LAUNCHING THE LIVING ALONE WITH COGNITIVE IMPAIRMENT (LACI) PROJECT: BRIDGING RESEARCH AND POLICY

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The Living Alone with Cognitive Impairment (LACI) Project bridges research and policy to develop policy recommendations to address the needs of people living alone with cognitive impairment (PLACI) through new expansions of long-term services and supports. There are an estimated 4.3 million PLACI in the United States. Access to formal LTSS is critical to them because they lack cohabitants to assist with activities of daily living and navigating LTSS, especially during the COVID-19 pandemic. To bridge research with policy, seventeen Policy Advisory Group (PAG) members were recruited, including representatives from state and local government, and LTSS policy experts. Between November 2020-January 2021, a total of 17 individual meetings were conducted with PAG members and one webinar convening of the group. The PAG identified preliminary recommendations in three areas, including: 1) important areas of inquiry for qualitative and quantitative research, 2) best practices for addressing equity across diverse racial/ethnic minority groups, and 3) preliminary policy recommendations that leverage existing innovations. The LACI Project team is actively incorporating the PAG feedback by: a) modifying research questions for the quantitative and qualitative research, b) convening a diverse Community Advisory Group, and c) crafting preliminary policy recommendations based on PAG input. To conclude, engaging the expertise of the PAG to develop policy recommendations to increase LTSS for PLACI is a promising method of bridging research and policy. The engagement of policy experts ensures that fore-coming research is designed to address the most important policy gaps and all policy recommendations are actionable and timely.

LOWER WAGES OF NURSES IN LONG-TERM CARE: DOES RACIAL AND ETHNIC DIVERSITY EXPLAIN THE DIFFERENCE?

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Registered nurses (RNs) are a key component of the long-term care (LTC) workforce and prior research demonstrates their importance to ensuring patient safety in LTC settings. RNs who work in LTC settings earn less than those who work in hospitals and also are more likely to be from racial and ethnic minority groups. This study seeks to measure wage differences between Registered Nurses (RNs) working in LTC and other settings (e.g., hospitals) and whether differences are associated with the characteristics of the RN workforce between and within settings. We used the 2018 National Sample Survey of Registered Nurses (NSSRN) public-use file to examine RN employment and earnings. Our study population included a sample of 15,373 employed RNs who provided patient care. Characteristics such as race/ethnicity, type of RN degree completed, census region, and union status were included in bivariate analyses and multiple regression analyses to examine the effect of these characteristics on wages. Logistic regression was used to predict RN employment in LTC settings. We found that RNs in LTC experienced lower wages compared to those in non-LTC settings, yet this difference was not associated with racial/ethnic or international educational differences. LTC nurses were also significantly less likely to be represented by a labor union, and there was not a statistically significant wage difference for LTC RNs who were unionized. Because RNs in LTC earn lower wages than RNs in other settings, policies to minimize pay inequities are needed to support the RN workforce caring for frail older adults.

WHOLE TEAM, WHOLE PERSON HIGH-INVOLVEMENT QUALITY IMPROVEMENT TRAINING FOR VA COMMUNITY LIVING CENTER LEADERS

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Long-term care is a challenging environment for quality improvement due to the high resident acuity, wide variation in resident needs, and wide variation in types and backgrounds of the large staff across three daily shifts. We report results from a learning collaborative undertaken to improve care quality and staff quality improvement skills in the VA CLCs through development of high functioning relationally coordinated teams operating in accord with person-centered care principles. The collaborative included 27 CLCs. Over 9 months leadership teams completed action assignments supported by 5 workshops and regular group coaching calls. Evaluation included fidelity monitoring (attendance, mid- and final progress reports), satisfaction questionnaires, and review of the VA quality measures (CLC Compare). Pre-post participant evaluations revealed a significant increase in positive responses to the question "to what extent do you think applying these new skills/knowledge will improve quality in your CLC?" and positive responses trending toward significance in ratings of abilities to apply new skills. Open-ended survey comments were positive and indicated change in understanding and practice: "utilizing the daily huddle to facilitate real time communication afforded the team a proactive approach to providing care and reducing acute exacerbations. We are able to avert, evaluate as a real time team and make it happen in the now not as a look back."; "definitely unified front-line staff and CLC leadership." Some changes were achieved in CLC Compare quality scores (e.g., falls with major injury rate had a 9.6 reduction (average rate = 3.39 pre, 3.07 post)).