Improving Care for Home Care Patients and Addressing Healthcare Disparities in 2021

Theresa Soriano, MD, MPH

Home Care Medicine colleagues,

As 2021 marches on, each day we witness events that remind us that our words and actions matter. They can bring people together and spark hope or create sparks of anger and division. We’ve seen how positive words and actions of public and private organizations, officials, and individuals, can accelerate access to life-saving vaccines, PPE for frontline workers, basic necessities for people in financial need, support for small businesses and essential workers, and even computers for the millions of at-home learners unable to attend school in person. However, we have also seen words and actions, or perhaps lack thereof, result in increased disparities in wellbeing — physical, mental, emotional, social, financial, and educational.

As a community of professionals in home care medicine, and within our respective disciplines, we pledge to hold ourselves to the highest standards of clinical practice, to treat our patients as whole people deserving of our care, to respect their goals and wishes, and to act as agents of change at the patient and community level. We advocate for and speak out against policies or practices that compromise our patients’ — or their caregivers’ — access to the care, services, and resources that improve their quality of life and enable them to remain as healthy as they can.

It’s with pride that we bring much-needed healthcare access, services, compassion, and support into the homes of vulnerable people from diverse communities. We teach our trainees the importance of being respectful

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“guests” in our patients’ homes, and of developing care plans that take into account patients’ priorities and social context as much as their vital signs. We continuously strive to learn about and develop better ways to deliver care in the home, to study the data to show the positive outcomes our care models enable. We use this evidence to publish, educate, and advocate for more people to have access to high-quality home based care, acting as the voice of our patients so they may be prioritized and heard.

Thank you to our AAHCM colleagues leading the way on the frontlines, sharing your efforts and lessons so your peers and more patients can benefit from home care medicine innovations and practices.

Let’s keep working hard in 2021 to stay true to our professional promises, ensure access to care for our patients, serve to address all populations in need, and use our words and actions to achieve equity across our nation’s communities. Together we can create opportunity for health and wellness in all its forms.

Be well, stay safe, and thank you for all you do for AAHCM and the field.

Regards,

Theresa Soriano, MD, MPH
President

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NOTES ON CAREGIVING

One Year Into COVID-19 Pandemic, Disparities in Advance Care Planning Discussions Remain

Jill Schwartz-Chevlin, MD, FACP, Senior Medical Officer, Landmark Health

Why is Advance Care Planning (ACP) of interest to providers of house call medicine? At this time, one year after the attack of COVID, our most frail patients remain at home, fearful of getting sick, isolated from friends and family, and with limited resources to engage in meaningful conversations about their goals, values, and wishes. As privileged providers of in-home care to patients, we have opportunities to connect with our patients, even with face-masks, shields, and other protective equipment. In addition, since March 2020, we can continue these conversations through telemedicine platforms using video capabilities, like never before, making these interactions more purposeful.

According to a consensus definition by a multidisciplinary Delphi panel, "Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals, and preferences during serious and chronic illness" (Sudore, 2017). From these conversations, advance directive documents can be completed using the information shared. Advance directive (AD) documents include living wills, designation of health care proxy, and other documents that serve as legal documentation of patient wishes. Medical directives like the POLST forms are medical orders that also can be completed based on these advance care planning conversations. These orders are durable and portable and remain in effect across all domains (home, SNF, hospital) (POLST). Completion of advance directive documentation on all patients is critically important, especially the designation of a healthcare proxy, who is familiar with patient wishes and can help to use substituted judgment if patients are no longer able to articulate their needs.

The purpose of these ACP conversations is to be able to understand what matters most to the patient, their hopes and fears, their concerns if their health should decline, and then understand how medical care can most optimally be aligned with expressed concerns. It is an opportunity to set out a roadmap for the patient and family to understand where they are now and where they may be heading if their condition deteriorates. Through this process, the patient (and surrogate) can be proactive in making further medical and other decisions — putting them in the driver’s seat for their own care.

Studies support early ACP conversations as they contribute to improved patient quality of life, increased patient emphasis on comfort, increased likelihood of use of hospice services, increased likelihood of a patient dying in their preferred location (home vs. hospital) (Bischoff, 2013), not to mention, reduced hospital admissions (Chen, 2018), and medical costs (Klinger, 2016) (Bond, 2018).

