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Why and How to Develop Day Centers: Putting the Well-Being of Older People and Caregivers First

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Putting the well-being of older people and caregivers first

Fiorella Benedetti[1], Mayte Sancho[2] and Marian Hernández[3]

Summary[4]

The accelerated process of population aging in Latin America and the Caribbean is leading to an increase in the number of elderly people in need of care. One of the region's challenges lies in developing care services at scale that respect the preference of most people to age in their homes and ease the burden of care for families.

In this study we analyze day centers in Latin America and internationally, particularly in Uruguay, Argentina, Mexico, the United States, and France. In addition, we have compiled the multiple benefits of day centers for their users, family caregivers and the social and healthcare system, as well as their prices in the region. Day centers are priced at $234 per month, which is lower than other care services. An added value of this study is that, based on learnings from good practices, we have developed an operational guide on how to design and implement quality day centers following the Person-Centered Care approach. We also provide detailed recommendations on physical resources (space, equipment and transportation), human resources, and how to organize the day-to-day running of the center, including the development of personalized itineraries for each user.

Key words: day centers, dependency, care, community care, long-term care, care services, elderly, aging, Latin America and the Caribbean.

JEL: H4, I18, J14, J18, O54

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1. Introduction

Demographic aging is a societal achievement, the result of health and social improvements occurring worldwide. The amount and ratio of older people are increasing worldwide (Christensen et al. 2009).

The countries of Latin America and the Caribbean are experiencing a faster aging process than other regions of the world. Between 1990 and 2020, the population over 65 years of age in the region increased from 21.4 million to 58.7 million. The population ratio for those over 65 years of age increased from 4.8% to 9% (Aranco et al. 2022b).

Aging, especially at older ages, can be associated with health problems, which can eventually lead to disability and dependence (Costa-Font et al. 2008) and thus affect the quality of life of aging individuals (Akosile et al. 2018). It is estimated that in the region nearly eight million people aged 65 and over are in a situation of dependency, which means, they need support to carry out at least one basic activity of daily living (BADL). These people in situation of dependency represent 14% of the population over 65 years of age. This prevalence is expected to increase to 16% by 2050, which would translate into an increase from eight million people to twenty-three million (Aranco et al. 2022b).

The tasks of caring for people in situation of dependency have traditionally been assumed within the family, particularly by women (wives, daughters, granddaughters and daughters-in-law). In Latin America and the Caribbean, most states assume that it is the families that are responsible for caring for those in situation of dependency (ECLAC 2014).

The demographic transition, which entails a decline in the birth rate, leads at the same time to a reduced availability of people for caregiving tasks. In addition, social changes, such as women joining the labor market, put the

informal care system in crisis. As this demographic process continues and social changes are factored in, the unmet demand for long-term care will continue to increase (Rosel 2016).

On the other hand, the prevailing preference among the elderly is to "age at home" (OECD 2011). They wish to receive support in their own home, in their usual living environment, whenever possible. Only a very small percentage of people want to live in a residential facility. In addition, the World Health Organization (WHO) has highlighted the multiple benefits of aging in one's own home, including the well-being and autonomy of older people (WHO 2015, Ch. 2).

Facing up to these realities, the need arises to reshape policies around home and community-based services, with the aim of promoting home-based care as an alternative to the institutionalization of the elderly and to relieve the burden on caregivers. Day centers for the elderly cater to these needs and have attracted growing interest in recent years.

In Europe, care systems have developed unevenly since the 1950s, with many countries prioritizing the development of residential facilities over other services. However, the negative impact of large institutions on people's well-being, demonstrated in multiple evaluations, has led to their gradually being replaced by other services that offer a response more aligned with people's wishes to age at home, even when they need help. As many countries in Latin America and the Caribbean are currently designing their care services, there is a unique opportunity to learn from international experience and prioritize services that facilitate aging at home.

In this study we analyze the evidence on the multiple benefits of day centers for their users, caregivers and the healthcare system. Day centers are associated with an increase in the well-being of the elderly, an improvement in their health and in their social life. It also reduces the burden of care for

family caregivers and, consequently, translates into improvements in mental health. Finally, when comparing day center users to non-users, the evidence shows a lower ratio of hospitalizations and emergencies and a delay in admission to residential facilities.

There is also a benefit in terms of prices. In this study, we estimate that the average price of day centers in the region is approximately $234 per month. Without taking into account the significant differences between the two resources, residential facilities cost approximately $804 - $939 per month (Fabiani et al. 2022; Government of Costa Rica 2022).

This study analyzes the main elements of day centers in five Latin American countries and internationally. Based on the lessons learned from good practices and as an added value, this study provides detailed guidelines on how to design and implement day centers following the Person-Centered Care model. This approach to care encourages the autonomy of users in their daily lives and promotes the development of meaningful and personalized activities for them. In other words, we propose quality day centers where each user has their own care and living plan, according to their uniqueness and preferences, instead of centers that offer rigid and standardized proposals for everyone.

This report on day centers is presented with the following structure:

- Section 2 describes the main characteristics of day centers. In particular, the main objectives are defined for both users and family caregivers. Their operation, target population and prices are also explained. In addition, the main conceptual components of the day centers we propose are developed: person-centered care and the integration of support and care at the day centers for their users, caregivers and the system
- Section 4 reviews the experiences of day centers both at the international level and in Latin America and the Caribbean. In particular, in Uruguay, Argentina, Mexico, the United States and France.
- Section 5 describes the main steps of implementing day centers. There are detailed guidelines on physical resources (space, equipment and

transportation), human resources, and how to organize the day-to-day operations of the center.

- Finally, Section 6 presents the conclusions.

2. Characteristics of day centers

2.1 Definition and goals of the day center

In this note, we subscribe to the definition of day center of (IMSERSO 2000): "A social and healthcare family support service that caters, during the day, to the basic personal, therapeutic and socio-cultural needs of the elderly with varying degrees of dependence or fragility, while fostering their autonomy and permanence in their environment".

The main objective of day centers is to improve the quality of life and well-being of both the elderly person and their family caregiver, enabling them to remain in their home and environment while receiving professional care and the support required by both the person and the family (IMSERSO 2000).

The specific goals of a day center can be systematized by focusing on the two key players in the care relationship: the elderly person in situation of dependency and the family caregiver.

In the first case, the objectives aimed at the elderly person in situation of dependency are (Martínez, T. 2010):

- To recover and/or maintain the highest degree of functional independence and personal autonomy, through the enhancement and rehabilitation of their cognitive, functional and social abilities.

- To encourage the elderly person to stay within his home and community environment, thus preventing unnecessary institutionalization.
- To improve or keep the person's health and to prevent the onset or worsening of diseases through preventive programs and social-health interventions.
- To ensure wellness from a person-centered approach, focusing on the person's wishes and preferences, and to collaborate with them to develop a care and living plan that makes sense to them.
- To develop self-esteem and foster a proper psycho-affective condition.
- Increase the quantity and quality of social interactions by providing an environment that fosters relationships and participation in rewarding social activities.

In the second case, the goals of the family caregiver are:

- To contribute to the employment and preservation of caregivers (mostly women) in the labor market.
- Provide time off and rest for caregivers.
- Offer families guidance, counseling and psychological support -if necessary- and develop skills to reduce stress and improve the psychophysical condition of caregivers.
- To provide caregivers with knowledge, skills and strategies that contribute to the improvement of the quality of care.
- To prevent family conflicts related to the caregiving role.

BOX 1. Social centers for the elderly

There are several types of day care resources within the framework of community services, and which meet different needs, generally derived from the varying degrees of dependency that people present throughout their aging process. In this context, we distinguish between day centers focused on the care of people in situation of dependency and social centers for autonomous elderly people or those with slight dependency.
The main objective of the social centers for the elderly is to promote their socialization and personal development from the conceptual framework of Active Aging (WHO 2002). Its target population is people over 60 years of age (although sometimes the age requirement is not restrictive) who are self-sufficient or with slightly dependency.

The activities in a social center are diverse:

- Social activities: games, dances, walks and excursions. The goal is also that older people contribute to community development with their knowledge and experience.
- Skills acquisition activities. There is enormous diversity, associated with the cultural and socioeconomic characteristics of its users: literacy, reading and writing lessons, and the use of technologies, handicrafts, etc.
- Activities of health promotion and prevention: talks, gym, and physical exercise.
- Other activities, which could be meals, hairdressing, or podiatry.

Many of these activities are also carried out in day centers. However, as mentioned above, the main difference between a day center and a social center lies in the attention to dependency situations. Consequently, the day centers include actions to slow down or prevent the increase in dependency. In this sense, one service cannot substitute for the other and the benefits of the day centers listed in section 3 cannot be attributed, too, to the social centers.

2.2 Target population of day centers

The main characteristic of the target population of the day centers is their dependency situation. At the beginning of the implementation of day centers in international settings -especially in the Spanish experience-, the population was more restricted and focused on people with mild or moderate dependency and generally with the possibility of recovery. The evolution of this service has broadened the spectrum of users and has made its operation more flexible, making it possible for users to remain in the center for a longer period of time, favoring aging at home and relief for families. This flexibility also allows day centers - depending on the needs and

availability of services - to define user profiles, priority intervention objectives and care and living plans that are better adapted to the people who use them.

