces and over time). Yet more national level data are needed before they can be used for cross-country comparisons.

Figure 3. Restraint use in nursing home in different provinces in Canada, 1996-2010



Source: Canadian data set available from InterRAI.org.

Responsiveness and care co-ordination

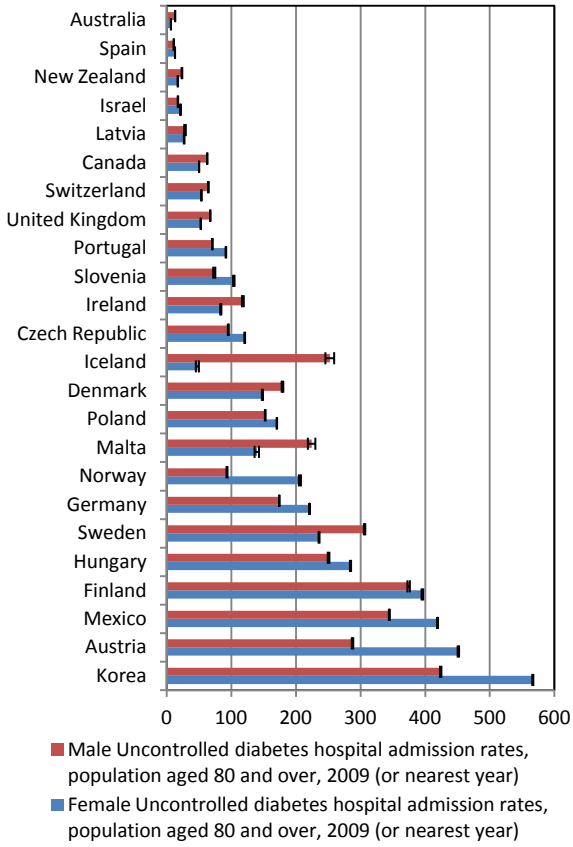
While various policies seek to make care services more attuned with individual wants and needs (for example by increasing the scope for choice of service provider), few measures exist:

- England, Korea, Germany, Portugal and the Netherlands assess user experience in LTC.
- Only half of the countries that are worried about waiting times for LTC services actually collect relevant data (such as hospitalised patients experiencing a delay in transfer to LTC services, as collected in England).
- Avoidable hospital admissions for chronic conditions for elderly people (uncontrolled diabetes, chronic obstructive pulmonary disease, asthma) point to how well primary care and LTC systems manage these conditions (Figure 4).

Quality of life (QoL)

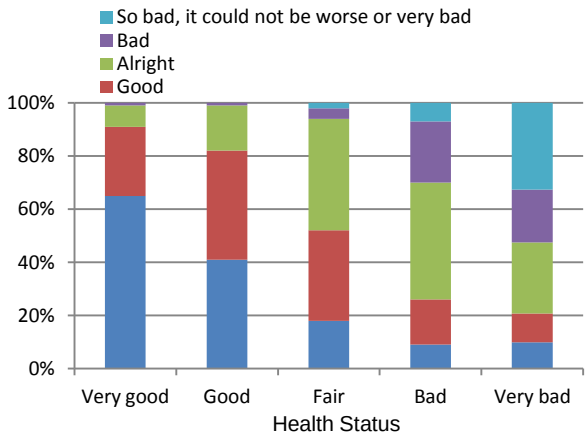
"Quality of life" relates to LTC recipients' ability to live at their highest physical, mental, emotional and social potential. Denmark, Spain, the Netherlands, and England (Figure 5) survey patient and user experience around issues such as consumer choice, autonomy, dignity, comfort, security, relationships and social activity.

Figure 4. Hospital admission rates for uncontrolled diabetes, people aged 80 and over



Source: *OECD Health Data 2011.*

Figure 5. QoL by health status, England



Source: NHS Information Centre, 2012.

