

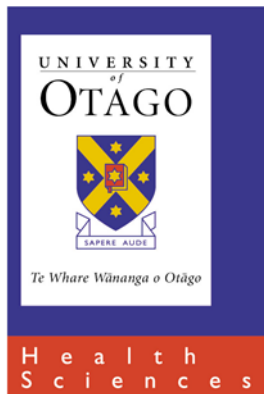
Risk factors for reduced social engagement in older people

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National Science Challenge

Ageing Well

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Assessing the needs of older people

- **Key messages** (since 2003, NZGG report)
- Comprehensive – covering multiple domains
- In context – home based, involving family and carer(s)
- Standardised, valid and reliable, and available to support integrated services, and change over time.

Evidence base – risks of reduced social engagement

- Can be both cause and effect, of poorer health outcomes
- Interplay with mood, mobility, everyday functions, physical activity
- interRAI - HC assesses three separate pathways to “risk”
- 3 pathways to improve outcomes, or to recommend cost-effective interventions.

ASSESSMENT PROCESSES FOR OLDER PEOPLE

The Guidelines Group has developed a best practice, evidence-based guideline with recommendations for appropriate and effective processes for assessment of personal, social and clinical needs in older people. This general summary provides an overview of the recommendations.

KEY MESSAGES

- Assessment of older people across New Zealand is essential.
- Assessment of older people should be comprehensive and multidimensional.
- Screening of the asymptomatic general population aged 75 years and over has been shown to reduce the greatest improvement in health and well-being.
- When conducting an assessment, the assessor should work with the older person to develop a treatment/management plan.
- Supporting carers' needs result in improved outcomes for both the carer and the older person, including reduction in abuse of older people.
- Māori and Pacific people and some people with known disabilities have a lower life expectancy than the general population and should be eligible for screening and assessment at an earlier age.
- Screening should be followed by timely and effective interventions and regular follow-up.
- A standard assessment tool and standard methods of collecting, reporting and comparing results should be used.
- Screening and assessment should be complementary parts of an integrated system.
- Assessors must receive specialist training, be part of a multidisciplinary team, and have awareness of older peoples' issues.
- Assessors should be fluent in te reo Māori me ōna tikanga where the older person whānau prefers its use, and should be known and respected in their community.
- Assessors should be from the same ethnic background and speak the language of the person being assessed wherever possible.

The Assessment Processes for Older People Guideline and summaries have been endorsed by:



DOMAINS OF ASSESSMENT

Areas of need of most importance to older people

- personal care
- social participation
- control over daily life
- food
- safety

Domains and dimensions

These are areas in which impairment can be detected at an early stage.

Physical health and functioning

key dimensions: chronic illness, continence, nutrition, gait, mobility, cardiac conditions, gastrointestinal conditions, pulmonary conditions, cerebrovascular conditions, co-morbidities, ADLs and IADLs (including self-care and domestic abilities), iatrogenic disease (specifically due to polypharmacy), sexual functioning, speech and language impairment, dental/ oral health, vision and hearing

Mental health and functioning

key dimensions: anxiety, depression, other mental illness, cognitive functioning, dementia, substance abuse, iatrogenic disease due to polypharmacy, emotional well-being

Social functioning

key dimensions: financial status and management, housing, family/whānau support/contact, social networks, social activities and support

Presence and roles of carers, especially informal carers

Risk factors

- aged 75 years or older
- socially isolated and/or living alone
- divorced/separated, never married, single or widowed
- recently bereaved
- has no children
- has poor or limited economic resources
- recently discharged from hospital
- presenting at an emergency department
- recent change in health status with an impact on capacity for independent living
- has multiple disorders or illness
- cognitively impaired
- depressed
- poor self-perceived health
- high or low body mass index
- at the lower extreme of functional impairment
- low physical activity
- taking 3 or more prescription/non-prescription medications
- impairment in sight or hearing
- carer showing signs of stress/change of care
- carer requests an assessment for the older person

Also consider:

- alcohol, tobacco and/or substance use
- abuse of the person by another

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An electronic copy of the full guideline is available for download from www.nzso.org.nz, or a printed copy is available from www.nzso.org.nz, phone 04-4 471 4100 or fax 10-645, Wellington, New Zealand.



Social functioning within domains of assessment

- Housing, and living situation (alone, with others)
- Family/whanau support/ contact
- Social networks,
- Social activities and support
- Financial status and management
- Presence and roles of carers, esp. informal

Conducting an assessment conversation at home



interRAI

inter = international, RAI = resident assessment instrument

A shift

- To a standardised and reliable assessment system
- To decision support for assessors and care managers
- To electronic form of communication
- To minimise omissions
- To provide a platform assessment → support services or further investigation
- To 'at point of care' data collection system

Appropriate software enables the data interfaces from one version to another, and data to be aggregated

How to measure and assess social engagement

Section F – Social Functioning

Involvement

Change in social activities (as compared to 90 days ago).

Isolation – a) length of time alone during day b) says or indicates that s/he feels lonely yes/ no.

Section G. Informal Support Services

Name 2 Key informal helpers – Primary and 2ndary

Lives with client yes/ no

Relat to client - Spouse, 2, other relative, 3. Friend/neighbour.

Areas of help: advice/ emotional support - IADL

ADL

If needed, willingness to increase help

Check - a) Caregiver unable to continue in caring activities -.e.g decline in health.

b) primary caregiver is not satisfied with support received from family and friends

c) Primary CG expresses feelings of distress, anger or depression.

Extent of informal help: Hrs of care, rounded: In last 7 days, IADL and ADL received over last 7 days

Ways reduced social engagement is assessed in interRAI

1. Through measures of social isolation, loneliness and depression, recently reduced social activity, and 'time spent home alone' is also included.
2. Presence or absence of family carer and whether they are co-resident or not.
3. Availability of social support - from family or others in neighborhood or community.

Research Team

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Impacts

- National information on social engagement by ethnicity, gender, age and region; association with significant clinical factors.
- To assist with targeting service planning
- Building NZ's own evidence base within interRAI methodology
- Improving individual care planning and integrating health and social services