Clinician's Commentary on McArthur et al.¹

How do we define *rehabilitation* for someone who is 82 and living with multiple comorbidities, including dementia? This is the typical profile of a resident in long-term care (LTC) in most facilities across Canada.² This topic raises many questions, to which there are few answers; it is an area ripe for more research, practice change, and policy recommendations to support better care for LTC residents. These questions clearly indicate that support for older adults in these settings must improve. McArthur and colleagues' study¹ underlines the importance of this conclusion. The authors found that most residents in LTC facilities across Canada receive no physiotherapy (PT) or occupational therapy (OT); that there are regional differences in who receives PT and OT; and that older, more cognitively impaired residents are overlooked for PT and OT. Why do these people not qualify for rehabilitation? More generally, how do we determine who qualifies for rehabilitation?

The regional disparities are significant: rates of rehabilitation use in 2009/2010 ranged from 5.6% in Manitoba to 31% in Yukon.¹ These disparities are symptoms of inequities in health care systems whereby people can be denied care because of their province or territory of residence. Another inequity is the phenomenon of older LTC residents with dementia and symptoms of depression being overlooked in the provision of rehabilitation services. It isn't that these residents can't benefit from therapy; as McArthur and colleagues point out, "Evidence contradicts this idea, demonstrating that residents with cognitive impairment can demonstrate physical and functional improvements," and "those with mood disorders see improvement with exercise."¹ If LTC residents do in fact need PT and OT but are not getting it, what is it about the assessment process that produces this result?

Assessments must have purpose, and must be based on measures and goals. But what is a rehabilitation goal for a resident of LTC? Rehabilitation often focuses on physical activity and on goals related to functional independence – goals that may not be appropriate for LTC residents with dementia and other comorbidities. Best care practices prescribe goals that are suitable for the individual, in that "healthcare providers should offer services in a way that is sensitive to an individual's needs and preferences."^{3(p.1)} Ideally, this means involving the individual in decision making. Perhaps the resulting decision-making process would produce goals such as drinking from a cup unaided. This and other seemingly modest goals are important for a person struggling with the basic physical activities. Moreover, some of these modest goals have significant physical health implications. For example, if no attempt is made to maintain some mobility, health complications such as pressure ulcers can develop. The mobility objectives here are more modest than the ability to walk; simply sitting up or moving about in bed, with or without assistance, can be an important goal.

Besides augmenting functional independence goals, we should enlarge the definition of rehabilitation. Functional independence may not be the main goal for everyone; as Young^{4(p.22)} notes, to be successful, "rehabilitation requires a broader definition." Rehabilitation can be defined as activities to realize a person's full potential. This is particularly true when a person is unable to carry out basic physical activities; in such cases, rehabilitation becomes "much more holistic and should be also concerned

with social, psychological and emotional health."^{4(p.23),5} In addition, rehabilitation should focus on preventing excess disability for this vulnerable group—that is, disability that may arise through the disuse of existing abilities, not necessarily from the course of the disease. In the long run, this approach is likely to increase independence for residents of LTC, and thus decrease the workload for the health care aides who perform most of the care.⁶

When we consider LTC residents' involvement in decision making, one question that arises is whether those with severe dementia are capable of making decisions. Many residents with dementia also suffer from depression, which, as McArthur and colleagues note, "a barrier to the provision of therapy in LTC."¹ It is difficult to determine the rehabilitation needs of residents who are unable to express their needs, who are apathetic, or who simply are not "up to it." How, then, can we ensure that those who are effectively without a voice are not overlooked, and are given treatments when required? When patients are unable to speak, decisions must be made by health care professionals, which means that we must enable these professionals, through education, to understand and address the special needs of LTC residents. Efforts are underway in this direction. For example, a National Initiative for Care of the Elderly (NICE) working group has developed a set of core inter-professional competencies for gerontology,⁷ which constitute an educational resource for use in developing curriculum and examinations to ensure that future health care professionals share a fundamental understanding of gerontology. The goal of these and other education programmes is that incidents of marginalizing and overlooking people with dementia will diminish.

Finally, when assessing LTC residents, we may need to consider PT and OT in the context of other rehabilitation. Cognitive and other therapies may improve receptivity to PT treatment, and can help determine the appropriate physiotherapy and the correct dose to maintain and/or improve function. This interdependence suggests that we need an interdisciplinary approach. What does this mean in practice? Perhaps an assessment by the physiotherapist at admission, followed by delivery of care plans by PT aides and nurse's aides under nursing supervision. PT assessment could also be part of a comprehensive assessment used to develop individualized care plans based on each LTC resident's multiple comorbidities. It is possible that aspects of these and other ideas are already being tried in some LTC facilities in some provinces. Certainly there is no consistent or comprehensive approach to rehabilitation of LTC residents with dementia, except in the sense that it appears not to be done very well. The result is not only inequity in health care but also a lack of regard for those who are in great need of help. Health care professionals, researchers, and public policy makers across Canada must find the momentum, the resources, and the will to solve this problem together.

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