HOW TO DECIDE IF AN ELDERLY PERSON WITH DEMENTIA CAN STAY AT HOME: THE “INTERVAL OF NEED” CONCEPT

considerations involve “INTERVAL OF NEED” and “INTERVAL OF SUPPORT”.

The “Interval of Need” is how long a caregiver can safely leave a person without seeing them. The “Interval of Support” is how often a caregiver is ABLE to see the person. If one compares the Interval of Need to the Interval of Support, one has a framework to decide whether someone can return home from hospital, or will require relocation to a retirement residence or nursing home. This applies to persons with or without dementia. The Interval of Support calculation involves live-in caregivers, “live-out” family, friends, CCAC/home care, and paid support. If one can engineer a match between the Intervals of Need and Support, an individual can safely go home.

The following chart was developed for persons with dementia, though the Interval of Need/Support concept applies to cognitively-well elderly who are frail, or dependent for activities of daily living.

Interval of Need	AD Stage (MMSE)	Functional Loss	Formal Services	Caregiver Situation
2 - 7 days	Mild (23-28)	Some Instrumental ADLs Behaviour 0 to +	+ to ++	- Alone - May have CG
24 - 48 hours	Mild-Mod (18-22)	Most Instrumental ADLs Behaviour 0 to +	+ to +++	- Alone, RH, or LTC - Family visits - May have CG
4 – 12 hours	Moderate (14 to 18)	Some Personal ADLs Behaviour 0 to ++	+ to +++ with respite (underutilized)	- Needs live-in CG, or RH - LTC needs to be considered
1 – 4 hours	Mod-Sev (10 to 13)	Most Personal ADLs Behaviour + to +++	++ to +++ with respite	- Live-in CG (usually spouse), or RH (assisted), or LTC (suggest apply now)
< 1 hour	Severe (<10)	All Personal ADLs Behaviour + to ++++	++ to ++++ with respite	- Devoted spouse CG or LTC (definitely apply now)

Legend: ADLs (activities of daily living), CG (caregiver), RH (retirement home), LTC (long-term care/ nursing home).

INTERVAL OF NEED ↔ INTERVAL OF SUPPORT— Part 2

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The first principle of Geriatric care is to maximize the “individual and family” before looking at supportive service options. For a person with dementia (PWD), this involves appropriate assessment – to confirm a diagnosis of dementia, what type of dementia, and the level of severity. If this cannot be established by the patient’s family physician, referral for specialist care is indicated.

INTERVAL OF NEED ↔ INTERVAL OF SUPPORT— Part 2

It is important to rule out reversible causes of cognitive impairment and delirium, such as infections, metabolic disturbances, and medications (especially sedatives and anticholinergic drugs). The local pharmacist can perform a "med-check". A PWD may not seek out care for concomitant chronic diseases, nor might they comply with health care recommendations. 'Tuning up' of conditions such as diabetes, hypertension, heart failure, lung problems, and chronic pain may make a big difference.

In terms of anti-dementia drug therapy, the recent Canadian Consensus Guidelines[1] advocated that all PWD should be offered a three-month trial of a cholinesterase inhibitor (unless contraindicated). This was based on over thirty comprehensive clinical trials and expert consensus documents produced by geriatricians, geriatric psychiatrists, neurologists, and general practitioners. My own clinical experience with thousands of PWD has been that 25% of patients improve on cholinesterase inhibitors, and 50% "stabilize", often for 1-2 years, and sometimes longer.

The issue of caregiver support is critical. This involves assistance with primary caregiver stress, ill health, burnout, and depression. Involving other family members (i.e. secondary caregivers) may provide welcome relief. Education is also very important. One study of caregiver education and a dementia care hotline demonstrated that families were able to keep their loved ones at home an extra 1.5 years with such services[2]. Referral to the local Alzheimer Society via "First Link" is essential for such education, counselling, and advice. As well, there are many books and on-line resources (www.alzheimer.ca/on). Remember, 90% of support for PWD is through family and friends. Arrange Power of Attorney for Finances/Personal Care AND discuss Advance Health Directives EARLY.

The Community Care Access Centre (www.ccac-ont.ca) can provide important support: 1) Personal Support Workers, but only if the PWD needs personal care help (e.g. bathing, dressing); 2) Access to Case Managers for system navigation; 3) Specialized therapists (occupational therapists, physiotherapists, and social workers); 4) Access to Day-Away Programs and respite services; and 5) Access to Long-term Care Homes. Retirement residences are increasingly specializing in care for PWD, including short-term respite stays. Respite is very important to ease caregiver burden: a day, overnight, a weekend, or several weeks can make a major difference to quality-of-life. Other useful services include Seniors' Centres, Meals-on-Wheels, private meal delivery services, and private home-care services. Driving safety must be assessed if the PWD is still driving. At the time of diagnosis, 85-90% of PWD are unsafe to drive (see Family Guide regarding driving at www.rgpeo.com). For complicated situations, referral to a Memory Clinic, Geriatric Medicine, or Geriatric Psychiatry services can help.

Once the PWD and his/her family/caregiving situation has been maximized, then examine publicly-funded and/or paid home-care services, and how the "Interval of Need" can be matched to the "Interval of Support" (see accompanying article). If this "match" cannot be made, then relocation to a Retirement Residence or a Long-term Care Home will need to be considered (see Senioropolis.com – RH/LTC guide).

REFERENCES

[1] Can J Neurol Sci. 2012 Nov;39(6 Suppl 5):S1-8
[2] Mittelman M Neurology 2006 Vol.67 #9:1592-99