

Difficulties and Solutions in Caring for Cognitive Disorders in Elderly People with Dementia from the Perspective of Social-ecological System Theory

-- Take the Example of NJR Organizations

Li Chen, Jiabin Wu

Hohai University, Nanjing Jiangsu, 210000, China

Abstract: With the deepening of population aging, the increasing population of cognitively impaired older adults in China has put forward an urgent demand for professional cognitive care. In the context of long-term care insurance policy, this paper will take R agency as an example and construct an analysis framework based on the social-ecological system theory at three levels: micro-system, meso-system, and macro-system. It will analyze the physiology and psychology of dementia elderly from inside to outside, how the sentinel care agency collaborates with the sentinel assessment agency, family, and community, how the LTCI policy support and financial support affect the cognitive intervention for cognitively impaired elderly, to promote the healthy operation of the care ecosystem, analyze the dilemma, summarise and put forward the optimization strategy, and provide the experience of providing care services for other aged care service agencies.

Keywords: Long-term Care Insurance; Cognitively Impaired Elderly; Ecosystem Theory.

1. Origin of the Study

Since China entered an aging society in 2000, the proportion of the elderly population has continued to grow, and the problem of the elderly with cognitive disorders is particularly prominent. The Report on the Current Situation and Development of Cognitive Elderly Care Services released by the China Association for the Aging shows that as of 2021, there will be about 15.07 million dementia patients aged 60 and above, and it is expected that by 2030, the number of dementia patients in China will reach 22.2 million, and by 2050, it will reach 28.98 million. Meeting the immediate need for care for cognitive disorders in the demented elderly has become an urgent shortcoming of the elderly service system.

In our country, due to the stigma of illness and the imperfection of the social care system, there is a serious lack of care support resources, and most of the elderly with cognitive dementia choose to be cared for at home. Their carers (mainly relatives) are under tremendous physical, emotional, economic, and social pressure. In addition, cognitive disorders are irreversible and incurable. The traditional family care model is faced with the challenge of the demand for medical and nursing care for the demented elderly, and is in the dilemma of "one family with dementia, the whole family is out of balance". This also reveals that when faced with the real difficulties of cognitive impairment, professional and relatively centralized care can provide better care for the disabled and demented elderly.

To alleviate the plight of the elderly with dementia, the Nanjing Government has introduced a series of policies to help families in difficulty share the burden of supporting and caring for the elderly with dementia. The establishment of disability care insurance (later renamed long-term care insurance) gives full play to the professional and institutional strengths of each elderly care subject and strengthens the whole chain of long-term care from professional institutions to the community and the home. In response to the real needs,

Nanjing R institutions in 2012, the beginning of dementia of the elderly as a service object, to become the first in Jiangsu Province, to specialize in the admission of dementia in elderly professional care institutions. 2014 set up a medical institution completed from a single pension to the transformation of medical care, in the dementia of the elderly in the family care of the elderly based on the difficulty of dementia the elderly to go out to the difficult to seek medical treatment again.

2. Literature Review

2.1. Research on Stigma Associated with Cognitive Disorders

Cognitive disorders are commonly referred to as "dementia", and most people's first reaction to the word "dementia" is the confused and dumb look of an elderly person with the disease. However, Cognitive disorders include but are not limited to, Alzheimer's disease (commonly known as dementia), but are caused by a variety of disorders such as Alzheimer's disease, vascular cognitive disorders, Lewy body cognitive disorders, and mixed cognitive disorders, of which Alzheimer's disease is the most common, accounting for about two-thirds of all cognitive disorders. In addition, Dementia has a clear medical definition, it is an acquired progressive degeneration of the brain, centered on cognitive impairment, which leads to loss of memory, calculation, judgment, attention, abstract thinking, and language, and ultimately to an inability to live independently.[1]

Although the number of people affected by cognitive disorders is growing, knowledge about them has not grown with it. Almost 20% of people with dementia feel stigmatized and hide or conceal the fact that they have the condition, Alzheimer's Disease International reported in 2012; 40% of people with dementia report being excluded from daily activities; and nearly two-thirds of patients and carers feel that

there is a lack of knowledge about dementia in their country.[2] Yuan Yi-Qing et al. argue that in the context of cognitive disorders and aging, the boundaries of the dichotomy between stigma perpetrators and bearers can be easily breached, especially when the pathological causes of cognitive disorders are unknown, and everyone is at risk of this stigmatizing event.[3]

