

CONTENTS

Notes on Caregiving

**INFORMAL CAREGIVERS: A ROLE THAT
DESERVES OUR RECOGNITION AND SUPPORT**
page 3

Addressing Ethics

**MORAL INCLUSION OF OLDER ADULTS IN
HEALTHCARE**
page 7

Models of Care and Health Policy

**MEDICAL FOSTER CARE, AN ALTERNATIVE TO
INSTITUTIONAL CARE**
page 9

Specialty Caregiving

**MEETING PATIENTS WHERE THEY ARE
THROUGH HOUSE CALLS**
page 13

Academy News

page 14

PRESIDENT'S MESSAGE

Leadership Across the Landscape

THERESA SORIANO, MD, MPH

"The first week of August hangs at the very top of summer, the top of the live-long year, like the highest seat of a Ferris wheel when it pauses in its turning." – Natalie Babbitt, author

Colleagues and friends of AAHCM,

I hope you are all enjoying the longer days and slower pace of summer, offering some respite from busy work and school weeks. Some of us have been enjoying long-awaited vacations, reunions with loved ones, and renewed hope for a return to "normal" as millions of people get vaccinated, and COVID-19 infection rates fall across much of our country and globe. Our HCM providers and practices have administered vaccines and/or helped facilitate public and private partnerships to ensure access for those in our community who are home limited. As we thanked you in our last issue of *Frontiers*, AAHCM thanks you again for your continued service to our patients and community to improve the public health.

However, this summer continues to show us that the only predictable thing is change. With all the highs of summer fun come the lows of continued challenges of controlling the highly transmissible COVID-19 Delta variant, continued efforts to vaccinate the remaining eligible Americans who have not yet protected themselves, and continued focus on providing safe in-home and virtual care to the vulnerable patients and caregivers who so depend on high-quality Home Care Medicine to improve their health and quality of life.

As healers and leaders in home care medicine, and as proud members of AAHCM, we must continue working to come out of this pandemic's shadow. As leaders, we must look ahead and help our communities recognize the value of home care medicine, promoting equity and safety for some of our most



307 South Eaton Street
Baltimore, MD 21224

PHONE 855.576.8482
FAX 443.451.8362
EMAIL info@aahcm.org
WEBSITE www.aahcm.org

EDITOR IN CHIEF

June Leland, MD, MBA

SECTION EDITORS

Katherine Lawson, PhD, LMSSW, OTR
Jill Schwartz-Chevlin, MD, FACP
Rachel Zimmer, DNP, AGPCNP-C

PRESIDENT

Theresa Soriano, MD, MPH

EXECUTIVE DIRECTOR

Brent Feorene

vulnerable neighbors and highlighting the amazing disciplines that make up our field. We can do this quietly, by dedicating ourselves to our clinical work, studying our model, training new clinicians in HCM, getting vaccinated and encouraging our loved ones to do the same. We can also be more active in our leadership, speaking or writing publicly about home care medicine's role in bettering our population's health, advocating for payment models that reflect HCM's true value, and, if in positions of leadership, expanding high-quality home care medicine models that respect our teams, patients, and the diversity of our field. Many aspects of HCM leadership are reflected in this issue of *Frontiers*; it is humbling and inspiring to see the leadership of our colleagues.

Before preparing for the activities of a new season (including our Annual Meeting — [register if you haven't already!](#)), please don't forget to enjoy the rest of the ride as we finish out our summer days. We have a lot to be grateful for, including the community we have all built in AAHCM.

Stay safe and well,

Theresa Soriano, MD, MPH
President



AAHCM 2021 Virtual Annual Meeting — Registration now open!

HOME-BASED MEDICAL CARE: LEADERSHIP ACROSS THE LANDSCAPE

Friday and Saturday, October 29 – 30, 2021 Pre-conference sessions October 28

The opinions and recommendations expressed in this publication are not necessarily those of the American Academy of Home Care Medicine, its editor, or publisher. Every precaution is taken to ensure accuracy, but responsibility cannot be accepted for the correctness or accuracy of the information supplied or any opinion expressed.

Before using procedures or treatments discussed in this publication, clinicians should evaluate their patient's condition, compare the recommendations of other authorities, consider possible contraindications, and consult applicable manufacturer's product information.

No material may be reproduced in whole or in part, in any form, without written permission. Vol. 35, No. 3 © 2021 by American Academy of Home Care Medicine.

Comments on the newsletter can be e-mailed to the editor at: info@aahcm.org. Advertising is accepted. Contact Stacy Warkentine at 855-576-8482 or swarkentine@aahcm.org.