Three main approaches have been adopted to drive LTC quality improvement

A review of approaches in OECD and EU countries shows that a combination of policies to drive LTC quality might be most effective:

- **Regulatory standards**, typically focused on setting minimum standards on inputs (labour, infrastructure) and enforcing compliance.
- **Standards to normalise care practice** in desirable ways, and to monitor that quality indicators match objectives.
- **Market incentives for providers and users**, including financial incentives and the grading of providers' performance.

Most regulatory approaches have focused on institutions and minimum standards

All countries have legislation setting principles of adequate and safe care, or protecting against abuse (Box 2). Decentralised bodies are often responsible for quality control.

Licensing, accreditation and minimum standards in nursing homes

In two-thirds of OECD countries, ***accreditation or certification of care facilities*** is compulsory (e.g., England, Spain, Ireland and France), a condition for reimbursement and contracting (e.g., Australia Germany, Spain, Ireland, England, and Portugal, the United States), or common practice (e.g., Switzerland). Accreditation shows that an LTC facility meets certain criteria and is fit to operate. National accreditation bodies are often independent authorities.

Minimum standards are often key elements of evaluation criteria for accreditation or authorisation to practise. Quality dimensions used in accreditation and standard-setting have evolved over time from inputs (e.g., ratio of skilled workers per LTC users) to processes of care (e.g., management of medication, record keeping, infection control), and, more recently, outcomes, quality of life, choice and human dignity, as now used in Australia and the Netherlands.

Accreditation and standards for home care and community-based care services are less common, but can be found in France, Japan, Portugal, Spain and the United States.

Box 2. Protecting old people against abuses

Legislation and regulations lay out the means and procedures to protect against abuses, such as mandatory reporting of neglect or improper care (e.g., in Israel; Ireland; Alberta, Ontario and Nova Scotia, Canada; Germany; Japan; Korea; Norway), or mandatory criminal reference checks for care workers as in Canadian provinces and the United States. National-level campaigns, including training for professionals and older people on responding to elder abuse have been broadly successful in Ireland, Canada, Israel, and the United States. Ombudsmen to act as advocates of old people exist in some provinces in Canada, Finland, and the United States, among others. Adult guardianship and trusteeship arrangements have been established in Australia, Canadian provinces, and the United States, for example. Multidisciplinary teams trained to prevent and intervene exist in Israel.

Staff qualification requirements

Qualification requirements for LTC workers are few, and often do not extend to continuous education or ongoing monitoring. Workers in home care even less likely to be regulated. The hours, settings, training modules, and final certification process vary from around 75 hours in the United States to 430 hours in Australia, and from 75 weeks of total training in Denmark to three years training for certified care workers in Japan.

Enforcement is not strong enough

Enforcement of regulation faces challenges:

- While in the most blatant cases of shortcomings, services are terminated and public payments are cut, for other, less serious cases, enforcement of standards has often been lenient.
- Monitoring of compliance is expensive for regulatory authorities, while adherence to norms and protocols can be costly for providers.
- Strict regulation has limits, for example it can stifle innovations, and providers might focus on what is regulated, rather than on broader quality issues.

There is potential for greater standardisation of care processes

The use of standardised assessment tools is becoming more widespread

Standardised assessment tools used by several providers across OECD and EU countries help develop individualised care plans, appropriate care interventions. They also promote consistency in care and can help to prevent adverse events such as inappropriate prescription of medication. Examples include: the Resident Assessment Instrument (RAI) used in Belgium, Canada, Finland, Iceland, Italy, the United States, and Spain; the AGGIR scale (autonomie, gérontologie, groupe iso-ressources) in France; and KATZ in Belgium.

Many countries using standardised assessment distinguish clearly between the (standardised) process of assessment, and the (tailored) process of drawing up a care plan. This makes it possible to strike the right balance between standardisation of assessment and tailoring of care to individual needs and circumstances.

Protocols of care should be developed

There are few clinical guidelines cutting across health and care settings. Clinical guidelines are usually developed based on randomised clinical trials, but these often exclude elderly patients, or have been developed around specific diseases, making it hard to adapt them to real cases of people having many diseases at the same time. Where guidelines are linked to assessment tools, as in the Programme of All-Inclusive Care for the Elderly in the United States, they provide useful recommendations for the management of users' conditions and interdisciplinary teamwork.