After realizing that "dementia" is discriminatory against patients and their families, Hong Kong renamed "dementia" as "cerebral degeneration". In Taiwan, out of respect for the elderly, medical workers and social workers successfully replaced "dementia" with "dementia" after years of effort; in Japan, "dementia" was changed to "cognitive disorder" in 2004 and "dementia" in 2005; and in Hong Kong, "dementia" was changed to "cerebral degeneration" after discrimination against the patients and their families. In Japan, "dementia" was replaced by "cognitive disorders" in 2004, and was officially used in the insurance system in 2005. In this paper, out of respect for life and care for patients, "dementia" is referred to as "cognitive disease".

2.2. Study on Long-Term Care for the Elderly with Cognitive Disorders

In terms of care models, the family care model is predominant, with professional institutional care gradually becoming more accepted and chosen. Research shows that caregivers, spouses, children, and hired nannies account for 32 percent, 38 percent, and 28 percent respectively.[4] The home care model for cognitively impaired elderly people is convenient for obtaining emotional support and care from relatives, but it also brings great pressure and burden to family carers. With the change in life structure in modern society, the resources for family caregiving have been drastically reduced. At the same time, elderly people with cognitive disorders have specialized needs in terms of care and living environment. Therefore, a professional institutional care model can not only help the elderly with cognitive disorders to maintain their physical functions and slow down the progress of the disease but also reduce the burden of care for their children.

In terms of care demand, Gu Tianying et al. used the ISM model to analyze and found that factors such as the family's economic level, the level of service charges, the degree of service specialization, the psychological monitoring status of the elderly, and the degree of awareness of long-term care services in the society as a whole affect the demand for care services of cognitively impaired elderly people and their families.[5] According to David Suganuma, providing humanistic care and satisfying the need for respect while providing care services to the elderly with cognitive disorders can make the care more effective and promote the improvement of the quality of life of the elderly.[6] In addition, it has been found that cognitive seniors need a professional and reasonable care environment that not only maintains and improves the level of functioning but also leads to a reduction in aggressive behavior.[7]

In terms of care intervention, the traditional way of intervention for the elderly with cognitive disorders is to treat the elderly as patients, caregivers focus on the cognitive function and mobility of the elderly in decline, caregivers tend to replace the elderly's ability to ignore the needs and emotions of the elderly, Montessori-type non-pharmacological interventions to guide and design a new model of human-centered care, focusing on the needs of the

elderly, tapping into the elderly's existing abilities while providing the elderly with provide love and respect.[8]

2.3. Research Reviews

Firstly, the stigmatization of cognitive disorders exacerbates the sense of shame and public rejection of cognitive disorders among elderly people with cognitive disorders. A correct understanding of cognitive disorders is a necessary prerequisite for cognitive care and intervention. Cognitive disorders include but are not limited to, Alzheimer's disease (commonly known as dementia), which is an acquired progressive degeneration of the brain, with cognitive impairment at its core, leading to loss of memory, numeracy, judgment, attention, abstract thinking, and language functions, and ultimately the inability to live independently.

Secondly, in terms of long-term care research, institutional care can effectively make up for the lack of family care, share the burden of care, integrate care resources as much as possible, enhance the efficiency of resource use, and effectively improve the quality of care. In terms of care needs, based on economic ability and specialized care services, the need for the elderly with cognitive disorders to be treated with respect and a professional care environment is gradually being emphasized. Care interventions have gradually shifted from single traditional drug interventions to person-centered non-drug positive interventions.

Finally, building a virtuous ecosystem of care for the elderly with cognitive disorders is of great significance to the development of an age-friendly society. At the micro level, it is important to explore the primary behavioral abilities of the elderly with cognitive disorders and to strengthen their sense of self-identity; at the meso level, it is important to integrate care resources and to provide high-quality care in collaboration with multiple actors; and at the macro level, it is important to give full play to policy support in terms of funding and services, to strengthen public awareness of science and technology, and to build up a cultural atmosphere of respect and care for the elderly with cognitive disorders in the whole society.