Day center users can be classified into three priority groups (Bermejo 2009 and Martínez T. 2010):

- Elderly people in situation of physical dependence and, sometimes, accompanied by cognitive impairment.
- Elderly people in situation of psychosocial fragility or slight dependence.
- Elderly people with moderate or severe cognitive impairment.

In urban settings, day centers tend to specialize and select similar user profiles. Internationally, services specializing in people with dementia are growing, based on the assumption that more specialized care can provide better outcomes. However, in rural environments or where the supply of centers is very restricted, specialization is not possible and all types of dependency situations are integrated.

In addition, the sociodemographic profile of users from the literature review identifies a predominance of women (Anetzberger, 2002) aged 65 and over. This result is consistent with the evidence that women live longer than men in most countries of the world[5] and perhaps also with a lower predisposition of men to attend day centers. Likewise, there are other dimensions that contribute to users being able to attend the center and sustain their attendance over time, avoiding the need for institutionalization.

Availability of social and family support. In situations of dependency, this support is crucial to ensure continuity of care and contribute to the user's readiness to attend the center and transfer. Home care services can also facilitate preparation and transfer tasks. However, the fact of living alone

[5] Aranco et al. (2018) show that in Latin America and the Caribbean there are two elderly women in a situation of dependency for every elderly man in the same situation.

will not be considered an exclusion criterion, but an important aspect for the design of the care and living plan.

Housing and its surroundings. On many occasions, the permanence of people in situation of dependency in the center and at home depends on the livability and accessibility conditions of their home and nearby environment (building, stairs, security of the area, etc.). The existence of architectural or social barriers is in itself a factor that promotes dependency and precipitates unnecessary institutionalization.

Although there is currently a tendency to avoid restrictive exclusion criteria, there is a consensus that it is inappropriate for people with the following profiles to attend the center:

- People with behavioral disorders who have difficulty to interact with others or pose a risk to their own safety or the safety of others.
- People requiring continuous healthcare or suffering from decompensated illnesses that, due to their characteristics, cannot be attended by the day center staff, which, as will be seen in section 5.4 on Human Resources, is made up of caregivers and does not include physicians.
- People with infectious diseases, when prevention of contagion cannot be guaranteed.
- People in a terminal or preterminal situation.

To determine the degree of dependency of potential users of day centers, an instrument is used to assess their limitations and needs. This allows us to assess whether or not they meet the inclusion and exclusion criteria and to verify whether the center has the resources to meet their needs. If they meet the criteria, they are referred to the day center service. Once the user begins attending the center, the staff conducts another assessment to understand the supports they need and draft their care and living plan.

2.3 How a day center works

The day center offers a range of activities and services to meet the different health, social and psychological needs, as well as the diverse preferences of the elderly people who come to the center.

On the one hand, the center develops therapeutic interventions to maintain or rehabilitate the functional, cognitive and social capacity of users, so that they can perform activities of daily living.

From a person-centered approach, daily life and meaningful activity are essential formulas in the day center. The tasks are mundane but meaningful - taking care of personal hygiene, tidying up, helping in the kitchen, setting and clearing the table, among others - and provide opportunities to meaningfully organize the day and, at the same time, maintain or regain functional skills in a rewarding and useful daily context.

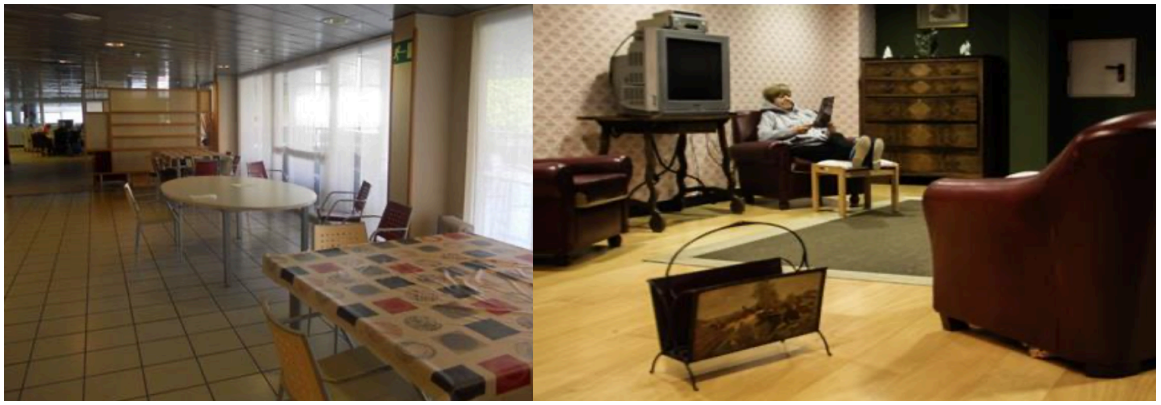
On the other hand, it is equally important to promote socialization and recreational initiatives, such as watching movies, playing cards, walking in the garden, or commenting on the news in the newspaper. Rather than sticking to an intense schedule of daily activities, most older people prefer to intersperse them with moments of rest, such as taking a nap, watching television or listening to music in an armchair. Annex 2 shows an example of the organization of a day in a center that favors a stimulating environment without unnecessary rigidity in the activities.

In addition to group activities, each user has specific support and activities at the day center. A personalized itinerary is constructed based on two tools: the life history and the care and living plan, which includes preferences, interests, expectations and concepts of well-being and discomfort. The purpose of these tools is to gather relevant information about the person, their background and preferences in order to identify the care and support they need and determine the activities they will do at the day center, based on what makes sense and is of value to them. The care and

living plan includes the areas in which the user needs support, the routines they values (e.g., napping), the activities they like to do, and the areas they wish to develop (e.g., strengthening back muscles). Section 5.5 explains how the daily life of each user in the center is organized on the basis of the care and living plan, and Annex 3 presents an example of the important information to be collected for its drafting.

All of this should take place in an environment that is as close as possible to a domestic one. Below, in Image 1, on the left is a counterexample of an impersonal, cold and functionally focused space, and on the right is an image of a welcoming, home-like space designed to meet the needs of the users. Both photographs depict the same day center, before and after reconversion. Section 5.1 explains in more detail how to design day center environments.

IMAGE 1. Photos of a Fundación Matia day center.



The day centers offer different types of assistance that try to facilitate the best adaptation to the needs of the elderly and their families. The main modality is daily attendance from Monday to Friday at full time (ideally from 8 or 9 a.m. to 5:30 or 6 p.m.). Some centers offer a part-time schedule, which can provide relief for family caregivers, although it does not necessarily facilitate participation in the labor market (because of the limited duration of support). There is also the modality of attendance one or several days a week, or hourly attendance for the elderly or caregivers who need less support. Finally, some centers offer weekend assistance.

2.4. Conceptual components: person-centered care and comprehensiveness

Like any other long-term care facility, setting up a day center requires the identification of a theoretical and conceptual framework to be shared, in a comprehensible manner, with the center team, its users, and their families. Based on Sancho, M. and Martínez, T. (2020), we highlight two essential components that guide the intervention and the daily organization of the center: 1) person-centered care and 2) integration of support and care.

2.4.1. The person-centered care model

The person-centered care approach is based on the recognition that the people receiving care know best what they need. In this sense, they are protagonists in the design of their personal support and in the organization of their daily lives.

There is evidence that the adoption of a person-centered model of care in gerontological centers is associated with improved well-being and reduced disruptive behaviors in older people, improved job satisfaction and reduced caregiver burnout, and increased satisfaction with caregiving (Brownie and Nancarrow 2013; Díaz-Veiga et al. 2014; Martinez 2016).

Given the complexity of these approaches, it is necessary to make this paradigm operational again to prevent it from being limited to a mere declaration of principles or intentions. In the following, and based on the many valuable contributions of Teresa Martinez, we highlight some considerations that help to realize person-centered care (Martinez, 2018).

Knowledge - recognition of the person. This first consideration refers to the need to know people from a double dimension: the diversity of their needs and the singularity of their life trajectory, which is unique and

unrepeatable. This implies not reducing the person to their current illnesses or deficiencies but, on the contrary, knowing and recognizing their biographical uniqueness, taking their life history as the main reference. As an example, a bad practice would be to focus solely on supporting a user to get around in her wheelchair. Instead, a good practice would also be to encourage them to continue singing (if they so desire), as they used to sing in a choir in their youth, and to encourage other music-related activities.

The biographical approach becomes especially relevant in people with advanced cognitive impairment, as it helps to maintain their personal identity and also to understand their needs and behaviors (Kitwood 1997; Edvardsson, Winblad & Sandman 2008). A good knowledge of each person should not only serve to identify their current care needs and provide timely assistance, but also to enable caregivers to get to know them as a unique and valuable person with a unique life project.

Support for self-determination and autonomy. Self-determination should be understood in two ways: as a person's capacity and right to make their own decisions and to maintain control over their life (López, Marín and De la Parte 2004). This means that when the person has the ability to exercise this right, the care environment should provide opportunities and support for the person to continue to make their own decisions and gain as much control as possible over their life and daily activities. An example of good practice is not to replace the user in the performance of daily life activities. If the user can manage to feed himself, even if done slowly or with difficulty, it is important that he continues to do so.