In reviewing the characteristics of who gets ACP conversations, we find that a majority of patients are older age, Caucasian, with a history of chronic disease, higher socioeconomic status, higher education level, and with more significant functional impairments (Teno, 2007) (Orlovic, 2019).

In contrast, studies show that Blacks and Hispanics disproportionately are not having ACP conversations (Teno, 2007), lack advance directives (Huang, 2016) (Clark, 2018), and are more likely to die in the hospital and receive more intensive treatments at end-of-life (Orlovic, 2019). Studies have shown that Blacks tend to be less likely to complete AD and were more likely to prefer aggressive treatment, compared with Whites, which has been thought to be related to distrust of the healthcare system (Kwak, 2005). Whether this disparity is due to race, culture, socioeconomic status, or education is not clear. What is clear is that these disparities continue to exist and need more concentrated attention by medical professionals and community groups.

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Other barriers for patients include increased emotion around the topic, fear of death, cultural and legal factors (Committee on Approaching Death, 2015), fear of affecting physician-patient dynamic, fear of affecting family dynamic, lack of time, and lack of priority (Bernard, 2020). For providers, barriers include fear of patient reaction (emotion, loss of hope), lack of expertise or skill in having these conversations, time commitment, lack of knowledge around ACP vs. AD vs. orders for life-sustaining treatments, or feeling that someone else is better positioned to have these conversations (Lund, 2015) (Howard, et al, 2018).

What is being done to help to promote further ACP? Senator Blumenthal (D. Conn), sponsor of the Compassionate Care Act on December 2, 2020, introduced a bill (S.4945) to the Senate which increases funding for Advance Care Planning public education, training and education to health care workers, telehealth availability to complete ACP, feasibility evaluation of a national ACP platform and registry to improve access for patients and health care providers (Famakinwa, 2020) (Congress.gov, 2020). The introduction of this bill is especially helpful during this COVID pandemic when patients may be living with family members, out of state, and may not have access to their ACP documents, in which case having improved access is critical.

COVID has brought to light the need for frequent ACP conversations for patients to express their goals and wishes and what matters most and to elect who they would like to make decisions on their behalf, if they are not able. Many patients are choosing to forego the hospital given the fear of being put on a ventilator, or even dying in the hospital without the ability to see family. This reality highlights the critical need to ensure patient wishes are discussed and documented. All healthcare workers should be training in how to have these conversations and patients should be asking their providers to engage in meaningful discussions around ACP. This bill, if enacted, will help facilitate more of these conversations with ease of use through telemedicine platforms, and with a national registry for improved access.

House call practices and providers have an opportunity to connect to all patients on what matters most to them and to ensure that everything possible is being done to facilitate aligning medical care with these wishes. Knowing that specific populations are underserved with regard to having these meaningful discussions, our practices can implement procedures and programs that ensure that all patients can receive goal concordant care.

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Disparities in Advance Care Planning Discussions

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Engaging Underserved Communities in Dialogue About the COVID-19 Vaccine

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Background
It is no secret that the COVID-19 pandemic is disproportionately affecting Black, Hispanic/Latinx, and American Indian communities, and older adults who have the highest rates of hospitalization and death caused by the virus.¹ There are many reasons for these health disparities, including discrimination based on race, age, socioeconomic status, and lack of access to healthcare. Underserved communities have experienced historical and current trauma from being exploited in clinical trials, systematically denied access to adequate healthcare, and receiving limited access to health information. These experiences have worsened distrust in medical institutions and hesitancy to receive a COVID-19 vaccine.² In addition, the political overtones that surround the COVID-19 vaccine have perpetuated distrust in many ethnic and minority communities and cannot be ignored by health professionals. In October 2020, Yale researcher, Dr. Alan S. Gerber released a study highlighting the public’s perception of the COVID-19 vaccination plan. He stated, “The value of any COVID-19 vaccine depends on people’s willingness to be vaccinated, and our work shows that politics has a substantial influence on how the public perceives the quality of a new vaccine.”³ To build trust and address vaccine hesitancy among underserved communities, there is a need to repair relationships by promoting transparency and addressing social determinants of health.