Critically, there is a need for better care guidance around people with complex neurodegenerative conditions such as dementia. Progress in developing clinical guidelines around dementia care has been made in Canada, France, Sweden, and Germany. Belgium, Denmark, France, the Netherlands, Norway, Sweden, England and Scotland have national dementia strategies that include dementia-specific care guidelines for LTC providers as well as provisions related to quality.

Transparency and market incentives for consumers and providers have potential, yet evidence on impact is not robust enough

Mixed evidence on the impact of public reporting

Public reporting on LTC quality, particularly in institutions, is mandatory in the United States, Japan, England, Germany, Portugal, the Netherlands, and Canada (Ontario), while it remains voluntary in Finland and in Austria. These reports have been shown to be effective in encouraging providers to improve their standards.

In England, the United States, the Netherlands, Germany and Sweden, public reports offering information on performance relative to other peers are available at provider level. Evidence from the United States and Korea suggests that this led to efforts to improve safety, communication and responsiveness among providers. However, there are also reports pointing to the contrary from Germany and Portugal, and there remain several challenges to address. For example, providers need a long time to correct deficiencies; they may assess LTC recipients as being more disabled to be able to show improvement; and they tend to be more sensitive to certain indicators where fear of adverse public reaction is high – such as the use of physical restraints.

Quality grading systems

Germany, Korea, Sweden and the United States publish reports on LTC providers along with a grading of their performance based on weighted quality indicators. In the United States, *Nursing Home Compare* – a web-based tool allowing comparisons across nursing homes -- has led to more informed decision making among LTC users. However, evidence from England, where a star-rating system has been discontinued, suggested that only one in six users were aware of public reporting and very few used this information. Furthermore, star rating systems raise questions regarding how to weight different indicators, how to use evidence to improve low-performers and whether frail older people are able to make informed choices.

Choice and consumer direction

Rather than focussing on carers, some countries support users so that they can make decisions on the sort of care they want, for example by giving them money to spend on care. Such mechanisms have been introduced in nearly two-thirds of the OECD countries, particularly in Europe. While they have been associated to higher satisfaction among users, unregulated use of cash benefits can be counterproductive for the quality of care, for example when there is little oversight over the standards for LTC workers, as shown by evidence from Italy and the United States.

Paying providers for higher quality shows potential, but needs more experimentation

Performance payments are gaining attention in health care as a means to reward higher quality and improved care co-ordination, yet few countries have initiated such incentives in LTC. In Korea, the Value Incentive Programme for LTC hospitals links evaluation results with fee payments. In the United States, some states have started a value-based purchasing model for nursing homes since 2009. Evidence suggests that financial incentives can help to change behaviour around specific outcome items, stimulate greater reporting of clinical data and the use of assessment systems. However better evaluation of impact on clinical and other aspects of quality is necessary before more widespread use is recommended.

Care co-ordination

People needing LTC services are more likely to have chronic conditions or multiple morbidities. Poor care integration is a main cause of dissatisfaction, leading to harmful events such as avoidable hospital re-admissions. Several initiatives show potential for improving care co-ordination in LTC, such as: i) good case management or primary-care co-ordinators in Japan and Sweden; ii) interdisciplinary care in Belgium, France and Portugal; iii) availability of integrated information system linking data through the continuum of care and portable across health and care settings as in Portugal; iv) multidisciplinary assessments teams, single-entry points as in the Netherlands and Sweden.

Box 3. Measuring and monitoring quality of long-term care in a selection of OECD and EU countries

In **Australia**, a set of common community care standards have been implemented by most jurisdictions since 2011 to integrate and standardise accreditation for community care services. According to this regulation, there are 18 indicators (and associated expected outcomes) covering management, access and service delivery, as well as service user's rights. The performance of providers is monitored through the Community Care Quality Reporting Programme.