Personalized care for maximum well-being. Personalization of care necessarily implies adopting a flexible approach that takes into account not only the needs but also the preferences of users, with the aim of seeking their overall well-being. This leads us to the recognition that person-centered care must move away from standardized or uniform care, avoiding rigid protocols that alienate people from what has been their daily life pattern prior to their admission to the day center. Some examples of personalization

are respecting the user's style and identity, the support without delay to go to the bathroom (Martinez 2018), the search for daily routines that suitably adapt to the tastes and preferences of each user, for example, doing crafts or knitting, while others will prefer to read the newspaper.

Person-centered communication. Care must be understood as an interpersonal helping relationship that seeks a person's empowerment. Person-centered communication involves seeking interactions that allow the person to express freely, to understand what is going on around them and, above all, to feel heard, understood, accepted and supported. Some crucial attitudes and actions in person-centered communication care are the development of empathy, emotional validation, and keeping the person's biography in mind during interactions. Facilitating conversations on topics away from technical caregiving tasks allows the older person to present other facets of their social identity and encourages communication (Saldert et al. 2018). Recent research (Savundranayagam et al. 2016) shows that greater use of person-centered communication by caregivers elicits more positive reactions (cooperation, for example) from the cared-for person. On the contrary, the absence of this communication generates more negative reactions (such as distress) on the part of the elderly. Finally, it is important to appreciate the moments in which people reveal details they consider relevant and, when they ask for clarification, to respond to them in a timely and careful manner.

Protection of privacy. We refer mainly to the privacy and warmth required for bodily care, such as grooming, dressing and medical examinations among others. This implies respecting the privacy of the individual's body and guaranteeing the confidentiality of personal information, ensuring its protection so that it is not shared with unauthorized people.

Participation in decision making. Participation in decisions is a right of both the people receiving support and care and of all the agents involved in caregiving. This involvement can range from menu or activity selection to

the selection of caregivers. Achieving real and effective participation is a complex challenge that goes beyond simply listening to different opinions on issues that impact a person's health and well-being. To make them a reality, it is necessary to reach difficult consensuses between the different interests of the elderly, professionals, families, etc. Things like regular meetings between the different stakeholders, satisfaction evaluations of all of them, and participation in care and living plans contribute to the realization of this principle. A qualitative study showed that the participation of older people with dementia in interdisciplinary meetings led to a better understanding of the cared-for person by most caregivers, who questioned their own practices and claim to have learned more about aspects related to their work (Villar et al. 2018).

2.4.2. Integrated care from the coordination and integration of support and care

Integrated care is based on a holistic view of the human being, recognizing the diversity of their needs, which are not only of a physical-body-health nature, but also psychological, emotional, relational, social and spiritual. This approach is identified by the World Health Organization (2015) as one of the key guiding principles for the reformulation of long-term services.

Integrated care entails coordination among all care services and between these and other social and health services. First, coordinated care services ensure continuity of care. For example, when a user attends a day center during weekdays and a personal assistant cares for them at home during the weekend, it is important to have fluid communication between the two services to coordinate the care plan. In addition, the day center can support and train both professional and family caregivers in certain essential caregiving skills.

Secondly, integrated care entails coordination between health and social services, whose common objective is to improve the well-being, health and quality of life of the elderly, guaranteeing the continuity of the care they require. Evidence shows that when there is robust health and social-health coordination, better health and functional outcomes are achieved (Lloyd-Sherlock et al. 2024). However, although health and social integration has been an aspiration for several decades, it is often difficult to achieve in practice. The day center can be a point of reference that can contribute to this coordination.

One of the main points of social and healthcare coordination is to streamline the referral of some services and systems to others. On the one hand, geriatricians can refer their patients to day centers when they detect a decrease in their functional capacity. On the other hand, since day centers are not medical services, fluid communication with health resources is essential, both for routine check-ups (in some centers a doctor makes a fortnightly or monthly visit) and for referrals for specific situations. Finally, the day center can be an opportunity to detect social needs and facilitate coordination with the proper program.

Third, the integrated approach transcends coordination between the health and social systems. Indeed, it encompasses a broader set of needs and opportunities that arise around the individual. Integrated care includes a wide range of possible support (pensions, housing, education, culture) and very diverse community resources that enable the elderly to relate socially and develop a meaningful life (Aranco et al. 2022a). The integrated approach is consistent with the conceptual framework of an ecosystemic, territorialized, community-based nature and, consequently, is based on the integration of various supports through the coordination of the care that the person requires.

2.5. Prices

Funding for day centers comes primarily from the public sector (Anetzberger 2002; Fields, et al. 2014; Lunt et al. 2020). Prices tend to be diverse for publicly funded day centers in Latin America and the Caribbean. In Costa Rica, for example, the government pays service providers $175 per month, as estimated by the current Care Policy (Government of Costa Rica 2022) or $210 per month according to Matus (2018). In Argentina, the monthly price per person paid by the government to service providers is US$189 (Resolution PAMI 2023) and in Uruguay, US$320. Based on the information available in this study, the average monthly price is approximately US$234. However, it is necessary to further investigate the costs of this service in future research.

In turn, there is price variability between government-funded services and services paid directly by users. In Mexico, according to our data, in some private centers the monthly price is US$720 for 5 days of service per week. This variability in prices may depend on the services provided and the professionals assigned.

Not to mention the significant differences between the two types of services, the price of day centers is more affordable than that of residential facilities (Government of Costa Rica 2022; Fabiani et al. 2022). For example, in Costa Rica, day centers cost an estimated US$175 per month, while residential facilities cost US$939. According to Fabiani, the price is $804 per month for residential facilities. This more affordable price of day centers allows for their deployment on a larger scale by the public sector, and with a smaller budget.

For a more rigorous price comparison, the other services that support day care and make aging at home possible should be added to the price of day centers. It is recommended that a model of care that aspires to meet the needs of dependent people should offer, as a complement, other services that guarantee their permanence in their usual environment. For example,

home care, remote care, voluntary action, and any other useful initiative developed in the community environment.

3. Empirical evidence of the impact of day centers

There is empirical evidence on the benefits of day centers for users, family caregivers and the public system in general. This evidence is based on seven reviews, four of which have been published in the last ten years. All reviews share the objective of assessing the impact of day centers, two of them focused on users (Anetzberger 2002; Catty et al. 2007), one in caregivers (Tretteteig et al. 2015) and the rest in both users and caregivers. Details of the characteristics of the revisions are included in Annex 1. Additional literature is used for some specific topics.

Only 17% of the 163 studies appearing in the reviews correspond to controlled trials. This data demonstrates the need for further research using the same methodology to obtain rigorous evidence on the impact of day centers on the health and well-being of dependent people and caregivers. There is also a need for more studies on day centers in Latin America and the Caribbean.

Finally, it is important to highlight that many of the benefits found vary among different centers and that the context and characteristics of day centers (size, services provided, staff skills, and leadership or philosophy of care) are key variables for explaining their benefits (Ellen et al. 2017). Given that the qualities of the centers have an impact on outcomes, section 5 develops a guide on how to implement quality day centers, based on international best practices. It should also be noted that more research is needed on the operational design of the centers that generate the best results.

3.1. Benefits for users

The literature review shows that attendance at a day center is associated with an increase in users' well-being, as well as with an improvement in health and social life.

Among the benefits of day centers for users, well-being is the variable that has attracted the most attention in the literature. Day centers are associated with improved mood, quality of life, and well-being. Seventy-seven percent of the studies that analyzed the mood of users found significant differences compared to non-users. Similarly, 89% of the studies that analyzed the quality of life of users and 86% of those that assessed their general well-being found significant differences with respect to non-users. Few studies have analyzed the benefits for self-esteem (only 5% of the studies analyzed), but all of them have found significant differences between users and non-users.

Health outcomes have also attracted considerable attention. The most frequently considered variables are functional status and cognitive status. However, it is observed that the effects tend to be greater on subjective variables, such as health perception, than on objective variables (Lecovich & Biderman 2013). 55% of studies analyzing functional status and cognitive status find significant differences between day center users and non-users. These results suggest a smaller decline of these functions in day center users.

To a lesser extent, the association between day center participation and social life has been studied. For example, only 13% of the research analyzes commitment and involvement in activities. Nevertheless, the results are very consistent: all the studies that include the variable of involvement in carrying out activities find a positive effect on day center users.

Table 1 shows the domains analyzed on the benefits of day centers for users (well-being, health and social), the outcome variables, the percentage

of studies that include each variable out of the total number of studies included in the review and the percentage of studies that find significant differences when comparing day center users with non-users.

TABLE 1. Effects of day centers on users, according to the existing literature.

Domain | Variables		Studies that include the variable		Studies finding significant impact
		N	%	%
Welfare	Mood/Affects	13	34	77
	Quality of Life	9	24	89
	Well-being/Happiness	7	21	86
	Self-esteem	2	5	100
	Satisfaction	1	3	0
Health	Functional status/Functional skills	11	29	55
	Cognitive status	11	29	55
	Depression/Mental Health	3	8	100
	Mortality	1	3	100
	Health or Health-related quality of life	2	6	50
Social	Commitment or involvement	5	13	100
	Activities	3	8	100
	Loneliness	1	3	0

Source: Developed by authors based on the studies included in Annex 1.

Some complementary studies suggest possible mechanisms through which these benefits occur. Attendance at a day center increases older people's social interaction and has positive effects on their social networks, current or new, which in turn increases their participation in activities and their well-being (Schmitt et al. 2010). In addition, social interaction in the day center allows users to have "a better perspective of their own abilities" and greater self-esteem (Orellana et al. 2020). Finally, the activities at the day center, including physical ones, have positive psychological effects (Lunt et al. 2020) and can stem health decline (McHugh et al (McHugh et al. 2015).