Relationship Building and Communication with Underserved Communities
One key step to building trust with underserved communities is using transparent, open, and bidirectional communication that lifts community-based approaches and acknowledges the influence of structural, community, and individual-level influences on COVID-19 health behaviors and outcomes. Currently, many of the communication messages about the COVID-19 vaccine have focused on trusting that the vaccine is safe and effective at preventing COVID-19; however, community members fear that the vaccine development was rushed and has not been tested in a diverse set of people with underlying health conditions. There are concerns about the ingredients of the vaccine, how it was made, and the motives of the government to vaccinate people so quickly. Moreover, there have been contradicting information in media outlets about where to get vaccinated and the potential side effects of the vaccines. Common fears that have arisen during conversations with underserved and minority communities include fears that the COVID-19 vaccine will cause infertility, can alter DNA, and may include a microchip allowing for tracking and deportation.

There are some efforts being done to address these concerns with considerations for culture and community to communicate effective COVID-19 related education.⁴ For example, healthcare providers are learning that it is important to spend time with local communities to allow individuals who live in traditionally underserved communities to talk through their fears relating to the COVID-19 vaccine with a trusted person. Ideally, these relationships should be built before a pandemic situation so that trust is established between the healthcare providers, community partners, and community residents. Local online platforms, such as town hall meetings, listening sessions, and radio interviews are great ways that healthcare providers are using to speak about health situations encountered by the communities they serve in a meaningful way. Specifically, these platforms and conversations are helping providers understand the sociocultural context underlying the fears people may have related to the COVID-19 vaccine and speak to these fears directly. By allowing for space for these conversations to occur, health professionals are given a chance to provide empathy for community fears, while also addressing these concerns with education that is grounded in the current understanding of science. These sessions can be recorded and then provided to older adults via a link in text-based messaging or streamed in partnership with a local news station or via social media.
How Providers are Engaging Minority Communities

In Forsyth County, NC, for example, healthcare providers and experts work alongside community leaders and health equity experts at the Maya Angelou Center for Health Equity to host town hall sessions on social media platforms and radio stations. These sessions are jointly planned by healthcare providers, media specialists, community leaders, and community residents. The diverse planning group provides rich perspectives and input on who to include in the town hall or listening sessions as well as what topics or questions to include. These sessions are then streamed live on social media platforms, recorded, and then distributed to local faith and community organizations for public education and engagement. This allows for bi-directional communication to occur during a rapidly changing pandemic.

Best Practices for Communicating Health Information with Underserved Communities

We can apply lessons learned from previous research as we learn more about how to build trust and stronger relationships with underserved communities. Earlier research has shown that factors such as age, culture, and education influenced the kinds of information that people received as well as their individual responses to the pandemic. For example, people with lower education were receiving most of their education from television, rather than newspapers or other information sources. In addition, they found that many public health messages were delivered at a literacy level that did not meet the needs of people with lower literacy levels.

Other suggestions from the CDC for communicating health information during a pandemic, include:

- Engaging community members in decisions around how education should be developed and implemented in their own communities.
- Developing ethnically specific educational materials, such as user-friendly infographics, and providing them through channels that communities trust.

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• Ensuring that the messenger speaks the language of the culture they are communicating to and can communicate in culturally responsive ways.
• Training of community health workers to help with navigation of resources.
• Ensuring culturally competent personnel are on the healthcare team.

Next Steps and Discussion
As healthcare providers, it is more important than ever to be intentional in addressing the cultural and historical contexts that underlie patient decisions surrounding the response to the COVID-19 pandemic and vaccine. This article provides an overview of recommended best practices when communicating to underserved communities and can be applied to your conversations with older adults.

References
ADDRESSING ETHICS

COVID and Its Effect on Minority Communities
Understanding the Reality of Healthcare Disparities

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Daily news drives home the numbers associated with the pandemic: the number of deaths, the number of hospitalizations, and the number of newly infected people in our communities and in our nation. Other findings related to the pandemic reported in public media include the financial impact of the pandemic and the disproportionate death burden for people of minority backgrounds. The latter is of particular interest for communities that are primarily comprised of minority populations. Although there is an abundance of speculation for this disparity, there is little exploration of factors that could contribute to this disproportionate impact of the pandemic. This is a qualitative study of a convenience sample of seven individuals who survived COVID-19 and who are of Hispanic background and live in El Paso, TX.

