Social and Functional Health of Home Care Clients with Different Levels of Cognitive Impairments

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IBENC: Identifying Best Practices for Care-Dependent Elderly by Benchmarking Costs and Outcomes of Community Care
Background

- According to ICF (WHO 2001) and its application guidelines (WHO 2013), people with considerable cognitive and intellectual disabilities have the right of participation and autonomy.

- However, to what extent are such participation and life in a community a readily realistic option for people with cognitive impairments? (We say: as long as possible).

- Even if HC-Services are provided, people with cognitive problems need some own capabilities + scope of discretion to cope their own way.
Why own resources are necessary

• Regularly: professional staff of „normal“ Home Care services (HC) are **better qualified for somatic diseases + physical disabilities** than for people with cognitive problems (Genet, et al. 2012).

• **Time** for HC provision **is limited in most European countries.** Cognitively impaired clients need time. With an increasing level of impairment more and more physical presence of caregivers or intimates is needed.
Research Questions

• How far are cognitively impaired clients able to participate in social activities?

• How far are they able to cope with (“demanding”) requirements?

• What are the determinants of successful coping with instrumental and social requirements?
Focus of this presentation:

Mildly to moderately cognitively impaired clients (=M+M clients), who are probably able to complete everyday tasks, even with tasks that may be ‘challenging’:

– managing payments and bills, self-medication, use of phone.
– maintaining contacts to some family members and significant persons.
Method

• Targets: “Typical“ HC-services in 6 countries and their clients (n=2,884), female=66.9%, male=31.1%  

• Comprehensive standardized Assessment, interRAI HC (Morris et al. 1997), Version 9.1.2, completed by trained staff + research nurses

• Inclusion: 65+ years, service use ≥14 days, probable utilization still 6+ months

• Exclusion: palliative, end of life, short-term clients
Method – cognitive status

- interRAI CPS (Hartmeier et al., 1995), range 0 (independent) to 6 (very severely impaired), includes the item „decision making“ in simple situations, communication, etc.
- Memory: short-term, procedural, situational
- Diagnoses from a pick-list:
  - Alzheimer‘s
  - Dementias (other than Alzheimer‘s)
Method – capabilities

**Everyday management:** demanding tasks (money/finances, [self]medication, phone use) = single items of IADLs

- Performance
- Capacity

**Social activities:**

- Participation in favored social activities
- Visits (receiving + actively visiting)
- Contacts „other than face to face“ (by mail or phone)

[analysis.pptx]
Sample: distribution of participants (HC-clients) in countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ice</td>
<td>14.6%</td>
</tr>
<tr>
<td>Fin</td>
<td>15.8%</td>
</tr>
<tr>
<td>Be</td>
<td>18.2%</td>
</tr>
<tr>
<td>NL</td>
<td>17.0%</td>
</tr>
<tr>
<td>De</td>
<td>17.1%</td>
</tr>
<tr>
<td>It</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

Total n = 2,884

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Cognitive status (CPS) – national samples

<table>
<thead>
<tr>
<th>Country</th>
<th>CPS Mean</th>
<th>% Mild to Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ice</td>
<td>1.1</td>
<td>35%</td>
</tr>
<tr>
<td>Fin</td>
<td>1.3</td>
<td>44.3%</td>
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<tr>
<td>Be</td>
<td>1.6</td>
<td>27.3%</td>
</tr>
<tr>
<td>NL</td>
<td>0.6</td>
<td>13.8%</td>
</tr>
<tr>
<td>De</td>
<td>1.6</td>
<td>36.1%</td>
</tr>
<tr>
<td>It</td>
<td>2.3</td>
<td>30.5%</td>
</tr>
<tr>
<td>Ø</td>
<td>1.4</td>
<td>30.9%</td>
</tr>
</tbody>
</table>
Coping with requirements—voluntarily or involuntarily?

Is there anybody who will care?

Live alone - average of countries = 57%,

- cognitively independent = 63.1%
- M+M clients = 58.1%
- cognitively worse than moderate = 27.1%

Yet more important: number of hours spent alone during the day!
### M+M clients: alone - living and being during the daytime

<table>
<thead>
<tr>
<th>Country</th>
<th>% live alone</th>
<th>% alone &gt; 8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ice</td>
<td>59</td>
<td>29.5</td>
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<tr>
<td>Fin</td>
<td>79</td>
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<tr>
<td>Be</td>
<td>47</td>
<td>24.5</td>
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<tr>
<td>NL</td>
<td>48</td>
<td>30.9</td>
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<tr>
<td>De</td>
<td>79</td>
<td>29.2</td>
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<tr>
<td>It</td>
<td>16</td>
<td>6.8</td>
</tr>
<tr>
<td>Ø</td>
<td>58</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

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Participation in social activities (of long standing interest) (%), n.s.

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Mutual visits \( (\chi^2(4)=39.94, p<.000) \)
Interaction by phone/email (%, $\chi^2(4)=45.5, p<.000$)

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Determinants

• **Capacity** for all three tasks depends on overall CPS-score, which significantly interacts with procedural memory and/or situational memory.

• **Performance** is also dependent on CPS-score in all three tasks. It is minimized if problems of procedural memory occur - but only in cognitively independent clients.
Role of “memory functions”

- Short-term memory = relatively unimportant
- It is the procedural memory that influences the fulfilment of „challenging“ requirements (Money, self-medication, use of phone)
- Problems of situational memory limit the frequency of visits. They also constrict the social participation to “close relations” only.
- These findings are important messages to caregivers and program implementors.
Conclusions

– The performance + capacity depend on the „overall“ cognitive status (as reflected by the CPS-score) more than on “memory functions”.

– Performance in all three activities is significantly dependent on time spent alone. Increase of # of hours alone means decrease of the performance. (Caution!)

– At least one third of M+M clients are able to manage challenging everyday tasks; up to 40% is able to keep social relations.
Thank you for your attention!

For references & more information please contact
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