3.2 Benefits for family caregivers

As discussed in section 2.1, day centers not only aim to improve the quality of life of the elderly who attend them, but also to provide support and

relief to family caregivers. Attending a day center reduces the need for home care, and allows the caregiver to perform other activities, such as working, studying, and providing for their own well-being.

Among the benefits of day centers for family caregivers, the one that has received the most attention in the literature is conditions derived from caregiving, especially the reduction in workload. Mental health, especially in relation to stress and well-being, has also been taken into account. Finally, the development of caregiver skills has not been as important in the literature analyzed.

Table 2 shows the fields analyzed regarding the benefits of day centers for family caregivers (health, well-being, caregiver burden and skills), the outcome variables, the percentage of studies that include each variable out of the total number of studies included in the review, and the percentage of studies that find significant differences when comparing family caregivers of day center users with those of non-users.

TABLE 2. Effects of day center use on family caregivers, according to the existing literature.

Fields| Variables		Studies that include the variable		Studies finding significant impact
		N	%	%
Health	Stress	10	48	80
	Depression	5	24	60
	Health condition	3	16	0
Well-being	Well-being	10	48	60
	Quality of life	3	16	33
	Anger	1	3	100
	Satisfaction	1	3	100
Burden of caregivers	Burden	18	92	61
	Hours of care and demands	5	26	80
	Free time	4	19	75
	Perception of support	1	5	0
Skills	Decision making	2	8	100
	Coping	1	3	100
	Management of behavioral problems	1	3	100
	Conflict management	2	8	100

Source: Developed by authors based on the studies included in Annex 1.

The use of day centers reduces the demands of caregiving for family caregivers. The most analyzed variable in the literature is caregiver burden (92% of the studies analyze it). Sixty-one percent of these studies find significant differences in caregiver burden between caregivers of center users and caregivers of non-users. Similarly, 80% of studies analyzing hours of care and demands find that these are significantly different between caregivers who have day center support and those who do not.

The literature suggests that there is a significant impact on the mental health of caregivers. The results indicate a decrease in the levels of stress and depression of caregivers whose family members make use of day centers. 80% and 60% of studies analyzing stress and depression, respectively, find significant differences between caregivers who have day center support and those who do not. In terms of well-being, the results are less consistent, ranging from 33% of studies showing significant differences in quality of life to 60% in well-being.

Finally, with respect to the development of skills, although the available evidence is limited, the results are encouraging. The two studies that analyze this issue find improvements in the development of caregivers' skills in terms of managing caregiver conflicts and decision-making. In this regard, counseling and training services offered to family caregivers by some day centers are of fundamental importance.

3.3 Benefits for the healthcare system

The benefits of day centers for the healthcare system have been assessed in the scientific literature mainly by reviewing the use of other services such as transfer to a residential facility and the use of healthcare services (hospitalizations and emergency room visits). Evidence reveals lower hospitalization and emergency room utilization, as well as delayed residential facility admission, among day center users compared to non-users. The latter

is very relevant since, as already discussed, most older people prefer to age in their homes, close to their family, friends and community (WHO 2015).

Table 3 presents the outcome variables analyzed, the percentage of studies included in the reviews that have included these variables and the percentage of studies that find significant differences when comparing the utilization of services of day center users, and the utilization of non-users.

TABLE 3. Effects of the use of day centers on the healthcare system, according to existing literature.

Variables	Studies that include the variable		Studies finding significant impact
	N	%	%
Transfer to residential facilities	10	93	89
Use of hospital services	4	18	67

Source: Developed by authors based on the studies included in Annex 1.

Contrary to what was shown when assessing the impact on users and family caregivers, few variables have been taken into account with respect to the healthcare system (only two). However, there are a remarkable number of studies that have considered them, especially with regard to moving to a residential facility. 89% of the studies that analyze it find significant differences between users of the center and non-users. In all cases -except one- a positive and direct connection has been established between attending the center and a delay in institutionalization. In exceptional research mentioned above, the reverse effect is observed: attendance at a day center is associated with less conflict in decision-making, which increases the probability of transfer to a residential facility.

4. Experiences of day centers at the international level and in Latin America and the Caribbean

This section describes the experiences of day centers in France, the United States, Argentina, Uruguay and Mexico. In all countries, definitions are revised to refer to day centers, their target populations and the services they provide. Table 4 summarizes these main characteristics. It also includes information on the personnel working in the centers, funding sources and service prices, when available.

4.1. International day center experiences

Day centers are probably the care service with the greatest variability and diversity under the same name, even if they always serve the same target population: dependent people. In order to show this variability, the different cases of France and the United States are developed. There are also similarities between the countries, such as having transportation deemed essential service for the proper functioning of the center. The information in this section was mainly provided by the Social Services and Social Policy Documentation Center (SIIS).

In Europe, care systems have developed unevenly since the 1950s. In 1995 Germany started a culture based on the right to care being integrated into its social protection system and provided specific contributions for its financing. This approach has been adopted by several countries, such as France, the United Kingdom and Spain, among others. In this context of change, evaluations of the negative effect of large institutions on people have generated a gradual process of promoting home and community-based services that guarantee the permanence of people in their natural environment. The adoption of the International Convention on the

Rights of People with Disabilities (UN 2006) has had a major impact on the trend towards deinstitutionalization. Currently, many European countries are, with different strategies, reducing the number of places in residential facilities and developing community resources, including day centers.

4.1.1. France

In France, day centers are a service which is supported and financed, in part, by the public sector, even if these services are managed by civil society. Its objective is to enable elderly people in need of care to remain in their natural environment for as long as possible.

Day centers seek to meet the different needs of both users and caregivers, offering the latter relief and providing them with tools to help them stimulate the dependent person. These day centers are considered a service that complements home support.

France has paid particular attention to the creation of day centers for people with dementia and Alzheimer's who live at home but are cognitively impaired. These centers have a greater presence of healthcare staff and are in close coordination with the health system. They may work with residential facilities or be integrated into community settings. These centers are the realization of the national Alzheimer's Plan strategy launched in 2008.

IMAGE 3. Snoezelen Room of the Center for Care and Residence for the Elderly (CSMR) in Podensac, France.

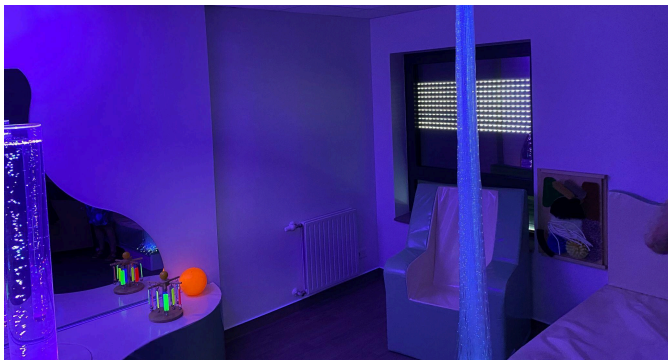


Photo: Marina Avdibegovic, June 2023.

Day centers in France operate mainly on weekdays (Monday to Friday), with an average of 258 days per year. The number of days per week that the person attends (between one and five) is determined jointly by the user, the family and the center. Flexibility is one of the interesting principles in the use of these services.

The target population is people in situation of dependency, over 60 years of age, who need support and care, as established by the 2003 law on care for the loss of autonomy of the elderly and for the personalized subsidy for autonomy (APA). Among the services funded under this law are day centers.

Anyone residing in France on a stable and regular basis can benefit from this law, since access to the APA is not limited to people with limited resources. However, the allowance for the elderly varies according to the degree of dependency and the resources available to the beneficiary, since a co-payment system is in place. To evaluate the degree of dependency, the instrument called "AGGIR grid *(Autonomie Gérontologique et Groupes Iso-Ressources)*" is used, which is presented as a national nomenclature that provides 10 activities of daily living and classifies the degree of dependency in 6 levels.

Admission is made after a thorough assessment of identified needs, capabilities, and physical and medical limitations. On this basis, a Life and Care Plan is drawn for each user, and must be adapted to their needs and developed through four types of actions:

- Activities aimed at cognitive stimulation.
- Activities and actions that promote better nutrition.
- Actions that contribute to well-being and self-esteem.
- Physical activities.

An example of actions adapted to the type of support needed are exercises for people with memory loss. Alternative therapies such as art therapy or music therapy, among others, are also offered.

Day centers must provide adapted transportation to their users, a service financed by the public sector. The center can arrange transportation in three ways: through its own vehicles, by contracting an external provider, or by compensating families for the cost of transporting their family members. The government, particularly through the health Insurance, grants the center a daily fixed price per place of 13.41 euros for a period of 300 days per year.

Approximately half the centers in France provide service of reception and support to families, including training, guidance and information. These activities are aimed at caregivers and are quite diverse, ranging from personalized support and listening to group talks and awareness-raising workshops.

Finally, it is interesting to note the multiple funding modalities for care services in France. The different components of the day centers are financed both by the public sector, at its different levels, and through user co-payment. The latter must pay the accommodation fee, while the service fee according to the level of dependency can be financed through the APA program. Finally, Health Insurance funds the care component through a daily flat rate that covers part of the costs related to the center's professionals and the aforementioned transportation expenses.