Informal Caregivers: A Role that Deserves Our Recognition and Support

RACHEL ZIMMER, RN, DNP, AGPCNP-C, ASSISTANT PROFESSOR, WAKE FOREST BAPTIST HEALTH

OVERVIEW

Currently, there are over 17 million informal caregivers who provide the backbone of support and assistance to individuals with a variety of illnesses and/or disabilities in the U.S. (Redfoot, Feinberg, 2013; James, Hughes, Rocco, 2016; The National Academies of Sciences, 2016). Given the advances in medicine and increased lifespan of Americans, the need for informal caregiving will grow over the next several decades, with the expected number of Americans requiring an informal caregiver expected to double by 2050 (James, Rocco, 2016; The National Academies of Sciences, 2016). In addition, virtually all states have seen a significant drop in skilled nursing facility occupancy rates since COVID-19. (Flynn, 2021) Informal caregivers have increased their capacity over the past several years to take on many of the tasks previously performed by trained clinicians and nurses, such as wound care and medication management (Wolff, Feder, 2016; Redfoot, et al., 2013). Without their important contribution to the wellbeing of loved ones, the health system would be under strain due to the high costs of long-term care and paid home health services needed to care for these individuals (Reinhard, Feinberg, 2015). A report released by the AARP Policy Institute found that in 2017, about 41 million caregivers provided an estimated 34 billion hours of care for an adult with disability or illness, estimating the value of the services to be about \$470 billion. (Reinhard, 2019)

It is well documented that caregiving takes a toll on the physical, emotional, and financial health of individuals (Bremault-Phillips, Parmar, et. al, 2016; The National Academies, 2016). Many caregivers report high levels of stress and feelings of isolation and are more likely to rate their own health as fair or poor compared to the general population (AARP Public Policy Institute, 2015). Additionally, caregivers frequently must miss days or even leave the workplace altogether to perform caregiving duties, which can have additional deleterious effects on their financial health and stress burden, with estimated lost wages approaching \$522 billion per year in the U.S. (AARP public policy, 2015; Chari, et al., 2015) Many caregivers report that caregiving negatively impacts their own retirement, causing them to withdraw funds early and/or drop out of the workplace prematurely (Tell, Nadash, 2021).



In 2017, about 41 million caregivers provided an estimated 34 billion hours of care for an adult with disability or illness.

PATH TO POLICY CHANGE

Congress passed the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act in 2018, which established the Family Caregiving Advisory Council tasked with creating the country's first national Family Caregiver Strategy. This council has worked with the John A. Hartford Foundation to create the RAISE Family Caregiver and Resource and Dissemination Center to, in part, develop caregiving resources for state and federal policymakers, while providing support for states as they develop policies to address family caregiver issues. This work has also helped support researchers as they work to identify the needs of caregivers, with goals of informing policymakers and stakeholders to develop legislation to support the role of informal caregivers.

The University of Massachusetts at Boston conducted listening sessions with 80 individuals designed to allow family caregivers to share their unique challenges and needs, recommendations for supports, and policies that would help meet the needs of themselves and the people that they care for (Tell, Nadash, Cohen, 2021) Overall, the report noted that caregivers ranked their highest priority concerns as the following:

- Caregiving education and training, specifically identifying training on medical aspects of caregiving, as well as strategies for dealing with the behavioral changes that occur in the setting of caring for an individual with dementia.
- Respite care, specifically assistance with finding qualified caregivers and financial support to afford respite care.
- Help with the navigation of community resources, care

continued on page 4

coordination, and care transitions.

- Workplace flexibility: allowing for flexible work schedules, work-from-home options, and flexible time and leave options for caregivers.
- Direct pay for being a caregiver, and a buildup of credits toward Social Security for caregiving hours provided.
- Changes in tax policies to benefit caregivers.

CONSUMER-DIRECTED PROGRAMS

To help support caregivers, states are starting to explore how insurance providers, including Medicaid, can help to support caregivers financially with consumer-directed programs, allowing individuals to choose who is hired for their care, and allowing for payment of services provided by informal and family caregivers. These programs are not new, with the first consideration of consumer-directed options beginning in the late 1960s, and all 50 states have at least one consumer-directed option for long term care services (Teshale, S., Fox-Grage, W., and Purington, K., 2021). A variety of federal initiatives have helped to promote state-initiated models for caregiver support, including the Centers for Medicare and Medicaid Services guidance, beginning in the early 2000s, and the creation of the Community First Choice state plan, developed under the Affordable Care Act that allows for the expansion of states' ability to provide consumer-directed programs. Most states utilize consumer-directed programs through the Medicaid home and community-based waiver (HCBS) authority and are required to provide support for the caregivers in the form of training and assistance and/or access to financial management assistance. For example, in Virginia, the waivers allow for a "services facilitator" to support individuals as they manage their consumer-directed services (Teshale, Fox-Grage, et., 2021). States can also allow nurses to delegate tasks to unlicensed caregivers who receive training through the program, and the AARP 2020 Long Term Scorecard (LTSS) notes that 26 states allow nurses to delegate at least 14 health maintenance tasks to caregivers, such as respiratory care, medication management, tube feeding, and skin care tasks (AARP, 2020).

STATE SUPPORT FOR CAREGIVERS

The AARP LTSS (2020) also provides an overview and assessment of how well states support informal caregivers through the analysis of four main indicators: 1) Supporting working family caregivers, 2) Person-and-family centered caregiving, 3) Nurse delegation and scope of practice, and 4) Transportation policies.