Of the seven participants, one needed hospitalization, two lost family members and friends to COVID-19, and none were over the age of 40. Nine interview questions were generated based on a common hypothesis put forth in the media to explain this disparity. Participants were interviewed face-to-face (virtually) but also had an opportunity to elaborate on their answers in writing after the interview.

Responses to the following questions were analyzed for common themes. Specific statements that exemplified the themes extracted are included in this presentation.

What was your attitude about the pandemic before you contracted COVID-19? Did you feel it was or wasn’t a serious problem? Please explain.

Concerning the perception of the severity of the pandemic, three of the seven respondents felt that the news of the pandemic and the steps related to prevention were exaggerated; they were skeptical of the news reports. However, four of the seven respondents reported that they knew the situation was very serious and one had already lost a family member, a friend, and a coworker to the virus prior to being infected. Despite personal attitudes about the pandemic and the situation in the community, most felt there was no structure at work to deal with it.

Did you go to work or school believing that your symptoms were nothing serious? Or, what symptom or symptoms made you worry or suspect that you had COVID?

This question elicited the richest responses. Most reported that initial symptoms were mistaken for allergies, bronchitis, or a common cold. Only one person reported having a fever at the start. All respondents reported they continued to go to work or school during the initial presentation of symptoms because they still did not believe that they were infected. Two reported that their motivation was to avoid being fired if they missed work. All reported increasing severity of symptoms after the first day of thinking it was “only allergies.” Symptoms reported included severe body aches, sore throat, dry cough, loss of sense of smell and taste, headaches, and fatigue. Five of the seven reported they could trace the source of infection to their place of employment. One was infected after her husband became infected at the hospital where he works as a nurse and the other became infected after needing to care for his wife and in-laws who contracted the virus. The ones who could trace their infection to work reported they were not told that coworkers had tested positive until after they too tested positive.

Did work, family, or extended family responsibilities influence whether you could maintain social distancing (stay at home) or whether you were able to seek medical treatment when you started exhibiting symptoms of COVID-19?

Respondent’s answers related to how family influenced when they sought medical attention centered around responsibility to caring for family. Most attended to

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the needs of their family members who had become infected at the same time or relied on extended family to help care for children in the home. Only one person reported they had to resort to seeking medical attention across the border because they did not have insurance and could not afford to see a doctor in the U.S. Another individual reported that she put off medical attention, not knowing who would care for her four children. Her delay resulted in the need for hospitalization and medical care in the ICU. Most reported they had maintained social distancing outside of work responsibilities or caring for ill family members in the home.

What thoughts or concerns affected your decision to seek testing or medical care?

One person’s response to this question best exemplifies the sentiments reported by the group:

"I was thinking about work, school, and family responsibilities. I had just lost my father-in-law to COVID and I felt the weight and burden of knowing that one of my peers and employees had also passed away from this virus. I wanted to make sure I did not ignore the symptoms and could medical treatment right away. I also felt the need to get everything ready for my wife if I passed away. I’m the one that manages the finances and knows about our life insurance policies. Therefore, the second day that I started feeling horrible, I gathered myself and showed my wife where everything is kept just in case I died suddenly. It was a very tough moment for my family, but I felt at peace knowing that my wife would know what to do if I was gone."

What was your employer’s/school’s response when you had to quarantine or be admitted into the hospital?

All respondents reported that protocol was observed once they reported they were COVID positive. Workplaces required that the quarantine period be completed and that the person receive a negative COVID
test before returning to work or school. One respondent reported that “the school responded immediately; the program director was understanding about the situation. I loved that all my instructors texted me often to make sure I was OK.” Overall, the respondents reported that they felt supported through the recovery period.

Where do you see the future of your career in these times and how did COVID-19 change this outlook?

What lessons, if any, have you learned during the pandemic?

For these two questions related to changes in outlook, future plans, and lessons learned as a result of being sick, peoples’ responses ranged from optimistic and positive to recognizing the negative aspects of humanity. Most responses centered around acquiring an appreciation for life, family, and the “small things” in life. Being grateful for the health and safety of loved ones was also a repeating theme.