4.1.2. United States

In the United States, day centers are considered non-residential services that are provided outside of a person's home for less than a full day. They are a key community resource that provides direct care to users and caters to the caregivers' need for relief, allowing them to work, fulfill other obligations and recover from the overload of ongoing care.

Three main models of day centers are recognized: a social model; a health/medical model, which is sometimes combined with the social model; and a specialized model.

- The *social model* generally provides a safe environment, supervision, assistance with some activities of daily living and therapeutic activities aimed at supporting participants physically and mentally.
- The *health or medical model* provides many of the services of the social model but also offers nursing and rehabilitation care.
- The *Specialized models* serve specific populations and provide intensive health support services. They are aimed at people with Alzheimer's disease or other dementias, multiple sclerosis, brain injury, chronic mental illness or developmental disabilities, as well as people who require extensive rehabilitation therapies after suffering a stroke.

The target population of day centers varies according to these three models of day centers and different state regulations. In most states, admission parameters are established indirectly through provisions relating to mandatory and optional services and staffing requirements. For example, if regulations state that day centers can provide skilled nursing services and therefore require registered nurses, it follows that they are able to care for people in need of intensive health services. One example is in the state of Kansas, where facilities are prohibited from admitting people in need of specialized services for mental illness unless they are under the care of a physician and can be provided with appropriate treatment.

Day centers in the United States provide multiple services, from socialization to nutrition services and health monitoring. In addition to these basic services, the following are considered optional or mandatory, depending on each state:

- Assistance with basic activities of daily living.
- Health education and counseling: teaching good health practices, self-monitoring of health conditions and counseling on healthcare.

- Health monitoring: includes medical examinations; monitoring of general health; daily monitoring of vital signs and hygiene; weight control, and dental health.
- Medication administration.
- Health-related nursing services, such as routine skin care; simple dressing changes; preventive medical exams; and ongoing care, including routine blood pressure or blood glucose checks for diabetes monitoring.
- Physical, occupational and speech therapy.
- Transportation.
- Social services: social and psychosocial assessment of families; access to supplementary services and individual and group counseling for participants, their families and caregivers.

4.2. Experiences of day centers in Latin America and the Caribbean

Based on previous research and 36 interviews with experts from government, civil society and the gerontological sector, we have analyzed 12 countries in Latin America and the Caribbean, all of which have some type of day centers. Their scope is national, provincial or municipal and their funding can be either public or private. Most of these centers are aimed at socialization or social containment.

Next, we will spotlight the experiences of Uruguay, Argentina, and Mexico, as they are among the few countries in the region that have day centers with care services for dependent elderly people. Although Uruguay and Argentina show greater coverage of these centers, it is still insufficient to cover the entire existing demand. We also describe the case of Mexico, where a model day center has been developed, in order to learn from experience and then implement it at scale. This approach can be replicated in other countries in the region. One limitation of this study is that it does not include experiences from the Caribbean.

4.2.1. Uruguay

In Uruguay, day centers are part of the services offered by the National Care System. Its objective is to contribute to the autonomy of the elderly and the permanence in their usual environment, in addition to providing support and advice to caregiving families (Aranco N. and Sorio R. 2019). In them, cultural, recreational and physical and cognitive stimulation activities are carried out, led by a team of professionals, and training of caregivers is also done. From 2022, transportation has been included as part of the service budget. This is a major innovation that has made it possible to eliminate one of the major obstacles to access (Sistema Nacional de Cuidados de Uruguay 2022). Thus, it is highly advisable to integrate transportation as part of the day center service to ensure effective access.

The target population of these centers are people over 65 years of age who are in situation of mild or moderate dependency, i.e., those who live at home but have certain difficulties in carrying out activities of daily living, due to both physical and mental limitations. Potential users apply on the care website or at the physical offices of the Ministry of Social Development. Their situation is assessed using the System instruments, which include five aspects of a person: biomedical, social, affective, cognitive and functional (Colacce, M. 2019).

The day centers provide care 20 hours a week, 5 times a week, throughout the year. Elderly people can attend 2, 3, or 5 days a week, as agreed between the institution and the user. This makes it possible for the number of effective users to be greater than the number of places available. Currently, there are 9 day centers in operation, with between 30 and 40 places each, serving 311 people (Sistema Nacional de Cuidados de Uruguay 2022).

Another innovation of the Uruguayan model is the existence, in all day centers, of a Committee of Users whose objective is to favor the participation and incidence of users in substantive aspects of the service, as well as to

promote dialogue and the collective construction of solutions around the space and the service they share (Sistema Nacional de Cuidados de Uruguay, 2022).

The day centers are strongly community-based and are managed by worker cooperatives or civil society organizations. Both its initial equipment and its operation are funded by the National Care System, which makes the service free of charge for users (SNC, 2019). The Care system transfers $320 per place per month to day centers.

In addition, there are day centers financed by direct payment from users, private for-profit and non-profit providers. Some of them are associated with residential facilities and others only offer daytime service. Some of these centers serve a population in situation of dependency in general and others specialize in specific users, such as the center provided by the Uruguayan Association of Alzheimer's and Similar Diseases (Asociación Uruguaya de Alzheimer y Similares).

4.2.2. Argentina

Most day centers in Argentina are financed by PAMI (National Institute of Social Services for Retired and Pensioners). In 2022 a new regulation was implemented, which establishes two new different modalities of day centers and regulates their operation (Resolution PAMI 2022):

- Day Center Model of Integral Care for the Elderly. It provides outpatient social and services during the day to elderly people who are frail or dependent and require care to promote their independence and autonomy in the performance of Activities of Daily Living. It also promotes social networks to encourage the creation of new relationships, and thus avoid isolation and loneliness. It also offers social, recreational and therapeutic services in order to enable active aging and facilitate the permanence of the elderly in their environment and community. Emphasis is placed on therapeutic stimulation.

- Day Center Specializing in Cognitive Impairment, Alzheimer's and other Dementias for the Elderly. It is a gerontological therapeutic device specialized in the treatment of dementia and cognitive impairment. It offers comprehensive care during the day in order to maintain and/or recover the highest degree of independence possible, through the enhancement and rehabilitation of their cognitive, functional and social abilities.

These devices seek to promote active aging so that the elderly can remain in their homes, integrated to their communities, fighting isolation and loneliness and, thus, avoiding or delaying admission to a long-stay residence.

PAMI centers operate in different ways: a) eight hours a day, five days a week; b) eight hours a day, three days a week; and c) four hours a day, five days a week.

Until 2023, PAMI had 74 centers throughout the country, of which 17 were Model Day Centers; 6 were Specialized Day Centers for cognitive impairment, Alzheimer's and other dementias; and the rest were standard day centers, established prior to the regulations described above (Roque, M., personal communication, 2023). It should be noted that the number of centers is not enough to cover the total demand in Argentina, but it is high compared to other countries in the region.

PAMI funds the service, which is free of charge for the members. According to data from October 2023[6], the monthly price per user at the Model Centers was 159,911 pesos (US$189) for 8-hour days and 111,937 pesos (US$133) for 4-hour days. In the Specialized Day centers for Cognitive Impairment, prices amounted to 205,599 pesos (US$244) for 8-hour days and 143,919 pesos (US$171) for 4-hour days in (PAMI Resolution 2023).

[6] For the peso-dollar conversion, the value of the MEP dollar of 843 pesos as of October 31, 2023 is used.

In addition to PAMI, national and provincial health insurance companies also offer coverage in day centers to their members. The user pays the service to a private provider and then the health insurance company reimburses a part of the amount paid. An example of this type of funding of day center services is IOMA, the Health Insurance of the employees of the province of Buenos Aires (Oliveri L. 2020).

4.2.3. Mexico

In 2023, the IMSS (Mexican Social Security Institute) launched, with technical support from the IDB, its first day center offering care services for people in situation of dependency. This initiative makes it stand out from other centers managed by public institutions in Mexico, as it focuses specifically on attention to users with care dependency. Its three main objectives are: 1) to allow the family some relief to improve their quality of life, 2) to generate well-being for the elderly, and 3) to fulfill the human right to provide and receive care.

IMAGE 2. IMSS Day Center.

The target population of the IMSS day center is people with mild to moderate dependency. The level of dependency is assessed by means of a

questionnaire applied prior to admission. It should be noted that 70% of the center's beneficiaries have dementia as a cause of their care dependency.

One of the strengths of the IMSS day center is its commitment to a Person-Centered care model, with protocols and procedures developed in accordance with this approach, and with ongoing staff training. The services offered include support in feeding, medication and hygiene; personalized activities to promote socialization and mobility; and therapeutic rehabilitation actions. In addition, the center facilitates medical support to users through timely communication with IMSS medical units. The family is also trained in self-care and management of behavioral symptoms in people with dementia.

The IMSS day center serves 30 people, offering 35 hours of service per week, Monday through Friday from 8 am to 3 pm. The center's team is composed of 5 institutional caregivers with nursing training, a physician in charge of the center, and an occupational therapist. This staff represents a ratio of 0.23 human resources per user, similar to the 0.2 (1/5) recommended in section 5.4.2.

Finally, another distinctive feature of this center is that it is implementing an impact assessment with a randomized design, and a process assessment, conducted by a team of independent researchers. The results of these assessments will help to improve the intervention and provide valuable evidence for the entire region.

Table 4 below summarizes the main characteristics of day centers in France, the United States, Uruguay, Argentina and Mexico.