In summary, this study will build on previous work and combine the practice of cognitive care intervention in R institutions in Nanjing, using the ecosystem theory to analyze how each system collaborates effectively and what the effectiveness and dilemmas at the macro, meso, and micro levels, to provide better care for the cognitively impaired elderly.

3. Theoretical Perspectives and Analytical Framework

3.1. Social-ecological Systems Theory and its Relevance

Ecosystem theory emphasizes that developing individuals are nested within interacting environmental systems. Individuals and systems interact and influence individual development. Bronfenbrenner categorizes social-ecological systems from the inside out into microsystems, mesosystems, ecosystems, and macrosystems.[9] On this basis, Zastrow argues that the three levels of systems in which each lives are always in a state of mutual influence and interaction. The microsystem refers to the individual system, that is, the seemingly single individual in the social-ecological environment, including the biological and psychological aspects of the individual system; the mesosystem refers to

small-scale groups that can have an impact on the individual system, including the family, the work group, and other social groups; and the macrosystem refers to a larger group or disembodied ideology compared to the former.[10]

The long-term care environment of the demented elderly as an individual can be regarded as an ecosystem, which is divided into three types from the inside out, i.e. micro-systems, meso-systems, and macro-systems, and analyses from different systems of how the R-institutions comprehensively and meticulously carry out the long-term care services for the demented elderly, to promote the healthy operation of the ecosystems of the demented elderly's care services under the LTCI policy.

3.2. Analytical Framework

Based on the social-ecological system theory, the problem

of caring for cognitively impaired elderly people in institutions is caused by the interaction of three systems - the individual cognitively impaired elderly people in the micro-system are influenced by the hospitals, institutions, universities, and communities in the meso-system, which in turn are influenced by the macro-system, and the individual micro-system is inevitably influenced by the macro-system in terms of cultural climate and financial support. system's cultural climate and financial support. Therefore, it is necessary to analyze how each system can work together effectively at the macro, meso, and micro levels to develop long-term care services for the elderly with dementia in a comprehensive and detailed manner, to promote the healthy operation of the ecosystem of care services for the elderly with dementia.