Supporting working family caregivers

AARP's overall assessment of the support of working family caregivers revealed that only two states, Delaware and the District of Columbia, were found to have statewide laws that protect caregivers from workplace discrimination as a protected classification under law. There are now 21 states that have some provisions addressing family responsibility, but many of these specifications are undefined and unclear. In addition, when considering Family and Medical Leave (FMLA), ten states go beyond the federal minimum FMLA requirements, covering family members outside of the scope of federal protections, such as grandparents and siblings. Since 2016, nine states have enacted paid family leave, with the District of Columbia exhibiting the most robust protections for FMLA. (AARP, 2020) In addition, nineteen states allow sick time to be allocated for purposes beyond one's own illness, to help with caregiving responsibilities; and half of states (25) allow temporary financial assistance for family caregivers who are returning to the workforce through state unemployment insurance programs if there is a "good cause" for job loss due to the illness of a family member. (AARP, 2020)

Person-and-family centered caregiving

Person-and-family centered caregiving is measured by a state's financial protections for spouses of Medicaid beneficiaries who receive home-based care services, assessment of family caregiving needs, and enactment of the CARE act. AARP (2020) found that there are seven states that allow a spouse to keep the maximum amount of income and assets allowed under federal guidelines for Spousal Impoverishment Protection. This policy is important because it helps to prevent couples from falling into poverty, allowing the spouse who is not on Medicaid to have a better chance of staying financially independent, paying for basic

continued on page 5

Interested in promoting your organization while supporting the field?

Contact us today to find out how you can participate with AAHCM.

EMAIL US »

needs without requiring state assistance. In states with high-performing LTSS, caregivers' needs, health, and work are assessed and addressed with training, respite care, and tailored services. Most states (41) perform these assessments, but most of these assessments happen in smaller caregiver support groups rather than in the broader Medicaid program. As of December 31, 2019, nine additional states have enacted the CARE Act, bringing the total to 43 states, providing support for family caregivers when family members enter a hospital and transition back home.

Nurse delegation and scope of practice

Nurse delegation and scope of practice indicators are measured by the number of health maintenance tasks that are delegated to direct care workers and nurse practitioner scope of practice. Key findings from AARP show that family caregivers benefit from the expansion of the types of health maintenance tasks that can be delegated to them. This delegation helps family caregivers who might have to leave work during the day to oversee a nurse to perform these tasks, by allowing them to perform the tasks themselves when available. Eighteen states allow RNs to delegate a set of up to 16 tasks to home care aides, with half of states allowing delegation of up to 14 tasks. Still, the bottom-performing states lag significantly on this measure, with four states (Florida, Indiana, Pennsylvania, and Rhode Island) who do not permit delegation of any of the sample set of health maintenance tasks; and another quarter of states (12) who permit nurses to delegate three or fewer tasks. In addition, giving nurse practitioners authority to practice to the full extent of their education and training is an important measure to help provide equitable care for older adults. Allowing NPs to practice at full scope of practice expands the options of both caregivers and care recipients to receive primary care services in the setting of their choice. Currently, twenty-three states allow patients to benefit from the full range of care nurse practitioners are educated and trained to provide. (AARP, 2020)

Transportation policies


Lastly, there are many older adults who depend on volunteer drivers to provide them with transportation to medical appointments, the grocery store, and other essential locations

for daily care. In most states, however, volunteers who provide transportation face risks for liability and spikes in their car insurance premiums. There are ways to protect volunteer drivers through legislation, but few states (seven) have done this. Enacting protective policies for volunteer drivers would make it easier to recruit volunteer drivers to help older adults and people with disabilities get around. (AARP, 2020)

ADVOCATING FOR INFORMAL CAREGIVERS

It is important that national public policies reflect investments in family and informal caregiving supports so that we can build a more caring society for our older adults, individuals with disabilities, and caregivers. There has been significant improvement in policies supporting caregivers since 2015, but there is much more work to do to keep up with the aging demographic and diverse social needs of caregivers and their loved ones. Most family caregivers (60%) are juggling paid work and caregiving, and without workplace and family leave supports, they experience undue financial and emotional strain. Since 2016, family caregivers report that they incur steep costs, around \$7,000 on average per year. (Reinhard, et al., 2019)

How can we help now? There are several recommended actions that stakeholders and HBMC providers can take to help advocate for the support of informal and family caregivers. This advocacy can be for any or all of the domains noted above, including the removal of workforce barriers that prevent nurses from delegating routine tasks to caregivers, universal caregiver assessments to help with the development of individualized care plans and supports, the expansion of access to health care by advocating for nurse practitioners to provide care at the full extent of their education and training, and the strengthening of FMLA policies and protections for caregivers through flexible time, paid policies, and work locations.

There are some great resources online that walk individuals through strategies for advocacy, including the [Family Caregiver Alliance](#) who also provide an e-newsletter, briefings on key legislation, innovative programs, and information related to family caregiving and long-term care policy. 

REFERENCES

AARP Public Policy Institute, N. A. F. C. (2015). Caregiving in the U.S. Retrieved from: <https://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf>

AARP Foundation. (2020). Long-Term Services and Supports

State Scorecard, 2020 Edition. Retrieved from: <http://www.longtermscorecard.org/-/media/Microsite/Files/2020/LTSS%202020%20Reference%20Edition%20PDF%20923.pdf>