On the negative end of the spectrum, however, there was confusion and disbelief. Respondents reported that they felt they were following the safety protocols correctly and yet they became infected. One person attributed this to other peoples’ selfish and thoughtless behavior — not maintaining social distancing and not masking or following quarantine guidelines when sick. All responses included enlightened self-discovery: I learned to care about the things that matter, I learned I am not that social, and I did not mind staying at home. The following responses are representative of the group’s sentiments:

“I’m more convinced of what is important in my life and the small things I need to enjoy. There is so much negativity in the world and so much confrontation and disagreement that when you are confronted with the possibility of being sick and dying, it makes you understand the countless times you have not enjoyed yourself throughout the journey of life. My perspective has changed tremendously.”

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“My career path has not changed due to COVID; however, it did affect how I acted at work to include being stricter about social distancing and mask-wearing even when in an area by myself.”

“Live, enjoy the little things, smile, don’t complain, be thankful all the time, and be patient with others.”

**How do you feel about an eventual return to work?**

The responses to this question also ranged in emotional valence. There was the fear of becoming reinfected and not being physically ready or well enough to return to work. On the positive side, people reported that they appreciated being able to work again.

**What is your level of education and in what field?**

This last question was included to address the hypothesis that low educational levels, low literacy, and low health literacy are contributing factors to the disproportionate impact of COVID in minority populations. Of the seven participants, all but one was trained in a health field and he had a master’s degree in administration. The other participants included healthcare providers including a doctor of veterinary medicine.

**Conclusions**

The overarching sentiment was that there are still many unknowns about the virus and how safety protocols are being implemented. For example, respondents questioned the practice of taking temperatures at entrances because most did not experience fevers through the course of the illness. They also questioned the efficacy of air ventilation and spacing in work environments where there is constant motion such as where multiple workers are providing care to patients or where people are walking up and down aisles. The other concern raised was with the timing of when they were notified by their employers when coworkers reported being positive. Participants reported they would have proceeded with COVID testing sooner had they known their co-workers' status, thereby reducing the possibility of infecting others.

The overall conclusion was that too many people in communities are not acting responsibly such as only partially following protocols to gain entry into worksites, stores, or other community areas. Examples provided were people “half-masking” or removing masks once no one was monitoring them as well as failing to report their status just to avoid missing work.

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CLINICAL PEARLS

COVID-19 Pandemic Puts Spotlight on Trauma-Informed Care

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Trauma has many origins including childhood abuse or neglect, as well as physical, emotional, or sexual abuse. It can arise from accidents and natural disasters, or from witnessing (directly or indirectly through stories or media) acts of violence. Trauma can be cultural, intergenerational, or historical as in the Holocaust or history of slavery. It can stem from war or other forms of violence as well as from medical interventions and grief and loss. Trauma can have adverse effects on physical, social, emotional, or spiritual well-being. The effects of traumatic events place a heavy burden on individuals, families, and communities. There is a body of evidence that the effects of trauma impact health behaviors resulting in chronic disease, effects on the immune system and, behavioral health disorders. The COVID-19 pandemic is a prime example of such a trauma for individuals, families, organizations, and communities locally, nationally, and globally.

To combat the effects of trauma and address the needs of multiple populations, trauma-informed care has been brought to the forefront, especially throughout the COVID-19 pandemic. Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people’s lives, their service needs, and service usage. A trauma-informed approach is one that incorporates an understanding of the pervasiveness of trauma and its impact on individuals, care systems, and the community. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. It includes the open-mindedness and compassion that all who enter the healthcare system deserve because anyone can have a history that impacts their encounter with the medical system. This compassion should extend to staff, colleagues, and the community as “cultural humility.”

COVID and Mental Stressors in the General Population

COVID-19 has led to diverse mental health problems, including anxiety, depression, posttraumatic stress disorder (PTSD), and other trauma- and stress-related disorders. Different groups have met the qualifying criteria for posttraumatic stress disorder (PTSD) according to DSM-5 as a result of the pandemic as outlined in June 2020 surveys of 5,000 adults living in the U.S. Findings include:

- 40% experienced at least one adverse mental or behavioral health condition
- 30.9% reported symptoms of anxiety or depressive disorder
- 26.3% reported symptoms of trauma and stressor-related disorder related to the pandemic.
- 13.3% started or increased substance abuse to cope with stress or emotions related to COVID-19.
- 10.7% had seriously considered suicide in the 30 days prior to the survey.

The group that had seriously considered suicide could be further broken down: 25% in the age group 18-24 years; 15.1% in the Black group; 18.6% in the Hispanic group; 21% in the essential worker group that performs necessary functions during a pandemic; and 30.7% in the unpaid caregiver group.