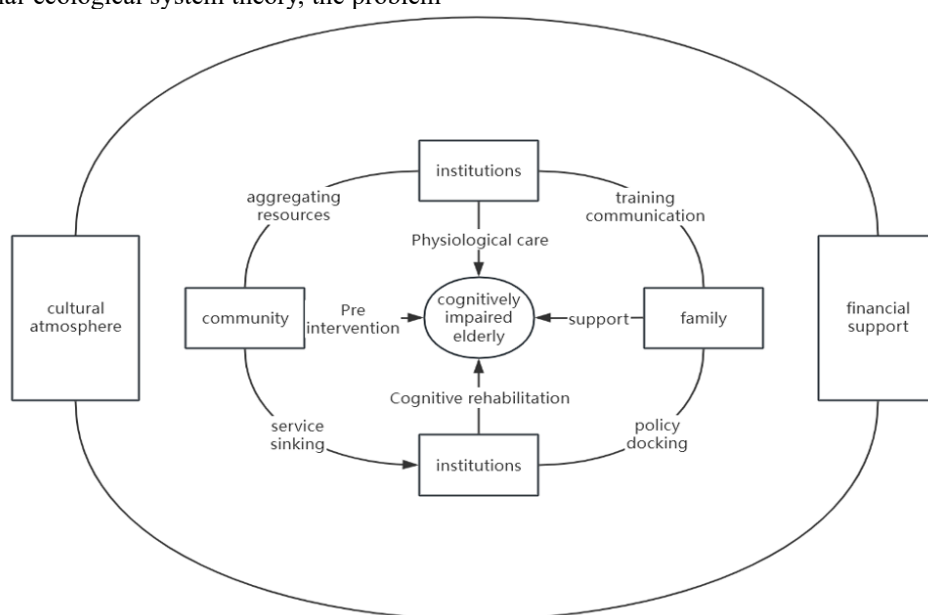


Figure 1. Diagram of the analytical framework

4. Analysis of the Dilemma

4.1. Risks and Stresses of Caring for Cognitive Disorders in Demented Elders

4.1.1. Fragile Subjects and Cognitively Impaired Elderly Care are at High Risk

Older persons with dementia need assistance day after day, year after year, with everything from eating, dressing, bathing, getting in and out of bed, toileting, walking, and so on. Although this may seem like simple assistance, it requires a great deal of time and effort on the part of the carer because of the poor self-care ability of the person being cared for. The higher the degree of disability and dementia, the longer and more intensive the caregiver's caregiving time is, and the completely disabled and demented elderly almost need 24-hour caregiver's attention. The need for daily care is the most basic need of the disabled and demented elderly to maintain their daily life and continue to live. Secondly, the disabled and demented elderly also need health care services to alleviate their physical and mental impairment and to improve their quality of life. The provision of medical care (including emergency medical treatment, surgical treatment, disease prevention, etc.), nursing care (including regular medical check-ups, daily use of medication, sterilization of supplies, etc.), and rehabilitation exercise (including the provision of

rehabilitation facilities, rehabilitation guidance, rehabilitation accompaniment, etc.) for the demented elderly can effectively alleviate their conditions and improve their physical condition. For mentally and physically impaired older persons with dementia, their second pressing need is for health care that can help alleviate their illnesses, prolong their lives, and improve their quality of life.

"There are a lot of things that need to be attended to by a caregiver in a cognitively ill senior. For example, what do you need to pay attention to when you take your medication, a normal person you give her the medication and she takes it. But a cognitive elderly person, he doesn't always eat it, he might hide it under his tongue, you go away and he spits it out"

--ZYZ (interview no. 2023102302)

All of these require a more refined service, Dean Chu then said.

In addition to meeting the needs of the disabled and demented elderly for life care and health care, there is also an urgent need to meet their needs for social support. As the disabled and demented elderly are unable to complete their daily lives independently and need to rely on the help of others, coupled with poor physical and mental health and the need for long-term medical treatment, they are bound to be under tremendous mental stress, easily agitated, have high self-esteem and are psychologically fragile. Demented elderly

people suffer from cognitive disorders, and their behaviors will be quite different from vigorous healthy elderly people, and in the process of getting along with each other, the gap between the two sides will make the demented elderly people feel even more insecure. "When he is more insecure, he will have more bizarre behavior, such as screaming and even scratching All these characteristics increase the difficulty and risk of our care."

4.1.2. Low Sense of Empowerment of Caregivers and High Stress of Caregiving

The irreversibility of cognitive disorders makes them more dependent on their carers than other diseases. As the disease progresses, memory loss, difficulty in dealing with problems, personality the disease and even psychosis, emotional loss of control, and other aggressive behavior, all of which bring great physical, psychological, and social pressure on the caregiver. Specifically manifested as 1. heavy caregiving tasks, physical and psychological burden; 2. emotional communication difficulties, the elderly and their families to understand the bias; 3. cognitive disorders are irreversible, the elderly difficult to heal, and a weak sense of acquisition.

"You get this disease and then it's just a constant decline, at first it's a short-term memory failure, then it's a complete memory failure it's all unrecognizable, and then at the end of the day it's aphasia, and no speech, and then you can't walk, you can't swallow, so it's a process that has to be gone through"

--ZZY (interview no. 2023102302)

President Zhu introduced us to caregivers in the process of a long-term relationship with the patient, but also gradually cultivated feelings, watching the daily care of the person who is deteriorating, under physical and psychological pressure.

4.2. Increased Administrative Pressure on Care Institutions under the Long-Term Care Insurance Policy

4.2.1. On the Management Side, The Daily Workload has Increased

At the management level, the daily workload has increased, and on the one hand, the designated care organizations need to be assessed by the designated assessment organizations all the time. Before the implementation of LTCI, the designated care organizations had their assessment system and criteria. Therefore, after the implementation of LTCI, the assessment by government departments will invariably increase the internal assessment burden of the organizations. On the other hand, the low education level of care workers and the complexity of the real situation affect the assessment monitoring. For example, for caregivers clocking in, "Caregivers are generally older, and then how big the level of knowledge is lower. Their punching cards many times will miss or forget to punch the wrong one, but now it's a miss and a wrong one becomes the insurance company will think that we don't have nursing punching cards. It's going to deduct money and not pay."