Bremault-Phillips, S., Parmar, J., Johnson, M., Huhn, A., Mann, A., Tian,

continued on page 6

- V., Sacrey, L. A. (2016). The voices of family caregivers of seniors with chronic conditions: A window into their experience using a qualitative design. *SpringerPlus*, 5, Article 620. doi: [10.1186/s40064-016-2244-z](https://doi.org/10.1186/s40064-016-2244-z)
- Chari, A. V., Engberg, J., Ray, K. N., Mehrotra, A. (2015). The opportunity costs of informal elder-care in the United States: New estimates from the American Time Use Survey. *Health Services Research*, 50, 871-882. doi: [10.1111/1475-6773.12238](https://doi.org/10.1111/1475-6773.12238)
- Family Caregiver Alliance. (2021). Advocacy Tips for Family Caregivers. Retrieved from: <https://www.caregiver.org/resource/advocacy-tips-family-caregivers/>
- Flynn, M. (2021). 48 States Saw Nursing Home Occupancy of 80% or Worse as 2021 Dawned — With Census as Low as 56%. *Skilled Nursing News*. Retrieved from: <https://skillednursingnews.com/2021/01/48-states-saw-nursing-home-occupancy-of-80-or-worse-as-2021-dawned-with-census-as-low-as-56/>
- James, E., Hughes, M., Rocco, P. (2016). Addressing the needs of caregivers at risk: A new policy strategy. Retrieved from: http://www.healthpolicyinstitute.pitt.edu/sites/default/files/CaregiverRiskPolicyStrategy_April2016_0.pdf
- The National Academies of Sciences, Engineering, and Medicine. (2016). Families caring for an aging America. Retrieved from: <http://nationalacademies.org/hmd/reports/2016/families-caring-for-an-aging-america.aspx>
- Teshale, S., Fox-Grage, W., and Purington, K. (2021). Paying Family Caregivers through Medicaid Consumer-Directed Programs: State Opportunities and Innovations. Retrieved from: <https://www.nashp.org/paying-family-caregivers-through-medicaid-consumer-directed-programs-state-opportunities-and-innovations/#toggle-id-1>
- Redfoot, D., Feinberg, L. F., Houser, A. (2013). The aging of the baby boom and the growing care gap: A look at future declines in the availability of family caregivers. Retrieved from: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf
- Reinhard, S. C., Feinberg, L. F., Choula, R., Houser, A. (2015). Valuing the invaluable: 2015 update. Retrieved from: <https://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf>
- Reinhard, Susan C. Lynn Friss Feinberg, Ari Houser, Rita Choula, and Molly Evans. (2019). Valuing the Invaluable: 2019 Update – Charting a Path Forward. Washington, DC: AARP Public Policy Institute. Retrieved from: <https://doi.org/10.26419/ppi.00082.001>
- Tell, E., Nadash, P., and Cohen, M. (2021). What Family Caregivers Need: Findings from Listening Sessions. Retrieved from: <https://www.nashp.org/what-family-caregivers-need-findings-from-listening-sessions/>
- Wolff, J. L., Feder, J., Schulz, R. (2016). Supporting family caregivers of older Americans. *The New England Journal of Medicine*, 375, 2513-2515. doi: [10.1056/NEJMp1612351](https://doi.org/10.1056/NEJMp1612351)



2021 Virtual Annual Meeting

REGISTER TODAY

Friday and Saturday, October 29 – 30, 2021 | Pre-conference sessions October 28

HOME-BASED MEDICAL CARE: LEADERSHIP ACROSS THE LANDSCAPE



Moral Inclusion of Older Adults in Healthcare

KATHY LAWSON, OTR, PH.D., LMSSW, OTA PROGRAM FACULTY, PIMA MEDICAL INSTITUTE

Gerontologist Robert Butler was one of the first to define ageism as “a process of systematic stereotyping or discrimination against people because they are old, just as racism and sexism accomplish with skin color and gender.”¹ Some common stereotypes related to aging include:

- All older adults have dementia
- Older adults can't work
- Older adults are in poor health

Let's address these stereotypes here and start a conversation about how to combat them as advocates for older adults.

MYTH: All older adults have dementia

Although older adults may experience changes in their brain, research shows that Alzheimer's Disease and other dementias are not correlated to aging.² That research further reported that routine memory, skills, and knowledge are stable and may even improve with age. Although normal brain aging may mean slower processing speeds and more trouble multitasking, these changes do not progress to dementia. They further added that up to 40% of dementia cases can be prevented or delayed.

MYTH: Older adults can't work

Regarding older adults' capacity to work, many can and do work for a variety of reasons, including a sense of purpose. With unemployment low at the time of this publication, a number of large companies are even reaching out to recent retirees to work on a limited basis.³

According to data from the U.S. Securities Exchange Commission (SEC), a growing number of older Americans find it necessary to work because they lack adequate resources to support retirement.⁴ Additionally, one-third of working adults aged 55 and older had no retirement savings or pension, with that proportion expected to grow. During 2018, more than one in six Medicare beneficiaries, or 10.1 million people, were employed, a steady increase from 7.5 million in 2012.³ In 2019, 20% of Americans over the age of 65 (a total of 10.6 million people) were either working or looking for work, representing a 57-year high.⁵ However, these numbers took a dramatic drop in 2020 as a result of the COVID-19 pandemic.^{6,7} Even though 13% of people age 65 and older (about 1.1 million people) lost their jobs during the pandemic,⁸ many older adults did not seek replacement outside work due to the pandemic.⁹



Routine memory, skills, and knowledge are stable and may even improve with age.