As demonstrated by the survey, mental health conditions disproportionately affected minorities, young adults, essential workers, and unpaid caregivers of adults as well as those with psychiatric disorders. Although unpaid caregivers of children were not separately evaluated in this study, approximately 39% of unpaid caregivers for adults shared a household with children (compared with 27% of other respondents). Given these findings,

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caregiver workload, especially for multigenerational caregivers, should be considered.  

Traumatic stressors related to COVID-19 include severe illness with serious and potentially long term sequelae, hospitalizations with limited or no visitation, death of loved ones including witnessing those deaths in person or via technology, and extreme exposure to COVID-19 details. General stressors include COVID exposures and quarantine, social isolation, loss of employment and income, working from home, childcare and school issues, caregiving, making medical decisions, lack of PPE and other supplies, and vaccine uncertainties and challenges.

**COVID Stressors in the Healthcare Community**

Many of the stressors are magnified for healthcare workers who are subject to acute stress reactions, vicarious traumatization, and traumatic stress. In addition to the trauma of direct patient care, healthcare workers face concerns about virus spread, their personal health and that of loved ones, and changes in work environment. Healthcare workers are also at risk for moral injury, that is psychological distress derived from actions (or the impossibility of implementing actions) that violate their personal ethical and moral codes. All these aspects contribute to the possibility that healthcare workers develop psychopathological disorders such as PTSD, severe depression, and substance abuse. For healthcare workers, early symptoms of psychological trauma, together with symptoms of anxiety, depression, and insomnia, must be recognized. Interventions geared toward healthcare workers at the organizational level consider risk and protective factors and possibly including actions to promote post-traumatic growth.

**COVID Stressors Among the Sick Elderly**

Residents of nursing homes and other congregate living situations, as well as those living alone, have been particularly vulnerable to isolation as a result of lockdowns, restrictions on activities, decreased community services, and in some cases, decreased visits to or by healthcare providers. Some of these services were replaced with telehealth or telemedicine visits, but not all homebound or institutionalized care recipients have this option available. To combat isolation among locked-down nursing home residents, CMS recommends safe communal activities with precautions of social distancing and PPE. Facilities vary in their requirements for visitation, and these are determined locally.

**Principles of Trauma-Informed Care**

Trauma affects an individual’s beliefs about themselves, those around them, and the larger society. These altered beliefs can directly impact an individual’s ability or motivation to connect with and utilize support services. A system utilizing a trauma-informed care approach realizes the direct impact that trauma can have on access to services and responds by changing policies, procedures, and practices to minimize potential barriers. Trauma-informed programs are welcoming and inclusive and based on principles of respect, dignity, inclusiveness, trustworthiness, empowerment, choice, connection, and hope. They are designed to attend to both physical and emotional safety, to avoid re-traumatizing those who seek assistance, to support healing and recovery, and to facilitate meaningful participation of survivors in the design, implementation, and evaluation of services. Supervision and support for staff to safely reflect on and attend to their own responses and to learn and grow from their experiences is another critical aspect of trauma-informed work.

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There are six key principles to a trauma-informed approach that can be applied organizationally in the context of COVID-19:

1. **Safety.** Ensure service users and staff feel they’re being protected and that their physical safety is a priority. Communicate clearly to staff, service users, and community partners about the crisis response efforts, eliminating any shaming or stigmatizing language. Support staff to feel safe to speak about vicarious trauma, work-related stress, and other emotional considerations. Demonstrate consistency and flexibility and be mindful of nonverbal communication.

2. **Trustworthiness and transparency.** Solicit input and feedback from staff and community partners. Communicate regularly and clearly and clarify the reason behind decisions. Make policies available. Demonstrate both strength and sensitivity.

3. **Peer support.** Provide opportunities to promote recovery and healing.

4. **Collaboration and mutuality.** Recognize that everyone has a role. Share power and decision making.

5. **Empowerment, voice, and choice for staff and recipients of care.** Promote shared decision making, choice, and goal setting. Facilitate rather than control recovery for care recipients and staff. Use a “what have you experienced?” instead of a “what’s wrong with you?” model which is both collaborative and empowering.