TABLE 4. Characteristics of day centers.

Country	Definition	Target population	Services
France	Day care services meet two needs: 1) To resocialize the elderly person within the framework of home support, and 2) To help family caregivers by offering them relief.	Elderly people in situation of dependency or people with neurodegenerative diseases (Alzheimer's, Parkinson's or related diseases).	- Activities aimed at cognitive stimulation. - Activities and actions that promote better nutrition. - Actions that contribute to well-being and self-esteem. - Physical fitness activities. - Social and leisure activities. - Support and reception service for families.
United States	Non-residential services provided outside the home for less than a full day; provides direct care to participants and meets caregivers' need for relief.	Individuals whose needs can be met by day care services.	- Basic services: socialization, social activities, nutrition services and supervision, health and performance monitoring. - Optional or mandatory services: assistance with basic activities of daily living, health education and counseling; health monitoring, medication administration, nursing services, physical, occupational and speech therapy, skilled nursing services, social services.
Uruguay	Day centers that seek to contribute to the autonomy of the elderly and their staying in their natural environment. In addition, they provide support to family caregivers.	People over 65 years of age who are in situation of mild or moderate dependency, living at home.	- Physical and cognitive stimulation. - Cultural and recreational activities. - Some centers provide transportation services.
Argentina	Day centers for therapeutic, stimulation and social containment purposes, with the objective of improving their users' autonomy.	Elderly people in situation of mild or moderate functional or cognitive dependence.	- Prevention activities. - Stimulation and rehabilitation. - Social activities.
Mexico	Center that seeks to provide care to people in a situation of dependency, contribute to their well-being, and allow relief to the family.	People in situation of mild and moderate dependency. At the IMSS center, 70% of the beneficiaries have dementia.	- Support in feeding, medication and hygiene, etc. - Personalized activities to encourage socialization and mobility. - Therapeutic rehabilitation actions. - Training family members in self-care and management of behavioral symptoms of dementia.

5. How to implement day centers

The effectiveness of day centers mainly depends on how they are designed, implemented and assessed. It is always advisable to include the perspective and needs of the main beneficiaries in the service design stage, i.e. the elderly with care needs and family caregivers. This section describes the main resources of day centers - physical space, transportation and human resources - and makes strategic and operational recommendations for their development. Specific guidelines for the care of people with dementia in these centers are also suggested.

These recommendations are based on the best practices observed in the implementation of day centers, especially in Spain since the 1990s, which currently has approximately 3,700 centers and regulations governing them in the different territorial areas or autonomous communities. In this case, the one issued by the Basque Government (Decree of the Basque Country 2000) has been used. Each country should adapt these recommendations to its own idiosyncratic characteristics and specific regulations.

5.1. Architectural and environmental design

There is scientific evidence on the effects of the architectural and environmental design of day centers on the health and well-being of dependent people using their services. From a multidimensional perspective, the environment has an important impact on people, as analyzed from different explanatory models of behavior (Lawton 1999, Moos and Lemke 1985, Fernández-Ballesteros 2000, Capprara and Corraliza 2009) and from gerontological architecture (Regnier 2012, Lantarón 2016, Sancho 2020). In addition to this evidence, there are other recommendations of an applied nature that will facilitate the proper functioning of the center.

5.1.1. Location

In line with the ecosystemic and territorialized conceptual framework, it is recommended that the day center be located close to the homes of potential users, in order to avoid long trips, promote their integration into the usual community environment, and foster relationships that develop there. It is also advisable to locate it close to socio-health or healthcare institutions with which it is possible to coordinate the necessary care. In short, the aim is to promote access to services, to spaces for social and community activity, and to guarantee the continuity of daily life and the users' feelings of belonging and identity.

Other recommendations for location include choosing areas that are not isolated, and are healthy, free of excessive noise, without risks to the physical integrity of the users and with well-lit surroundings (Basque Country Decree 2000). Finally, when the day center is located on the premises of another social resource (e.g., residential facilities), it is good practice to assign it a specific physical space that is distinguishable from that other service.

5.1.2. Accessibility

Another good practice is to ensure that the center is fully accessible to all types of users, following international universal design standards. It is suggested that they include the following essential elements:

- Support products, ramps and handrails to facilitate ambulation.
- Friendly slopes. When the difference in level exceeds two meters, the best practice is to install elevators. To ensure that all people can circulate, we recommend that the slopes be slight. In particular, that the maximum slope should be 8%, i.e., that for every 8 meters climbed, 100 meters should be advanced horizontally (Accessibility Institute 2024).

- Adapted restrooms with handholds, grab bars and the necessary space for the access of devices such as geriatric cranes and wheelchairs.
- Gentle access to the center, allowing entry from adapted transportation, and facilitating the entry of wheelchair users, avoiding slopes and using ramps.

5.1.3. Recommended spaces

The following are some recommendations for the design of spaces within day centers:

- Two distinct areas: one for daily living activities and the other for rest. Ideally, these spaces should be interconnected, without any architectural barriers and with access to the outside (Decree of the Basque Country, 2000).
- A space where users can store their clothes and personal items.
- An office for multiple uses: to receive family members and users, medical consultations, cures, or first-aid kit, among others.
- Adapted geriatric bathroom, equipped with shower, toilet and sink.

It is advisable to maintain an adequate ratio between the available surface area and the number of users: 10 square meters per user is considered optimal. If the day center receives more than 30 people, it is suggested to organize smaller living groups within the center itself, taking into account the tastes and affinities of the people attending the center.

5.1.4. Sensory stimulation

In day centers, an adequate level of sensory stimulation must be guaranteed, avoiding too much or too little of it. Some aspects to be taken into account are:

- Noise control, avoiding the unnecessary use of megaphones or loudspeakers and ensuring that people, especially professionals, use an appropriate tone, especially with people with hearing loss.
- Moderate and non-permanent use of television and background music.
- Adequate lighting: natural light is recommended whenever possible, while ensuring the best vision and avoiding unnecessary glare or flashing.
- Moderation in the use of posters and announcements and, when necessary, to ensure that they are written in an easily legible font size.
- Avoid excessive decorations in color and quantity, prioritizing the relaxing effect of non-strident home decorations.
- If possible, use objects that are meaningful to the users to help them feel at home.
- Avoid mirrors in areas of the center frequented by people with severe cognitive impairment. Conversely, place mirrors in the bathrooms, adapting them so that wheelchair users can see themselves in them.

5.1.5. Security

It is essential to guarantee the safety of people in the day center, preserving their autonomy and well-being. In this regard, we recommend that the center:

- Comply with the safety regulations required by the country.
- Have an architectural structure that allows for adequate evacuation if necessary and a protocol for "prevention of emergencies, accidents and disasters".
- Have a fire protection system (signage, emergency lighting, fire extinguishers, detection and alarm system).

In addition to the above, it is important to consider the following aspects:

- Non-slip, smooth and colorfast floor. It is important to contrast the color of the floor with the wall and the furniture.

- Walls with washable paints.
- Bells in toilets and bathrooms.
- Absence of obstacles in walking areas.
- Furniture which is stable and avoids dangerous angles or designs in case of potential falls.
- Proper cleaning and disinfection of the center, as well as good maintenance and upkeep of equipment.

5.2. Equipment

As we have mentioned, day centers set up with a person-centered approach seek to reproduce, in the care services, domestic and home environments that favor continuity in the users' way of life. In addition, the day center seeks to support the person so that they can carry out their daily life activities as independently as possible. Finally, the goal is to favor their intimacy and independence and to reinforce their personal identity. To achieve these goals, here are some practical recommendations for equipping the center.

- Given the high therapeutic capacity of light for people suffering from some type of dependency, it is recommended that the main spaces have natural lighting and ventilation. It is advisable that the windows be large, with a security system for opening, and that the exterior be visible even to wheelchair users. If there is artificial lighting, it is preferable that it be warm.
- As far as possible, it is recommended to have heating and air conditioning systems in order to have adequate temperature and create comfort.
- It is advisable that the equipment, furniture and decoration have home-like characteristics, as similar as possible to those of a home. The space is intended to be cozy, warm, familiar and comfortable.
- To enable users of the day center to cook, a significant activity of daily life, it is recommended that ovens, stoves, microwaves, refrigerators, washing machines and extractor hoods be available and accessible. It

is preferable that electrical appliances are electric and that safety measures are in place to minimize risks.

- It is recommended that the furniture be selected for comfort, for example, by placing comfortable armchairs in the lounge and use solid chairs with a good base and washable material. Tables must be accessible to wheelchair users.
- In all day centers for the elderly, and especially in those attended by people with advanced cognitive impairment, it is advisable to reinforce temporal and spatial orientation and memory through the use of clocks, calendars, signs, among other useful objects for this purpose.
- We recommend avoiding infantilization in decoration and work materials, such as using puzzles for children.
- The center must have a telephone for users to contact others and also receive calls.

5.3. Transportation

One of the most important recommendations for the installation of a day center is that it should have adapted transportation to take users from their homes to the center and vice versa. This helps them keep their attendance at the center and ensure that it does not represent a significant burden for their families. In addition, care must be taken to ensure that the transport is discreet, so that it does not contain signage that stigmatizes users.

In Uruguay, the absence of transportation included as part of the service in the day centers was the main obstacle to regular attendance by users. As a result, from 2022 the government will also cover transportation costs, as in France and some U.S. states.