The need to work is also prompted by the need to pay for healthcare services. By age 65, U.S. citizens are eligible to receive Medicare benefits regardless of their income status or employment status. However, Medicare does not cover everything. Traditional Medicare coverage has the following limitations:

- no coverage for dental, vision, and hearing care.
- no coverage for long-term services and supports (LTSS).
- significant cost-sharing for hospital stays.
- substantial premiums and copayments for physician and other professional services and for prescription drugs.
- no limit on out-of-pocket spending for beneficiaries (unlike all other insurance since the enactment of the Affordable Care Act).

According to Schoen et al., although some Medicare beneficiaries have supplemental private coverage to cover Medicare cost-sharing, the policies may cause older adults to incur significant out-of-pocket costs.¹⁰ In 2016, between Medicare premiums, cost-sharing requirements, and out-of-pocket payments for services not covered by Medicare, older adults paid more than 20% of their income for medical services.¹⁰ This could cause older adults to do without preventative care or to forego needed medications due to financial hardships.

MYTH: All older adults are in poor health

Although the cost of healthcare can be the source of significant hardship, not all older adults are in poor health. In an online survey conducted by WebMD and Capital Caring Health (CCH) among older adults in Virginia, most U.S. adults (77%) age 50 and older in the United States rated their overall health as good, very good, or excellent.¹¹ However, it should be noted that the

continued on page 8

self-reported ratings differed by race, employment status, and income: 43% of Whites reported excellent to very good health, vs. 25% of Blacks and 38% of Hispanics. “Good health” was reported by 34% Whites, 46% Blacks and 45% Hispanics. Fair to Poor health was reported by 23% Whites, 29% Blacks and 17% Hispanics. (Interestingly, the survey also took the pulse of older adults’ feelings toward aging in place — 85% of respondents 50 and older already living at home expressed a desire to remain there for the duration of their lives.)

Although the common stereotypes associated with ageism can be dispelled with statistics, the numbers do not change the impact of attitudes on the lives of the elderly population. The coming of age of baby boomers magnifies the need for the

community in general and healthcare providers specifically to learn the facts about aging to ensure that we promote every citizen’s right to respect and their right to participate in valued occupations in the environment of their choice. //

“If you are a man and you are prejudiced against women, you will never know how a woman feels. If you are white and you are prejudiced against blacks, you will never know how a black person feels. But, if you are young and you are prejudiced against the old, you are indeed prejudiced against yourself, because you too, will have the honor of being old someday” — Lewis C. *How the myths of aging impact rehabilitative care for the older person*; 1989.

REFERENCES

- 1 Butler, R.N. (1975) *Why Survive? Being Old in America*. Harper and Row.
- 2 Livingston, G., Huntley, J., Sommerlad, A., et al. (2020) Dementia prevention, intervention, and care: 2020 report of the Lancet Commissions. *Lancet*. 220;396(10248):413-446. doi:10.1016/S0140-6736(20)30367-6.
- 3 Terrell, K. (2018, August 13) *Why Working After Retirement Works*. AARP. Retrieved from <https://www.aarp.org/work/working-at-50-plus/info-2018/why-work-after-retirement.html>
- 4 *Perspectives on Retirement Readiness in the United States: A White Paper*. (2016, November 28) U.S. Securities and Exchange Commission, Office of the Investor Advocate. Retrieved from <https://www.sec.gov/files/retirement-readiness-white-paper.pdf>
- 5 *Labor Force Statistics from the Current Population Survey: 18b Employed Persons by Detailed Industry and Age*. (2020, January 22) U.S. Bureau of Labor Statistics. Retrieved from <https://www.bls.gov/cps/cpsaat18b.htm>
- 6 *Labor Force Statistics from the Current Population Survey: E-16 Unemployment Rates by Age, Sex, Race, and Hispanic or Latino Ethnicity*. (2020, July) U.S. Bureau of Labor Statistics. Retrieved from https://www.bls.gov/web/empstat/cpsee_e16.htm
- 7 *Economic News Release: Table A-14. Unemployed Persons by Industry and Class of Worker, Not Seasonally Adjusted*. (2020, July 2) U.S. Bureau of Labor Statistics. Retrieved from <https://www.bls.gov/news.release/empstat14.htm>
- 8 Li, Y., Jan E. Mutchler, J.E. (2020) Older Adults and the Economic Impact of the COVID-19 Pandemic. *Journal of Aging & Social Policy* 32, no. 4–5 (July–Oct. 2020): 477–87. Retrieved from <https://www.tandfonline.com/doi/full/10.1080/08959420.2020.1773191>
- 9 Jacobson, G., Feder, J., Radley, D.C. (2020, October). COVID-19’s Impact on Older Workers: Employment, Income, and Medicare Spending. *The Commonwealth Fund*. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/covid-19-impact-older-workers-employment-income-medicare>
- 10 Schoen, C. et al. (2017, May 12) Medicare Beneficiaries’ High Out-of-Pocket Costs: Cost Burdens by Income and Health Status. *The Commonwealth Fund*. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2017/may/medicare-beneficiaries-high-out-pocket-costs-cost-burdens-income>
- 11 Frellick, M. (2021, July 9) Most U.S. Adults 50 and Older Report Good Health: Survey. *Web MD*. Retrieved from <https://www.webmd.com/healthy-aging/news/20210709/us-adults-50-older-good-health-survey>

Medical Foster Care, An Alternative to Institutional Care

BY JUNE LELAND, MD, MBA, MEDICAL DIRECTOR, HOME BASED PRIMARY CARE, JAMES A. HALEY VA, ASSOCIATE PROFESSOR, MORSANI COLLEGE OF MEDICINE AT THE UNIVERSITY OF SOUTH FLORIDA COLLEGE OF MEDICINE

The term “foster care” may refer to placement settings such as group homes, adult family care homes, residential care facilities, emergency shelters, and supervised independent living for adults. For the purposes of this discussion, the term “foster home” refers to a home providing room, board, and personal services in a home-like setting where the foster caregiver lives in the home. Medical foster care refers to foster care that includes medical care according to the needs of the resident.