--ZZY (interview no. 2023102302)

President Zhu said so. To prevent the above phenomenon from happening, the designated care institutions have to increase their staff so that the nurses within the R institutions can supervise our carers. In addition, the administrative staff within the R organization, which we call the Commissioner for Disability Insurance, needs to go to work every day to

check that there is no sign-in and sign-out. Every month to schedule, to punch the card invariably increases the administrative pressure of the institution, in the process of understanding revealed that some originally smaller nursing homes also had to additionally re-recruit staff in this area to cope with the heavy workload.

4.2.2. On the Docking Side, Cash Flow is Affected

Interviews revealed that many care institutions indicated that the LTCI assessment not only made their management work more difficult but also deducted 5 percent of their set aside if problems were found in the assessment. Before this, care organizations were required to make monthly contributions from family members, and the organizations provided the corresponding care services. After the implementation of LTCI, designated care organizations need to reconcile their accounts with the health insurance administrators first, and the system will allocate funds after the reconciliation is correct. It has been reported that there is a 5 percent set-aside because the system is slow in allocating funds. However, the designated care agency's exemption for family members is paid on time every month, so it becomes a case of the agency paying the money first and then giving it to the family members. Then there is the assessment of the care organization by the operator. If the agency considers the assessment to be unsatisfactory, the 5 percent set aside will not be released to the designated care agency, and in this regard, the agency has to pay in advance but cannot receive the full amount on time, thus incurring a cash loss.

In addition, in the area of contributions, there has been a shift from payment before service to payment after service. Families have been less motivated to make contributions, and the lag in allocating funds for disability insurance and the change in the order in which families make their contributions have to some extent affected the cash flow of the designated care institutions.

4.3. Environmental Aspects, Lack of Social Support

4.3.1. Social Exclusion Exacerbates Stigma

When we think of "dementia", we think of stupidity, foolishness, and clumsiness. Many patients and their families are intellectually and emotionally reluctant to accept the term, and the stigma associated with the label prevents people from seeking a medical diagnosis promptly. On the one hand, there is discrimination and prejudice against mental illness all over the world. A lack of understanding of the disease divides people into "normal" and "mentally ill" people who exhibit psychotic behavioral symptoms, thus labeling the mentally ill as "abnormal". Social exclusion thus arises. On the other hand, people with dementia and their families internalize a sense of shame. The more they learn about the "abnormal" mental and behavioral state of the disease, the more they internalize the inherent social norms, and the greater the sense of shame they feel when they are ill.

"Don't pay any attention to her, she's demented, sits around talking to herself all the time, talks non-stop, is delirious, can't recognize people, and runs around a lot"

--SH (interview no. 2023102303)

Medical research has identified more than a hundred diseases or medical causes that can cause a person to experience symptoms of cognitive dysfunction. Of these, Alzheimer's disease (dementia) is the most common type of cognitive disorder, accounting for approximately 60 percent

or more of the total number of cases.

4.3.2. Insufficient Subject Collaboration

The causes of cognitive disorders are not yet well understood. The complexity of cognitive disorders itself determines that the process of cognitive care and cognitive interventions requires multidisciplinary knowledge and specialized medical and nursing knowledge. However, as an ordinary caregiver, these are not enough, and cooperation with hospitals, universities, etc. is needed for better cognitive rehabilitation services.

Second, mild cognitive impairment (MCI) carries a higher risk of developing cognitive disorders but does not necessarily mean that they will develop into cognitive disorders, and with appropriate intervention, they will not develop or even improve. Many elderly people with cognitive disorders arrive at institutions having missed the optimal time for intervention. Therefore, in the process of institutional care, community support is needed to go into the community for early screening, intervention, and rehabilitation. However, the cooperation between institutions and the community has repeatedly hit a wall. Low social awareness, lingering stigma, and limited collaboration between the various actors hinder cognitive disorders from going into the community.

"What are cognitive disorders? Is it dementia? How can I have dementia? My neighbor's blood pressure is so high and he's fine."