6. **Cultural, historical, and gender issues.** Sources of trauma are recognized and incorporated into policies and services that move beyond bias and stereotype and acknowledge history. Toxic stress resulting from racial and social inequities have been magnified during the pandemic, with implications for poor physical and mental health and socioeconomic outcomes among communities of color. We must invest in addressing health inequities and work across sectors to build self-efficacy and long-term capacity within communities and systems of care serving the most disenfranchised, now and in the aftermath of the COVID-19 epidemic.
A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in healthcare recipients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices. Identification of populations at increased risk for psychological distress and unhealthy coping can inform policies to address health inequity and social determinants of health and to provide economic and social support while providing appropriate screening and culturally appropriate messaging to promote emotional well-being. Social determinants of health include economic stability, education access and quality, health care access and quality, social and community context, and neighborhood and built environment.10

Home health providers are in a unique position to assess the needs of adult caregivers of homebound patients who are at increased risk of suicide. In addition to supporting the caregivers, there is a role for advocacy in the community. Interventions might be aimed at strengthening economic supports and promoting social connectedness as well as supporting those at risk for suicide. They must also consider the possibility that the pandemic has been personally and professionally traumatic and work to provide trauma-informed care for themselves as well as those with whom they interact.

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4 Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020 Weekly / August 14, 2020 / 69(32);1049–1057 Mark É. Czeisler1,2; Rashon I. Lane, MA3; Emiko Petrosky, MD3; Joshua F. Wiley, PhD1; Aleta Christensen, MPH3; Rashid Njai, PhD3; Matthew D. Weaver, PhD1,4,5; Rebecca Robbins, PhD4,5; Elise R. Facer-Childs, PhD1; Laura K. Barger, PhD4,5; Charles A. Czeisler, MD, PhD1,4,5; Mark E. Howard, MBBS, PhD1,2,6; Shantha M.W. Rajaratnam, PhD1,4,5. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm


7 The State University of New York, University at Buffalo, Buffalo Center for Social Research http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care.html


ACADEMY NEWS

Welcome, New Members
The Academy welcomes the following new members who joined AAHCM between November 13, 2020 and February 11, 2021:

**Arizona**
Richard Bass
Lisa Swansen

**California**
Carie Chin
Stephen Poses
Valerie Wong
Paolo Zizzo

**District of Columbia**
Wesley Cook
Kirsten Das

**Georgia**
Darcy Deviner

**Illinois**
Roshani Patel
Ronalyn Stephen

**Kentucky**
Randeana Collett

**Maryland**
David Campbell
Craig Johnson
Kiahanna Miles
Elizabeth Schwartz
William Swann

**Massachusetts**
Caroline Berchuck
Kamau Karanja
Megan Young

**Michigan**
Bilal Malek

**Minnesota**
Brandon Verdoorn

**Missouri**
Munier El-Beck
Melissa Lyon
Beth Sjoblom

**New Jersey**
Faris Ghawi

**Ohio**
Miranda Huffman

**Pennsylvania**
Caitlin Cafaro

**South Carolina**
Christy Jeffcoat

**Texas**
Natalie Roman
Kate Taylor

**Utah**
Brandi Lloyd

**Virginia**
Jonathan Ansell
Carol Martin

**West Virginia**
Milton Havron

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**Become a member today!**
Reminder: COVID-19 Resources for AAHCM Members

With COVID-19 news and information rapidly evolving, AAHCM is committed to providing the resources and up-to-date information home healthcare providers need for their practices and patients.

We’ve assembled a comprehensive COVID Resources page on our website with the tools, updates, vaccine information, and educational resources for providers and patients to help our members navigate the pandemic landscape.

Call for Frontiers Contributors

If you’re enjoying the in-depth articles in this quarterly issue of Frontiers, consider submitting one of your own! We strive to represent diverse disciplines across the industry and would love to hear more from our members specializing in:

• Education
• VA
• Palliative medicine
• Hospital at home
• Billing and reimbursement
• Technology

If you would like to write for Frontiers, please send your resume, subject area of expertise, and a writing sample to info@aahcm.org.

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A Special Thanks to the IRC Partners Featured in This Issue

The Industry Relations Council (IRC) is an adjunct group of key industry supporters who provide goods and services in the home care setting and share a common goal of advancing care for patients in that setting. For information on all IRC members, visit us here.