Foster home refers to a home providing room, board, and personal services in a home-like setting where the foster caregiver lives in the home

FOR CHILDREN

Foster care for children, also known as out-of-home care, is intended to be a temporary service provided by the state to children who cannot live with their families. Children in foster care may live with other relatives or with unrelated foster parents. Through the title IV-E Foster Care program, the Children’s Bureau supports states (plus the District of Columbia, Puerto Rico, and the Virgin Islands) by providing board and care payments for eligible children who are under the supervision of the state and placed in foster family homes or childcare institutions that are safe and licensed.¹ Care regulations vary from state to state but have some commonalities for foster caregivers. These include:

- age over 21
- passing a criminal background check
- family stability
- character references
- regular source of income
- home safety evaluation
- and family home evaluations.

A subset of children’s foster homes provide care to medically needy minors. In Florida, for example, the Medical Foster Care Program (MFC) is coordinated between Florida Medicaid within the Agency for Health Care Administration (AHCA), the Department of Health and Child Welfare, and the Community Based Care Program within the Department of Children and Families (DCF). The program provides family-based foster care for medically complex children under the age of 21 who cannot safely receive care in their own homes. They must be identified as requiring medically necessary services to meet their medically complex condition, be in the custody of DCF, and be medically stable for care in the home setting rather than

requiring a higher level of care. The MFC Program establishes and supervises the oversight and training of the foster parents, and care teams also include:

- Nursing and social worker staff that provides 24-hour oversight and case management services to the children and families
- A medical director who reviews each child’s medical needs and provides medical direction to staff and families.
- A primary care physician, and, in most cases, several medical specialists assigned to them.²

Medical foster care has the potential to provide many advantages for these children, but systematic reforms are needed to make this care more efficient, cost-effective, and comprehensive.³ An internet search for pediatric house call services reveals limited entries, with concierge services and hospice services predominating. This suggests opportunities for home care medicine providers. In addition, pediatric hospital at home has multiple benefits and has had success in other countries but has not been developed in the United States.⁴

FOR ADULTS

Depending on the state, foster care programs for adults with disabilities may be regulated by a different agency than that regulating foster care for children, but only typically differ by number and age of residents. Disability is broadly categorized as physical, developmental, behavioral/emotional, or sensory impaired disorders. Much like for children, adult foster care may be distinguished as medical or non-medical. For example, DePaul Community Resources in Virginia distinguishes adult foster care from sponsored residential care, which can provide physical assistance, medication management, healthcare coordination,

continued on page 10

and behavior intervention in a home setting.⁵ Long-term care is provided by a trained and compensated residential sponsor who is not a family member, although this model invites family members to be part of the broader support team.

FOR THE ELDERLY

Foster care for the elderly is of course subject to state and federal regulations as well. For example, in Massachusetts the MassHealth (Medicaid) program under the Massachusetts Executive Office of Health and Human Services pays caregivers in adult foster homes to provide 24-hour personal care, including activities of daily living (ADLs) and instrumental activities of daily living (IADLs).⁶ Room and board for the foster is a personal financial responsibility. In this program, family members can be caregivers, and a nursing-home level of care is not provided. In Oregon, foster care locations are known as adult care homes and the caregiver can't be a direct family member nor house more than five residents. The owner of the home, who may be a different person than the caregiver, may have more than one home and is separately licensed from the

home (which is also licensed). He/she must be available in the event of an emergency. Inspections include:

- a review of all resident records,
- medication administration logs
- physician orders
- written care plans
- change of condition notes
- contracts⁷

A CLOSER LOOK: The VA Medical Foster Care Model

The Veteran's Administration offers another model of foster care. A Medical Foster Home (MFH) can serve as an alternative to a nursing home or assisted living. It may be appropriate for Veterans who require nursing home care but prefer a non-institutional setting with fewer residents.⁸ Medical foster homes are private homes in which a trained caregiver and relief caregivers provide services to no more than three residents, 24/7. The caregiver assists with ADLs and IADLs, but the VA foster care team ensures that the caregiver is also well trained to

continued on page 11

Comprehensive, High-Quality Home Based Health Care Solutions

- Primary Care
- Palliative Care
- Health Risk Assessments
- Diagnostic Services - Lab & Mobile Radiology (standalone service option)
- Skilled Home Health Care
- Hospice Care
- Durable Medical Equipment

Office Locations:

Florida, Illinois, Indiana, Michigan, Missouri, Ohio, Pennsylvania, Texas, Virginia, Washington, Wisconsin

For more information or to learn more about our rewarding career opportunities,

visit: usmmlc.com



provide VA-planned care including medication administration, wound care, transportation to specialty appointments, and other needed services and care coordination. While living in a Medical Foster Home, veterans also receive Home Based Primary Care (HBPC). Initial and ongoing annual training is provided by the MFC Coordinator, the HBPC team, and subject matter experts to the MFH providers. MFH caregivers are not VA employees and, though many have a background in health care, others have gained experience by caring for a family member with complex needs such as ALS, ventilator dependence, or advanced dementia. Some, but not all, residents are veterans, which gives the caregiver the flexibility to care for the veteran and his/her spouse, or to serve a non-veteran in need.