--SQ (interview no. 2023102404)

5. Pathways to Practice

5.1. Micro: Physiological and Psychological Support for Each Other

5.1.1. Physiology: Discovering the Subject's Capacity to Act

The cognitive problems of the elderly with cognitive disorders are accompanied by physical disabilities. Physiologically, cognitive seniors often suffer from varying degrees of physical dysfunction, and the organization has been able to improve the overall level of care by training specialized elderly care practitioners, providing professional care, and using advanced technology and hardware and software facilities. To slow down the course of the disease, the institution introduces foreign systemic therapies and respects the needs of the elderly for self-realization and self-management. As a result, the caregivers have changed from purely providing services to assisting the elderly, paying attention to the needs of the demented elderly at all levels, and through therapeutic activities such as music therapy, memory space, and handicrafts, the elderly are given the best possible use of their autonomous behavioral abilities and the deterioration of their bodily functions are maintained or slowed down under the condition of ensuring the safety of the elderly.

5.1.2. Psychological: Strengthening the Elderly's Sense of Self-Identity

Elderly people with cognitive disorders face more serious negative psychology than vigorous and healthy elderly people. As their body functions decline, cognitive seniors become more and more dependent on others, and their sense of self-identity continues to diminish, making them prone to negative psychology such as low self-esteem, depression, and anxiety. Inner insecurity easily induces the elderly to engage in bizarre behaviors such as screaming and scratching. To take care of

the spiritual needs of the demented elderly and provide them with psychological support, the organization has made efforts at three levels, namely, atmosphere, staff, and activities, to take care of the mental health of the demented elderly. Firstly, the institution specializes in the treatment of the disabled and demented elderly, making the demented elderly independent from the elderly group. In the institution, they have changed from a special group to an ordinary group, and are more able to understand each other, creating a safe and stable atmosphere of mutual tolerance. Secondly, it adopts a whole-person management model and establishes a detailed personal health record of the elderly, to track and understand the elderly in all aspects, from their physical condition to their hobbies and interests, and from their living habits to their daily lives, to provide long-term and systematic attention and personalized therapeutic services to the elderly with dementia. Finally, through systematic therapeutic activities, we train and exercise the physical and mental strength of the elderly in the four areas of social interaction, physical exercise, cognitive stimulation, and living ability, to slow down the process of dementia and reduce their sense of emptiness and insecurity.

5.2. Zhongguancun: A Multi-pronged Approach to the Maintenance of a Barrier for the Care of Cognitive Disorders in Elderly People with Dementia

5.2.1. Hospitals: Docking and Cooperation with Institutions, Linking Hospital Resources

The hospital is deeply linked to hospital resources through cooperation with institutions. Hospitals and institutions to establish a new type of care medical consortium will explore and build a new model of health care integration, through the grass-roots first diagnosis, two-way referral, emergency, and slow treatment, up and down linkage, fully highlight the social public welfare of the hospitals, and facilitate the people to enjoy a high level of health care services close to home. In the specific cooperation, the emergency green channel is guaranteed to be open 24 hours a day, and the elderly patients referred by the institution will be quickly diagnosed, examined, and hospitalized through the hospital's green channel; relevant experts will be sent to the nursing home for a consultation when necessary; the hospital will also send professional physicians to the nursing home regularly or from time to time to provide voluntary medical treatment and health consultation for the elderly living in the nursing home.

5.2.2. Institutions: Systematisation of Cognitive Rehabilitation Techniques to Slow Down the Disease Process

The organization learns and explores advanced foreign experiences to promote the systematization of cognitive rehabilitation and to slow down the process of the disease. A team of social workers was gradually introduced to lead the demented elderly to provide cognitive intervention using professional techniques such as music therapy, gardening therapy, and social training. The introduction of scientific rehabilitation techniques has propelled the organization's special cognitive rehabilitation services from monotonous to systematic. Based on the results of the multi-dimensional assessment of the cognitive ability, emotional state, and physical condition of the demented elderly, the institution formulates a targeted cognitive rehabilitation program. Then with the help of the German MAKES rehabilitation system, combined with the rehabilitation theories of various

disciplines, the institution designs effective personalized non-pharmacological cognitive intervention programs in terms of memory, attention, orientation, judgment, and language rehabilitation according to the characteristics of the elderly with dementia, providing technical support for the rehabilitation of the elderly with dementia.

