



## Chronic Conditions in Elders in Assisted Living Facilities: Associations With Daily Functioning, Self-Assessed Health, and Depressive Symptoms



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### ABSTRACT

**Background:** The increasing life expectancy of older adults has prompted an increase in chronic conditions that may interfere with their daily living and impact physical and mental health.

**Objectives:** This study examined associations between commonly reported chronic conditions, daily functioning, self-assessed health, and depressive symptoms of elders.

**Methods/Design:** A secondary analysis of existing data from 314 elderly residents of 29 facilities was conducted.

**Results:** The most frequently reported conditions were arthritis (64%), hypertension (47%), and heart problems (35%). Elders who reported having all three of these most frequently reported conditions differed significantly from those who reported none or one of the three conditions ( $p < .001$ ) on their perception of interference with daily functioning and self-assessed health. Although differences on depressive symptoms were found between groups defined by number and combinations of conditions, specific trends in the data were not detected. Elder's rating of interference of their chronic conditions on daily functioning was moderately associated with their self-assessed health ( $r = -.50, p < .001$ ) and depressive symptoms ( $r = .41, p < .001$ ).

**Conclusion:** While chronic conditions may be unavoidable, assessing their comorbidity in elders is important for developing interventions to preserve their daily functioning and promote their optimal health.

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The population of older adults in the U.S. is rising rapidly as a consequence of increasing life expectancy and the aging of the baby boomers (Karel, Gatz, & Smyer, 2012; Rice & Fineman, 2004). The elderly population is expected to reach 72 million by the year 2030 (Administration on Aging [AOA], 2011). The prevalence of chronic illnesses increases with age (National Center for Chronic Disease Prevention and Health Promotion, 2011), currently 80% of older adults have at least one chronic condition, and 50% have two or more (National Center for Chronic Disease Prevention and Health Promotion, 2011). The average 75 year old has three chronic conditions and consumes an average of five different prescription drugs (MIAH, CDC, & GSA, 2004).

Chronic diseases are defined as illnesses that last longer than 3 months; they are incurable, though not necessarily life threatening/nor self-limiting; however, they place a strain on elders, their families, and their communities (Bishop, 2005; Centers for Disease Control and Prevention, 2009; World Health Organization, 2012). Older adults are at high risk for developing chronic diseases. Among the most common identified chronic diseases are: diabetes mellitus, arthritis, and congestive heart failure (United States Department of Health and Human Services [HHS], Healthy People 2020, 2011).

Chronic diseases such as heart disease and diabetes can cause years of suffering and they are the leading causes of death and disability in the United States (Centers for Disease Control and Prevention, 2012). Disability interferes with daily functioning and decreases elders' function, independence, and quality of life (Whittemore & Dixon, 2008). Currently, because of chronic disease and disability more than 7% of non-institutionalized persons 65 years of age and above are unable to perform one or more activities of daily living such as dressing, bathing, using the toilet, and getting in and out of bed or chairs, and the figure increases to more than 18% for those over 85 years old (Centers for Disease Control and Prevention, 2011). Recent research has indicated that those who live with multiple chronic conditions are at the highest risk of disability, poor self-rated health and poor quality of life (McDaid et al., 2013). In fact, self-assessed health has received much attention in gerontological research (Damian, Ruigomez, Pastor, & Martin-Morena, 1999; McDonald, Zauszniewski, Bekhet, DeHelian, & Morris, 2011) and it typically reflects an individual's overall sense of physical well-being (McDonald et al., 2011; Pinquart, 2001). Self-assessed health has been viewed as a valid indicator of health status and it has been correlated with objective health, functional decline, mortality, and the use of health services (Bekhet & Zauszniewski, 2012; Liang et al., 2005; McDonald et al., 2011; Pinquart, 2001).

In addition to physical suffering, negative psychological consequences of chronic illness have been documented for elders (Yang & George, 2005). Fear of being dependent on caregivers may precipitate depressive symptoms in susceptible individuals (Clarke & Currie, 2009; Gignac, Cott, & Badley, 2000) and further, the risk of depressive

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symptoms increases with the number of chronic diseases (Clarke & Currie, 2009). At the same time, it has been documented that late-life depression increases the likelihood of becoming disabled and can decrease the chance for recovery or even worsen chronic diseases (Cronin-Stubbs et al., 2000; Moussavi et al., 2007). It is a vicious circle: impaired physical health—results in depression, which in turn leads to poorer health. Late life depression is common in long term care facilities, and it has been found to be associated with decreased functioning, disability, increased health care costs, and poorer quality of life (Unutzer & Bruce, 2002). Older people with even minor levels of depressive symptoms have been found to experience significantly poorer quality of life (Chachamovich, Fleck, Laidlaw, & Power, 2008). Furthermore, previous research has found that depression is one of the largest contributing factors to poor self-assessed health among middle aged and elderly men and women (Molarius & Janson, 2002).

Multiple factors, including difficulties with mobility, cognition, self-care and decision making, interfere with elders' ability to remain independent (Lindquist & Colub, 2004). To deal with these difficulties, elders need caregiving services (Talley & Crews, 2007), but they may be impossible to obtain for some elders. An alternative option for seniors who are unable to care for themselves or to have somebody to care for them is placement in an assisted living facility (Fields, Koenig, & Dabelko-Schoeny, 2012; Lindquist & Colub, 2004).