The care level and reimbursement contracts are facilitated between the foster home care provider and the patient or his representative through the MFH Coordinator. The coordinator serves as a liaison between the caregiver, patient and/or the patient's family or legally authorized surrogate, and the HBPC team. The coordinator has expertise in local care options as well as eligibility and costs and considers the home, caregiver, and veteran's needs to ensure a good "fit" between the caregiver, the veteran, and their family. Medical management is provided in the foster care by the HBPC team with core members from medicine, nursing, social work, pharmacy, dietary, rehabilitation specialists, psychology and recreation services. Other services provided as needed include respiratory services, disease management, and telemedicine. Many HBPC teams provide a 24 hour call service maintained by medical staff. Additional services such as skilled home care or hospice can be arranged using VA resources, Medicare/Medicaid, or private insurance, provided that there is no duplication of services by HBPC and the other service providers.

The VA inspects and approves all MFHs and caregivers prior to certifying the home. A caregiver must be able to perform care duties, including the ability to evacuate the residents in the event of an emergency. The building and the caregiver are subject to unannounced inspection which can lead to corrective action if opportunities for improvement are identified. If deficiencies arise, a corrective action plan is instituted. VA MFH programs are under 38 CFR § 17.73.

Requirements for Foster Care as Outlined by North Florida/South Georgia MFH Program⁹

Medical Foster Home Requirements

- Owned or rented by the caregiver (CG) and must be the

CG's actual place of residence

- Located, designed, equipped, and maintained to ensure a home-like setting and to give safe care and supervision for all residents
- Inspected and approved by VA Medical Foster Home Coordinator, Home Based Primary care (HBPC) and by a VA safety specialist
- Meet state and local licensure requirements and rules. This includes construction, fire, maintenance, and sanitation regulations.

Caregiver Requirements

- Complete an application and be interviewed by the MFH Coordinator and other staff as needed.
- Be financially stable.
- Be at least 21 years old.
- Have had experience caring for disabled and/or elderly people.
- Have a designated relief person.
- Be physically able to give the care needed and have a backup plan if they should become injured or ill.
- Be able to communicate with the HBPC team about the Veteran's medical condition and follow the Veteran's treatment plan.
- Ensure a friendly, home-like feeling in the home.
- Have a heart for caregiving, especially for Veterans.
- Complete Criminal History check and State Registry checks.

THE COST OF CARE

Veterans and others served in these programs include the frail elderly, those with mental health or behavioral disorders, spinal cord injury, traumatic brain injuries, and homeless veterans requiring a supervised medical program. VA Medical Foster Care is available in nearly every state, Washington DC, and Puerto Rico.¹⁰ The cost of foster care is usually in the range of \$1500-\$3000 monthly and includes room and board as well as personal care services, ADLs and IADLs, medication management and other medical care, and recreational activities. In contrast, in 2021 nursing home costs for a semi-private room are \$255/day and \$7756/month and vary by location. This cost is projected to rise to over \$10K/month by 2030.¹¹ The cost of assisted living facility (ALF) care varies widely by state, with an average cost in 2020 of \$4300 per month.¹² VA payment for private nursing home care is limited. At this time, the VA does not pay for ALF or Medical Foster Care. Benefits such as Aid and Attendance can offset some of the costs and are best discussed with a VA social worker or benefits counselor. There is currently a bill in congress entitled "Long-Term Care Veterans Choice Act"

continued on page 12

(HR1527) that would allow for such payments. This would save eligible veterans the cost of MFH care while also saving the VA the added cost of covering nursing home care.

Research has shown quality-of-life benefits for both foster home caregivers and the veterans living in their care.¹³ The combination of foster care with medical management in a residential home could serve as a model for other populations that receive care in private homes but have no access to in-home medical care. //

SUCCESS STORIES

[Medical Foster Care](#) (video)

[A Visit to a Medical Foster Home for Veterans](#) (video)

[VA uses foster homes to help veterans in need of care](#) (video)

[VA Medical Foster Home](#) (video)

[Medical Foster Home Program for Veterans](#) (video)

[Foster Families for Veterans Keep America's Heroes in the Homes They Deserve](#) (Southern Living News)

[Indiana Family of Eight Fosters Three Veterans Who Are Disabled: 'We're One Big Family Now'](#) (People Magazine)