5.2.3. Universities: Matchmaking Cooperation with Institutions and Integration of Multidisciplinary Support

Colleges and universities combine the educational level and positioning of their schools, choose suitable talent cultivation goals, buttress the demand for institutional positions, and provide multidisciplinary talent support for them. Intermediate and higher vocational as well as technical colleges and universities have positioned the cultivation of elderly talents in the cultivation of elderly nursing skill-based talents; undergraduate colleges and universities have focused on cultivating complex operation and management talents who can engage in planning, designing and managing in the elderly industry; colleges and universities and scientific research institutes with research points in the elderly discipline have focused on cultivating postgraduates, and have delivered high-level scientific research talents and business backbones to elderly institutions and vocational colleges and universities. Conditional general colleges and universities explore cultivation modes such as minor or double bachelor's degrees to accelerate the cultivation of management and training talents in fields related to the social service industry. Regarding the setting specializations, colleges, and universities will flexibly set up specializations by the new positions and new demands of the industrial development of home economics, elderly care, medical care integration, hospice care, psychological comfort, indoor aging design, and planning and design of community service outlets, and so on.

5.2.4. Communities: Linking Recreational Resources and Promoting Prevention at the Gateway

The community promotes the forward movement of the prevention gate by linking up recreational resources. Through extensive health education, risk assessment, early intervention, family support, and resource linkage on cognitive impairment in the community, we can help people at high risk of cognitive impairment to achieve early detection and identification, early intervention, and early treatment, and gradually form a favorable atmosphere of concern, care, and concern for elderly people with cognitive impairment and their families. To achieve the goal of having a place to go for screening and treatment of cognitively impaired patients in elderly care institutions and a circuit for their care. Community health centers introduce guidance from hospitals to carry out early screening for cognitive impairment in street neighborhood committees and elderly care institutions, to raise the level of early detection and carry out early medication, behavioral interventions, and rehabilitation treatments according to the level of cognition; if primary medical care, elderly care institutions and community families find that the condition of the patient has progressed or is not determinable, the patient will be referred through the green channel of tertiary hospitals, or tertiary specialists will come down to carry out cognitive diagnosis and treatment and rehabilitation services regularly. Cognitive diagnosis and treatment and rehabilitation services; patients with cognitive impairment whose conditions have stabilized after diagnosis and treatment are admitted to primary medical care, elderly

care institutions, or return to their families in a graded manner.

5.3. Macro: Humane Care and Financial Support

5.3.1. Cultural Atmosphere: Forming an Altruistic Value System for Care, Building Mutual Assistance and Trust in Care Relationships

Caregivers in the community establish an altruistic value system that focuses on caring for cognitively impaired elders, treating them with love and charity, instilling confidence and hope in the process of caring for cognitively impaired elders, and providing humane services. Due to the special characteristics of the cognitively impaired elderly, the community and the agency have set up continuous training for caregivers of cognitively impaired home care families. Even if the caregivers are certified by the Human Resources and Social Security Bureau as caregivers, they are still required to receive on-the-job training on the skills and safety knowledge of caring for the elderly with cognitive disorders every quarter after joining the organization and to undergo an assessment to continuously improve their professional skills, to ensure that the care provided is professional and comprehensive. During the care process, the caregivers develop mutual support and trust with the demented elderly and promote the expression of positive and negative emotions of the cognitively impaired elderly. Based on long-term exchanges and effective communication, the mobility of caregivers in the organization is low, and they are basically on duty for a long time to accompany the elderly, which establishes a relationship of trust between caregivers and the elderly with dementia. The family members of home caregivers have a natural emotional link of trust with the elderly, which is further deepened in the process of caregiving. The relationship of trust encourages the caregivers to think from the perspective of the elderly, care for their inner feelings, and maintain their dignity so that the elderly with cognitive disorders can feel the presence of humanity and the care of human beings.

