Specialized care for younger nursing home (NH) residents may be necessary to meet their unique health and quality of life needs; however, key attributes of younger NH residents are poorly understood and limit the development of effective, tailored interventions. This study described differences in clinical and nonclinical characteristics of younger vs. older nursing NH residents. In a retrospective cohort study, we used SPSS and analyzed comprehensive Resident Assessment Instrument – Minimum Data Set (RAI-MDS 2.0) data from NHs in Western Canada, for the period from January 2016 to December 2017. We included all assessments (full and abbreviated) performed quarterly. These findings indicated that younger (age 18-64) vs. older (age >=65) NH residents differed considerably: younger residents were predominately male, single, more obese, more depressed, had higher prevalence of depression, cerebral vascular accident, and hemi- or quadriplegia, and required more assistance in activities of daily living than older residents. The findings will contribute a better comprehension of the characteristics of the younger NH population and how they differ from other residents. The study provides useful information to policymakers, providers, and researchers to guide them in developing tailored policies, programs, and interventions. Also, findings may guide consumers as they plan for long-term care needs of loved ones. Finally, the findings provide a baseline estimate as researchers continue to track the growth of and changes in, the populations served in nursing homes.

ACUITY DIFFERENCES AMONG NEWLY ADMITTED MEDICARE RESIDENTS IN RURAL AND URBAN SKILLED NURSING FACILITIES

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Using the 2015 national Minimum Data Set Version 3.0, the Area Health Resources Files, the 2015 Provider of Services File, and the Rural-Urban Commuting Area codes, this study assessed rural-urban differences in newly admitted, Medicare skilled nursing facility (SNF) residents' functional status, cognitive performance, and behavioral issues using self-performance, early loss, and late loss Activities of Daily Living (ADLs); the Cognitive Function Scale (CFS); and indicators of aggression, psychosis, or wandering, respectively. The study evaluated 686,881 unique patient assessments for newly admitted Medicare SNF residents across 15,157 facilities in 47 states. Negative binomial and generalized linear models with state fixed effects and clustering by SNFs were used to evaluate rural-urban acuity differences before and after adjusting for socio-economic factors; admission source, and market area characteristics. Compared to urban SNF residents, rural residents were more likely to be cognitively impaired (45% Isolated Small Rural, 44.5% Small Rural, 41% Large Rural, 38.8% Urban), and have behavioral issues (6.7% rural, 4.8% urban). Unadjusted and adjusted regression models confirmed bivariate findings that rural SNF residents were less functionally impaired (IRR range: 0.974-.987), but had more cognitive and behavioral issues in more remote rural locations than urban. The (unadjusted) odds of cognitive impairment were 1.1-1.3 times higher for residents of rural vs urban SNFs; while the odds of having any one of the behavioral issues were 1.2-1.6 times higher in more remote rural locations. The capacity of rural SNFs to manage complex cognitive and behavioral problems deserves further research.

FACTORS AFFECTING THE SUSTAINMENT, SUSTAINABILITY, AND SPREAD OF PRACTICE CHANGES IN CANADIAN LONG-TERM CARE HOMES

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Our understanding of the post-implementation sustainment, sustainability, and spread (SSS) of complex quality improvement interventions is limited. We explored factors that influenced the SSS of a care aide-led quality improvement initiative (Safer Care for Older Persons (in residential) Environments [SCOPE]) implemented in 6 Manitoba long-term care homes two years after the conclusion of SCOPE in 2017. We analyzed small group interview data collected from all unit- and facility-level managers who participated in SCOPE and were still working in these facilities. We asked about SCOPE implementation, post-SCOPE quality improvement activities, factors that influenced them, and about inter-unit spread of SCOPE following the project's conclusion. The interviews were audio-recorded, transcribed verbatim, de-identified, and analyzed using thematic analysis. Five of the 6 facilities reported sustained SCOPE quality improvement activities, tools, and facilitative structures. In the same 5 facilities, SCOPE benefits (e.g., increases in care aide empowerment and self-efficacy, manager belief in care aide capacity) continued post-implementation. Spread beyond the original SCOPE units had occurred in 3 facilities. Factors that influenced the SSS of SCOPE were related to the team (e.g., care aides' quality improvement capacity), to the unit and facility (e.g., culture of innovation and change), and to the long-term care system (e.g., competing imperatives). Some factors influencing SSS differ from factors known to influence implementation. The identified factors affecting SSS highlight the influence of social dynamics (i.e., interactions, communication, relationships) among staff on SSS. Further research is warranted to explore interactions among these influencing factors and how they lead to SSS.

FEASIBILITY OF ROUTINE QUALITY-OF-LIFE ASSESSMENT IN LONG-TERM CARE HOMES

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