5.4. Human Resources

A key element in the implementation of quality care services is human resources. The adequate rendering of the service must be guaranteed, both in terms of qualification and training of human resources as well as in terms of quantity (Villalobos et al. 2022). The human resources of day centers should be made up of a multidisciplinary and coordinated team with the ability of developing an individualized care plan for users (Du Preez et al. 2018; Lunt et al. 2020).

5.4.1. Professional profiles and functions

All centers will have a director who will be in charge of the center and may share their functions with someone else (another day center, a residence, etc.). It is good practice to ensure that the director has a university degree, preferably in the health or social sciences (social work, psychology, medicine, nursing, occupational therapy, among other specializations).

The day center team will be interdisciplinary and will be made up of caregivers and other technical staff. Regarding professional categories, caregivers may be trained in care, or be geriatric or nursing assistants. Other technical personnel may include nurses, social workers, physicians, geriatric nurses, psychologists, occupational therapists, and senior sociocultural technicians, among others. For centers for people with dementia, we recommend enlisting a psychologist, preferably specialized in neuropsychology or with specific training in dementia.

Caregivers are responsible for the personal care of the users. In Latin America and the Caribbean, there are an estimated 3.1 million paid caregivers caring for the elderly or people with disabilities (Fabiani 2023). From the person-centered care model, it is a good practice that the same caregivers support the same users on an ongoing basis. This allows them to acquire an

in-depth knowledge of each user, their preferences, strengths and interests. In addition, stability in care generates closeness and security.

The rest of the technical staff intervenes with functional capacity maintenance exercises, regular physical activities and therapeutic and meaningful activities for the user, and contributes to the training of caregivers. This technical team does not require exclusive dedication, which allows it to provide support to more than one day center.

5.4.2. Staffing ratio and work modality

The recommended ratio of staff (caregivers and other technical staff) to users is between 1:5 and 1:6, depending on the users' profile. This ratio only considers paid staff and does not include cleaning, maintenance, kitchen, janitorial and management staff.

In the United States, all but six states require minimum direct staff-to-participant ratios in their regulations. Mandatory staffing ratios range from 1:4 to 1:10 and most states require ratios of 1:6 or 1:8.

The work modality should be team-based and interdisciplinary to ensure a holistic approach to users. To this end, it is necessary to share common objectives and work by combining the knowledge, techniques and resources of each professional, with the actual participation of each member of the team.

Each user and family will have a reference person at the day center, who will have a comprehensive view of the care and living plan, integrating the needs, expectations and desires of the user, and will maintain the essential dialogue for its implementation and updating. This work methodology, based on the recognition of the uniqueness of each cared-for person and also of the professional who assumes this role, generates high satisfaction among users and professionals.

5.4.3. Training and continuous support

All day center professionals should be equipped with technical, emotional and self-care tools. Some examples of technical skills are feeding support, posture change, or carrying out hygiene, among others. Emotional skills include listening skills and empathy, among other skills. Finally, the self-care of caregivers and other professionals is critical to the sustainability of care, and this requires the ability to identify signs of physical and emotional exhaustion, and to develop tools for improvement. Aldaz et al. (2023) analyze the skills needed for day care and the training requirements in this regard.

In order to acquire the aforementioned skills, it is recommended that caregivers receive basic training in caregiving prior to entering the center, and then continue their training on site. In many cases, a process of support is required to help caregivers review their own skills in relation to the care model to be developed. In addition, the center's management will be responsible for detecting specific training needs, such as the person-centered care model, certain techniques, relational skills, among others, and for ensuring ongoing training, which can often be provided by the center's own technical team.

Finally, it is essential that professionals perceive that all parts involved recognize, value and support their work. In short, the aim is to promote the health and well-being of professionals, with special attention to caregivers.

5.5. Day center organization

The planning of life in the center comprises two generic types of interventions: group and individual. An example of the organization of a day at the day center, interspersed with group and individual interventions, is included in Annex 2.

To identify individual activities, two core - and generally integrated - tools are the life history and the care and living plan. The objective of both is to collect relevant information about the person, their background and preferences, in order to personalize the necessary care and support. The biography, therefore, is the main tool for personalized care (Martínez T. 2010), which allows us to get closer to people's identity, to their individuality and to what has meaning and value for them.

Because each person is unique, their care and living plan will also be unique. A comprehensive assessment should group together the fundamental areas that affect the person's health and well-being-their basic needs, risks in care, and personal goals (e.g., eating on their own)-in order to properly establish the actions to be developed in the day center. Annex 3 presents the form used at the IMSS day center in Mexico to collect information and proceed with the drafting of the care and living plan.

Thus, each person will have their individual plan, drawn up with their information and participation, which will be implemented provisionally in the first days of their admission. The plan will be flexible and will be reviewed, together with the user and their family, at least every six months and whenever deemed necessary, in order to adjust it to the person’s needs.

It is important that care plans are not reduced to compensating for functional difficulties, but that they identify capabilities and strengths, and contemplate the life project that the person wishes to maintain. A comprehensive care and living plan should include the person's assessment and resources (e.g., going to the day center alone, not needing support for eating, etc.), their home environment and services close to home that they can use (e.g., hairdresser, newsstand, etc.).

BOX 2. Recommendations for day centers that care for people with dementia

Below are a number of issues to consider when providing support to people with dementia:

- Carefully observe the person to identify the essential elements that build their identity, choices, significant objects, preferences and the degree to which they maintain their abilities. This information should be included in their life history, supplemented with information from their family and environment about their current and previous lifestyle.
- Continually adjust the goals of the intervention and their care and living plan. As cognitive impairment increases, achieving the greatest possible well-being becomes a priority.
- Establish and maintain routines in predictable environments. It is advisable to break down daily activities into very simple, routine tasks in an environment that facilitates orientation, understanding and well-being. These tasks should maintain a rigorous order and sequence so that people with dementia can continue to perform them. A good practice of routine and meaningful activities for individual is presented in the wakaba work day center in Japan, where users (called "workers" in the center) perform daily gardening and cleaning tasks in parks, contributing to the well-being of the community. For example, they sweep up fallen leaves, mow the lawn, water the flowers, and clean the playgrounds. Tasks are adjusted according to the progression of each person's dementia.
- Working with homogeneous groups, according to the degree and behavioral realization of cognitive impairment facilitates the intervention and organization of activities. However, care must be taken not to overly exclude people with dementia from group activities shared with others with less or no cognitive impairment, which can be stimulating and satisfying for them.
- To use sensory and cognitive stimulation techniques that have had good results in the preservation of intellectual skills in people with severe cognitive impairment. Some examples are visual recognition and praxical exercise (the execution of movements for the performance of a purposeful action, such as using cutlery or waving goodbye). Another good practice is the use of snoezelen rooms, which emerged in the Netherlands in the 1970s. These are physical spaces of multisensory stimulation (through music, lighting, aromas, among others), achieving relaxing and pleasant environments.
- Train all human resources so that they can apply good professional practice in dealing and communicating with people with dementia. Specific skills are required to stimulate and maintain psychic and physical functions (psychostimulation, reality orientation, behavior management, among others).

While these proposals are restricted to people with dementia, they can also benefit from other stimulating activities typical of any day center discussed in previous sections.

6. Conclusions

Traditionally, the care of elderly people living in situations of dependency has been polarized into only two alternatives: family and feminized care; and professional and institutionalized care, also feminized. These forms of care do not meet the needs of today's society. On the one hand, demographic and social transformations make it difficult for caregiving tasks to be confined to the private sphere; to which we must add the express desire of the elderly to age in their own homes. Both circumstances require a response to caregiving situations, through the design of care services that contribute to aging in place, and the relief for family caregivers. Day centers contribute to this double objective.

In this study we have analyzed and compared day centers in Latin America and internationally. Unfortunately, we do not have any examples from the Caribbean in this work. Although day centers that provide care services for dependent elderly people are widespread internationally, few countries in Latin America offer this service. In contrast, centers with social purposes are more common in the region.

One of the findings of this study is that day centers have benefits for both their users and family caregivers. However, limitations remain in the scientific literature on these benefits. Very few studies have randomized service assignments, so more research with this methodology is needed to obtain rigorous evidence on the impact of day centers. In addition, most of the evidence corresponds to high-income countries, so more evaluations are needed in Latin America and the Caribbean. Finally, many of the benefits of day centers are heterogeneous and there is lack of research that explains this variability in outcomes based on differences in day center attributes (services provided, human resources, and model of care, among others).

Another added value of this study lies in the fact that, based on the lessons learned from regional and international good practices and mainly from the experience of day centers in Spain, we have developed a detailed operational guide to set up day centers from a Person-Centered Care approach. It explains in detail how to develop the physical space, transportation, human resources and daily organization, in order to contribute to the expansion of this service in the region. It also provides specific recommendations for caring for people with dementia in facilities, and for working with personalized care and living plans for each user. The latter is key to ensure the quality of the service and that each user has an itinerary related to their needs, interests and desires.

Respecting people's preference to age in their homes must be an ethical choice of all parties involved, including governments. The design and implementation of day centers at scale to cater for situations of dependency is a policy decision that achieves the dual objective of respecting this preference and alleviating the burden of care for families.