5.3.2. Financial Support: Long-term Care Insurance Policy and Charitable Fund Financial Support

Long-term care insurance policies and charitable funds reduce the financial burden of caring for elderly people with cognitive impairment at the level of formal and informal support networks. Long-term care insurance, as an important practice in China's welfare-based elderly care system, can provide basic care for the cognitively impaired, as well as subsidize the costs of closely related medical and nursing care services, thus reducing the financial burden on families. In Nanjing, for example, demented and incapacitated elderly people who are admitted to care service institutions to receive care services are settled by the disability insurance fund with the care service institutions at a standard rate of RMB 60 per day, which alleviates the cost burden on families to a certain extent and reduces the financial risks that elderly people bring to their families. By granting subsidies to the agencies, they are also encouraged to take in elderly people with cognitive disorders. In addition, the intervention of charitable organizations has also eased the financial burden of families with cognitive disorders. Relying on professional service organizations in the field of elderly cognitive disorders, early screening services for elderly people with cognitive disorders are provided to reduce the cost of screening. Relying on elderly service capacity-building bases to carry out practical work for cognitively impaired service personnel reduces the

cost of training talents for the institutions and lowers labor costs, which in turn is beneficial to lowering the cost of care.

6. Conclusion and Recommendations

6.1. Standardizing Training and Building Professional Care Teams

First of all, the professional nursing team is created through refined and specialized division of labor. Licensed caregivers provide 24-hour life care for the demented elderly, a team of professional physicians with rich experience in treating diseases common to the elderly escort the health of the demented elderly, a team of nurses led by a physician-in-charge who has been practicing for many years provide professional medical care, and a team of social workers formulate a one-on-one cognitive rehabilitation program to alleviate the cognitive symptoms of the demented elderly, and so on. Secondly, case management provides special cognitive rehabilitation services, introduces international forward-looking measures, and designs intervention programs based on the characteristics of demented elderly in terms of memory, attention, orientation, judgment, language rehabilitation, and so on. Music therapy, horticultural therapy, painting therapy, and the creation of a familiar and relaxing atmosphere for the demented elderly are fully utilized to provide attention and intervention from multiple perspectives to slow down their symptoms.

6.2. Financial Support from Various Sources to Safeguard the Foundation of Service Development

First, the assessment model is optimized to enhance the efficiency of care. Within the designated home care organizations, which are the target of long-term care insurance assessment, they should adapt to the implementation of the policy, change their assessment concepts, gradually establish an assessment culture, and create a favorable assessment atmosphere. The appraisal parties of long-term care insurance - within medical insurance operators at all levels - should, firstly, establish good management and service attitudes and guide all parties to promote the implementation of long-term care insurance. Secondly, they should give full play to the dual mechanism of accountability and incentives, thus prompting care organizations to pay attention to the assessment from within. Secondly, the market mechanism should be utilized to reduce the pressure on the organizations. On the one hand, the government can issue subsidies for long-term care insurance to individuals, so that individuals can choose their own institutions, thus realizing the two-way choice between individuals and the market. On the other hand, it actively develops commercial long term care insurance to improve the efficiency of the system. [11]Thirdly, it plays the role of the three allocations, and charity is actively supplemented. In addition to government allocation and market operation, institutional funds can be raised from the community through charitable funds, utilizing the means of "charity + business" to reduce the construction and operating costs of nursing homes, so that more needy elders can enjoy quality and affordable elderly care services and facilities.[12]

6.3. Linking Community Resources to Build a Multi-Dimensional Collaborative Care System

On the one hand, cooperate and complement each other to link medical and nursing resources. Break the previous model of separating medical and nursing care, and promote the integrated development of medical and nursing care. Point-of-care institutions can link resources with local hospitals to realize time-saving, high-quality and accurate community screening, thus effectively reducing the losses caused by irreversible cognitive disorders in the elderly after discovery. On the other hand, go into the community to strengthen preventive health care popularization. First, cognitive disorders prevention and support activities should be carried out according to local conditions. Communities and streets should be fully empowered to co-ordinate community resources and actively build a 30-minute care service supply circle, to ensure that elderly people with cognitive disorders can have their care needs met in a timely manner when necessary. Second, popularization of science and technology should be put in place, and online and offline should be combined. Popularizing knowledge about cognitive disorders through lectures and exhibitions can not only increase the public's understanding of cognitive disorders and build a friendly and mutual-help society, but also bring into play the concept of front-loading the problem, so as to do a good job of preventing the condition from the front-end and screening it, and to find out and prevent the disease as early as possible and treat it early, so as to reduce the chances of the elderly suffering from cognitive disorders. In addition, the target audience is the receiver of the information, but also continues to pass it on to others through their own social networks, raising awareness of early prevention and diagnosis.[13]

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