In fact, assisted living facilities are the fastest growing among types of senior housing, at an annual growth rate of 15–20% (Chao, Hagsavas, Mollica, & Dwyer, 2003). In the U.S., there are currently 30,000 to 40,000 assisted living facilities that house approximately 1 million elderly residents (Abrahamson, Bradley, Morgan, & Fulton, 2012; Neville & Teri, 2011; Sloane et al., 2011). Assisted living facilities are home-like residential programs that have been found useful in maximizing the dignity, privacy, and independence of residents (Stachel, Bornschlegel, & Balter, 2012; Wood & Stephens, 2003). They provide social activities, 24 hour supervision, and some health related services (AARP Public Policy Institute, 2004; Neville & Teri, 2011). Such facilities provide care for persons with disabilities and functional limitations and have beneficial effects on their physical and mental well-being (Fields et al., 2012). It has been pointed out that assisted living facilities, in general, have not been studied sufficiently in terms of their role in the broader long-term care marketplace (Grabowski, Stevenson, & Cornell, 2012; Kahn, 2012). Further, research has found that the growth rate of assisted living facilities led to a 1.4% decline in private-pay nursing home occupancy (Grabowski et al., 2012). For all these reasons, there is a compelling need to focus research on enhancing our understanding of the care needed for older adults in assisted living facilities in order to tailor interventions to best meet their needs.

Indeed, there is a strong, well-known direct relationship between physical health and mental health. More specifically, physical and mental health go hand in hand and their prominent association has been supported by research that shows that persons with chronic physical illnesses often suffer simultaneously from a mental health problem (Jeong et al., 2014). In fact, people living with chronic physical health problems experience depression and anxiety twice as frequently as the general population (Canadian Mental Health Association, 2008). On the other hand, people living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions (Canadian Mental Health Association, 2008). For example, persons with mental illnesses, including depression, often have physical problems, such as joint pain, back pain, gastrointestinal problems, and appetite changes that could interfere with the treatment and detection of depression (Jeong et al., 2014; Trivedi, 2004). Co-existing physical and mental health problems can have serious effects on quality of life and other health outcomes (Canadian Mental Health Association, 2008). Therefore, understanding the mind–body connection is vital for the development of strategies and tailored interventions to support those who are living with mental illnesses and chronic physical health problems (Canadian Mental Health Association, 2008).

Several studies have looked at effects of chronic conditions on elders' daily functioning, and studies have also examined self-rated health and its correlates with chronic conditions (Lindquist & Colub, 2004; National Center for Chronic Disease Prevention and Health Promotion, 2011; Whittemore & Dixon, 2008). Yet, the effects of chronic conditions, individually and in combination, on perceived interference with daily functioning, self-assessed health, and depressive symptoms have not been examined in elders. Therefore the study reported here looked at these relationships in elders residing in assisted living facilities. In fact, it is important to know the relationship between the most frequently reported conditions and which of them, alone or in combination with other conditions, interfere the most with daily functioning and affect self-assessed health and depressive symptoms in order to tailor interventions to help older adults to accept their chronic conditions and to better manage their health and depressive symptoms.

This study addressed the following research questions: (1) What are the most commonly reported chronic conditions in elders in assisted living facilities? (2) Is the number or combination of the most commonly reported chronic conditions associated with poorer daily functioning, poorer self-assessed health, and more depressive symptoms? and (3) Is there an association among perceived interference with daily functioning, self-assessed health, and depressive symptoms?

## METHODS

### Design

Data for this secondary analysis were obtained from baseline data obtained in a clinical trial of 314 older adults in assisted living facilities that examined the effects of providing small group activities (resourcefulness training, acceptance training, reminiscence, and diversional activities) on the elder's perception of health and functional status (McDonald et al., 2011; Zauszniewski, Eggenschwiler, Preechawong, Roberts, & Morris, 2006a, 2006b). Baseline data from the parent study, which were not confounded by the effects of the group activities, were used for this secondary analysis to determine the potential role played by the elder's chronic conditions in their self-assessed health, perceived functioning and self-report of depressive symptoms.

### Sample

The sample for the clinical trial was composed of older adults who resided in 29 randomly selected assisted living facilities in Northeast Ohio. To be included, elders had to have the ability to read, understand, and speak in English; receiving services or assistance with self-care, including ambulation, movement, or toileting or instrumental activities of daily living, preparing meals, shopping, and housework; and be cognitively intact as determined by a score of 7 out of 10 on the Short Portable Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1975).

The sample was composed of 250 women and 64 men; 291 Caucasians, 22 African Americans, and 1 American Indian participated in the baseline interviews that provided the data for this analysis. Their ages ranged from 64 to 98 years, with a mean of about 83 years. The total sample of 314 elders was considered sufficient for examining the relationships among chronic conditions, self-assessed health, daily functioning, and depressive symptoms, and for examining the differential effects of combinations of self-reported chronic conditions on self-assessed health, daily functioning, and depressive symptoms, across eight groups, with an alpha of .05, power .80, and small to medium effect sizes for the required correlations and analysis of variance (ANOVA),  $r > .10$  and  $< .30$ ,  $f > .15$  and  $< .25$ , respectively (Cohen, 1992). Because the analysis required three ANOVAs, i.e., one for each outcome of interest (self-assessed health, daily functioning, and depressive symptoms), we considered F-values significant at the  $p < .05$  level as suggestive of trends and those significant at  $p < .02$  as definitive (Sedgwick, 2012).

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