In **Canada**, data on LTC quality are collected through standardised assessment instruments (RAI) and submitted to the Continuing Care Reporting System of the Canadian Institute for Health Information (CIHI). Information is provided on volumes and pathways, demographics, outcome scales, quality indicators, and resource utilisation, at the provider level.

In **Finland**, quality indicators are derived from a voluntary quality development network using the RAI assessment instruments in place since 2000. Although the coverage is about 30% of the total LTC users, the collected information are standardised and comparable across different counties using RAI assessment instruments. Some local authorities require RAI-based quality information as part of the service procurement contracts for residential care.

In **Germany**, The Medical Advisory Boards of the Health Insurance Funds (*Medizinische Dienste der Krankenversicherung*) is a central body responsible for needs assessment and quality assurance in LTC. Providers are obliged to meet transparency agreements and report information which feed into transparency reports (started in 2009). These include information on inspections of the rooms, living areas and documentation on relevant activities, as well as the results of personal visits among the residents. The quality related indicators measured by the audits and inspections are related to nursing and health care and patient satisfaction as well as structural aspects.

In the **Netherlands**, the Ministry of Health developed the CQ®Index to measure the experiences of patients in nursing homes and homes for the elderly. The CQ®Index is based on the national quality framework for "responsible care" which specifies ten quality domains such as quality of life and satisfaction of users. The institutions are ranked and the information is available to the public.

In **Portugal**, an on-line web based system of data management (GestCare CCI) was developed to compliment the National Network of Integrated Continuous Care (RNCCI) in 2007. This allows the continuous monitoring of assessments of recipients across transitory care and long-term care at provider, regional and national level. Providers are required to collect and report data for a minimal data set. Needs assessment is the instrument that assists the monitoring process and provides a basis for the publication of a report every six months.

In **Sweden,** registries offer a rich source of quality information among elderly people. For example, the Senior Alert Registry, started in 2009, gathers individual data on falls, pressure sores and malnutrition to help in identifying elderly people at risk. By 2012, 274 municipalities (out of 290) reported data to the registry. Using such data and surveys, Sweden has recently started a website, "Elderly Guide" containing quality data for all municipalities as well as special housing, home-help services and day care services units. Thirty-six indicators such as responsiveness, care co-ordination, and quality of life are reported.

In **the United States,** some of the data submitted from Medicare and Medicaid certified nursing homes and home health agencies are posted on the website of the Centers for Medicare and Medicaid Services (CMS). The public is free to access the information and evaluation of each facility and provider.

Did you know? Key Facts about Long-term Care in OECD countries

- In 2010, OECD countries allocated 1.6% of GDP to public spending on LTC. LTC expenditure has grown on average at an annual rate of over 9% since 2000 across 25 OECD countries, compared to 4% for public expenditure on health.

- LTC services are increasingly being delivered in care recipients' homes. In 2010, over 8% of people aged 65 years old and over received care at home while less than 4% of them received care in institutions.

- Less than a third of OECD countries collect LTC quality measures systematically – e.g., in Canadian provinces, Finland, Iceland, Korea, Germany, the Netherlands, Norway, Portugal and the United States.

- In more than two-thirds of 27 OECD and EU countries reviewed, accreditation of LTC institutions is either compulsory (England, Spain, Ireland and France), or is a condition for reimbursement or contracting (e.g., Australia Germany, Spain, Ireland, England, and Portugal, the United States).

- Protection mechanisms to prevent elder abuse include national awareness campaigns (e.g. Ireland), training of care workers to identify and respond abuses (e.g., Ireland, Canada, Israel, the United States), and complaint or reporting mechanisms (e.g. Alberta, Ontario and Nova Scotia, Canada; Germany, Norway, the United States, the Netherlands, Japan, England and Scotland.

- Educational requirements for personal care workers vary significantly, ranging from around 75 hours in the United States to 430 hours in Australia, and from 75 weeks of total training in Denmark to three years training for certified care workers in Japan.

- More than one-third of OECD countries make information on care providers available in the form of public reports at the national level.

Further reading

OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264194564-en

Colombo, F. et al. (2011), *Help Wanted? Providing and Paying for Long-Term Care,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264097759-en

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