ANNEX 1. Characteristics of considered reviews

Authors	Date of publication	Place of execution	Goal	Type of review	Number and design of studies included
Anetzberger	2002	United States	Identify community resources and describe their benefits for successful aging.	Narrative	
Catty et al.	2007	United Kingdom	To determine the effects of non-medical day center care for people with severe mental illness.	Systematics	More than 300 citations were identified, but none were relevant to the review. No randomized controlled trials of non-medical day centers were found.
Du Preez et al.	2018	Australia	Determine the extent to which these services support the occupational participation of people with dementia and how they impact their primary caregivers.	Integrator	16 studies: 2 systematic reviews, 1 narrative review, 1 qualitative longitudinal, 7 qualitative cross-sectional, 3 mixed-method, 2 controlled trials.
Fields, et al.	2014	United States	Review the effectiveness of day centers, with special attention to caregiver and participant outcomes, healthcare utilization, and future directions to be investigated.	Systematics	61 studies: 19 articles on caregivers: 4 cross-sectional, 2 controlled trials, 9 quasi-experimental, 4 longitudinal; 39 about users: 10 on day centers and healthcare utilization; 8 randomized control trials. Other cross-sectional, longitudinal or quasi-experimental methods 10 on the social and healthcare system.
Lunt et al.	2020	United Kingdom	Establish the current evidence of outcomes for older people with long-term care attending day centers, and outcomes for caregivers.	Systematics	45 studies: 6 qualitative and 39 quantitative studies: 4 randomized controlled trials, 2 controlled trials, 6 quasi-experimental, 11 case studies, 5 cross-sectional, 1 systematic review and 10 cohort studies. Relating to day centers 36/45.

Authors	Date of publication	Place of execution	Goal	Type of review	Number and design of studies included
Mason et al.	2007	United Kingdom	Identify, assess and summarize the effectiveness and cost-effectiveness of different models of community support care for frail elderly people and their caregivers.	Systematics	20 systematic reviews, 22 effectiveness studies (10 randomized controlled trials, 7 quasi-experimental and 5 uncontrolled studies) and 5 economic evaluations.
Tretteteig et al.	2015	Norway	To provide an expanded understanding of the influence of day centers on family caregivers.	Integrator	19 studies: 2 qualitative, 8 non-randomized quantitative, 7 descriptive quantitative studies, 2 mixed design

Annex 2. Example of the organization of a day at the day center.

The following describes the organization of a daily routine in a center, where environmental opportunities are enhanced, following the dynamics that can be typical of any home without the need to enforce strict rules.

Each person supported by the center has their individual support needs and activity proposals. The development of this personalized itinerary is based on the life history and the care and living plan. The objective of both tools is to collect information relevant to the person, their occupational history, potential, present needs, issues they wants to develop further, interests and priorities, hobbies, among others. The content of the care and living plan will be dynamic and constantly revisable. This proposal was designed for Mexico and each country will have to adjust this organization to its idiosyncratic characteristics.

9 a.m. Opening of the day center and reception of users. The center staff asks them how they are doing, how the transfer went, etc. Personal belongings are stored in the space that each person has been assigned for this purpose.

9 to 10 a.m. Breakfast and medication. It is a time for breakfast (in the welcome process each person will have indicated whether they want to have breakfast at the center or at home) and medication. Not everyone arrives at the same time; they join gradually.

Auxiliary staff prepare the coffee, heat the milk, water, toast bread. At that time, if there are users who can collaborate with this task, they set the dishes on the tables, put water jugs, napkins, etc. In the course of this hour there is a dynamic of daily activity and a conversation about how they spent the night, what they used to have for breakfast in their youth, customs of their villages, among other topics. After breakfast, the tables are cleared and the dishes are put in the dishwasher, always taking into account the people who can collaborate in this task with the help of the auxiliary personnel. Breakfast is not merely an activity, but rather a search for meaning: there is the smell and the sound of home, a meaningful conversation is engaged in while reminiscence is worked on.

10 to 11 a.m. Cleanup and different meaningful activities. One or two assistants perform toilets/showers. The rest of the staff sets up tables in different spaces and in each location different activities are done, which people have requested and are meaningful to them. These activities are dynamic over time, they are not closed and vary according to the tastes of each person and the moment in which they find themselves.

Crafts are made on a table (avoiding those that are childish, such as painting figurines or putting together puzzles for children, among others) that can be used to decorate the center. They can also redecorate a mirror, a screen or make flower arrangements. At another table there are people reading a book, a magazine or the press. Others may settle into an armchair, decide not to participate, and keep observing and quiet. Also knitting, sewing, arranging a center curtain. Finally, another group performs cognitive stimulation exercises: word search, arithmetic, painting, memory and orientation exercises. During this time there is background music, chosen by the users or from the radio.

11 a.m. Group activity. The press is read aloud, current news, the horoscope of each person (which allows them to work on date and place of birth, as well as the current date). This activity is followed by group gymnastics: body exercises or with the help of a ball, foam ball or hoops. The materials must be adapted to ensure the exercises can be carried out without difficulty.

They can also opt for baking or cooking activities: prepare cakes, muffins, an apple pie, sauces, custards, donuts, or a salty snack. Users can bring their own recipes. While they are being made, they engage in conversation about the ingredients or about how others usually make them. Again there is scent and domestic noise.

Another option for a group activity could be to organize a mass or religious event (if there are people who demand it), or to watch movies. These are chosen by users and can generate conversations about their youth. It is also possible to go out to a nearby place with a small group: visit a park or go shopping.

11:45 a.m. Toilet reminder. Some people may go alone or need supervision; others require support and diapering. Beyond this reminder, it is important to promptly attend to bathroom needs at any time of the day.

12 h. Going outdoors and table setting. Weather permitting, users go for a walk in the garden or on the street, do the gardening, or chat in the open air. If the weather is bad, they can sweep, tidy cabinets or decorate the room to their liking. In the meantime, other people prepare the dining room tables with the help of staff: set the dishes, serve the bread, place the water jugs.

1 p.m. Lunch. Some people eat alone, others need help, for example, to cut some foods, and some even need to be fed by hand. Each person is assisted in what they need. The nursing staff is in charge of distributing the medication and, in their absence, the auxiliary staff does so. When the users of the center are eating the second course, the auxiliary staff sits down to share the table and engage in conversations about the shopping list, the menu, how it has been prepared. After the meal, they go to the bathroom again and perform their oral hygiene or personal hygiene.

2 p.m. Break. Most people need a break at this time and lie down in armchairs or recliners, usually in a darkened room. A documentary or relaxing music is played on TV at a very low volume. In the dining area, other people are in charge of picking up the dishes, putting them in the dishwasher, sweeping with a broom or washing the dishcloths, among other tasks. Users progressively wake up from their nap between 3 and 4 p.m.

4 p.m. Snack and recreational activities. A caregiver begins to prepare the snack, together with those who want to collaborate. It is time to offer them a coffee, a fruit, or a dairy product. They can be on the couch watching TV and have a snack there and then, in an informal way. When pastries are made in the morning, they can snack on them that same afternoon.

The afternoon is reserved for recreational activities. They can walk outside, or play cards, bingo, dominoes, or Parcheesi at a table. Other people knit or embroider, or watch a soap opera. Another day may involve singing, dancing, listening to music, watching a movie, or activities related to technology, such as playing games on the tablet or searching for information. They can also take a walk, celebrate different festivities of the year, or craft decorative objects. Finally, personal image can be worked on (hair styling, nail painting, among other things).

This proposal for organizing a day at the center is simply an example, which needs to be flexible in order to customize and adapt routines to the reality and preferences of the users.

Annex 3. Care and living plan

My personal data

First and last name: _____

Start date at the center: _____

Expert Professional: _____

Family member or designated contact: _____

Who I am - This is relevant information about my life history:

Childhood, youth, adult life, my work. Places I have visited.

Now: _____

The most important thing for me today:

These are the values that have shaped my life. My religion and beliefs, and relation to spirituality

What others admire about me: _____

Observations: _____
_____
_____
_____
_____

What I need

Comprehensive assessment

My physical health (history, diagnoses and treatments): _____

My emotional health: _____

My social relationships: _____

Observations: _____
_____
_____
_____
_____

Support plan for the day

Allergies/intolerances: _____

Oral hygiene and prosthesis (if required): _____

Personal care in day center (yes/no and frequency)

My routine, likes, dislikes, and preferences: _____
_____

Degree of support (and products for it): _____

Special care: _____

Observations: _____
_____
_____
_____
_____

Movement

Degree of support (and products for it): _____

Eating

My routine, schedules, likes, dislikes, and favorite foods: _____
_____

Diet and hydration

Degree of support (and products for it): _____
_____

Toilet

My routine, likes, dislikes, and preferences: _____
_____

Degree of support (and products for it): _____

Continence: _____

Special care: _____

Sleeping

My routine, schedule, quality of sleep: _____

Challenging behavior:

What happens to me: _____

When and where it happens to me: _____

What a need I am expressing: _____

How can you help me: _____

Observations:_____

_____

_____

_____

My activities, relationships and significant places at the day center

My meaningful activities, what I like to do:

What I want to learn: _____

My therapeutic activities: _____

My significant relationships: _____

Where I prefer to be: _____

What makes me have a good day: _____

What things might make me uncomfortable or bother me at the day center:

Observations: _____

_____

_____

_____

Care coordination:

With my family: _____

With my community: _____

With my health service: _____

Observations: _____

_____

_____

_____

_____

_____

_____

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