REFERENCES

- 1 *Foster Care*. (2021, January 25) U.S. Department of Health & Human Services. Retrieved from <https://www.acf.hhs.gov/cb/focus-areas/foster-care>
- 2 *Medical Foster Care*. (2020, June 15) Children's Medical Services. Retrieved from <http://www.cms-kids.com/providers/fostercare.html>
- 3 Seltzer, R., Henderson, C. & Boss, R. (2016) Medical foster care: what happens when children with medical complexity cannot be cared for by their families?. *Pediatr Res* 79, 191–196. Retrieved from <https://doi.org/10.1038/pr.2015.196>
- 4 Klig, J., Pian, J. (2020, June) Acute Pediatric Home Hospital Care. *Pediatrics*. 145 (6) e20190074. Retrieved from <https://doi.org/10.1542/peds.2019-0074>
- 5 *Sponsored Residential Vs. Adult Foster Care*. DePaul Community Resources. Retrieved from <https://www.depaulcr.org/sponsored-residential-vs-adult-foster-care/>
- 6 *Caregiver Homes of Massachusetts: Adult Foster Care from MassHealth*. (2020, September) Paying for Senior Care. Retrieved from <https://www.payingforseniorcare.com/massachusetts/caregiver-homes>
- 7 George, S. *What Is An Adult Care Home? – Part 1* (2017, October 7) Oregon Senior Referral Agency Association. Retrieved from <https://osraa.com/what-is-an-adult-care-home/>
- 8 *Medical Foster Homes*. (2020, February 27) U.S. Department of Veterans Affairs. Retrieved from https://www.va.gov/Geriatics/pages/Medical_Foster_Homes.asp
- 9 *Medical Foster Home*. U.S. Department of Veterans Affairs. Retrieved from https://www.northflorida.va.gov/NORTHFLORIDA/services/medical_Foster_Home.asp
- 10 *Medical Foster Home Locations*. U.S. Department of Veterans Affairs. Retrieved from https://www.va.gov/Geriatics/docs/VA_Medical_Foster_Home_Locations.pdf
- 11 Hoyt, J., Witt, S. *Nursing Home Costs*. (2021, June 22) SeniorLiving.org. Retrieved from <https://www.seniorliving.org/nursing-homes/costs/>
- 11 *What is "Assisted Living" and How Much Should it Cost?* AssistedLiving.org. Retrieved from <https://www.assistedliving.org/cost-of-assisted-living/>
- 13 Gilman, C., Haverhals, L., Levy, C., Manheim, C. *The Veterans Health Administration's Medical Foster Home Program: Where Heroes Meet (Older) Angels*. (2018, September) *Generations* 43(3): 47–50. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6816278/>

Become an Annual Meeting Sponsor

Maximize your visibility and show your commitment to the practice of medicine in the home. Becoming a sponsor will benefit you in so many ways! Email [Stacy Warkentine](mailto:Stacy.Warkentine) for more details.

Meeting Patients Where They are Through House Calls

BY JILL SCHWARTZ-CHEVLIN, MD, FACP, SENIOR MEDICAL OFFICER, LANDMARK HEALTH

House call services are usually thought of as primary care delivered by nurses, advanced practice providers, and physicians. However, throughout the past fifteen years of providing house calls to vulnerable complex medical patients, I have been fortunate to encounter lots of other specialists who make house calls. For example, I was once able to have a patient seen by a neurologist to confirm the diagnosis of ALS. Since that time, many different types of practices have realized the critical need for house calls for this dependent, frail population. What we didn't realize was the impact these patients would have on our lives. In each situation, specialty providers that venture into the home are gifted by relationships with people who still have so much to give. This is the secret treasure of doing house calls.

We will hear from two different providers, an optometrist and a dentist, who have thriving house call practices and have found a way to provide the most patient-centric care in patients' homes.



Interest in primary and specialty home care has exploded due to COVID-19. How might specialty providers adapt their practices to make house calls?

In 2008, I developed a home care business after meeting with primary care physicians and understanding there was a vital need to bring eye care to individuals that are homebound. Originally, I serviced the Philadelphia area. However, the need for eye care quickly

expanded to include all Southeastern Pennsylvania and New Jersey. What started as just me performing 10 patient visits per month has exploded in just a few years to three optometrists and over 450 patient encounters per month.

Providing eye care to home bound patients is the most physically and mentally demanding care I provide, but at the same time has been the most professionally rewarding experience. Every visit is more than just making sure the patient can see their TV or pictures of their grandkids. It's making sure their glaucoma is controlled, their diabetes is not affecting their vision, or helping them with dry eyes. I also quickly realized that every patient has a story to tell and being in their home setting creates a personal connection.

While providing house calls during the pandemic, it has become more evident that the demand and necessity for all providers is greater than ever. Patients need that interaction with their family and providers. The simple touch, casual conversation, or simple deed to help the patient has such a positive impact on them. Whether it is bringing up the garbage can, getting them a drink, or simply just listening, it all matters.

Most recently, I began consulting with other optometrists in the country to help them develop the same model in other areas. This will allow for more patients to benefit from at-home eye care.

Stephen Hess, OD
DaVinci Eye Care, LLC

continued on page 14

Dental Home Services was founded by Dr. Stu Rubin after his father-in-law suffered a debilitating stroke that left him homebound, inspiring Dr. Rubin to help homebound seniors and the disabled with their dental problems. The practice has grown to a team of six dentists, including his daughter, Dr. Lindsay Rubin, that sees patients in private homes as well as over 230 assisted living facilities (ALFs) throughout New Jersey. They have put together high-tech equipment that allows them to do any procedure in a person's home that can be done in a traditional dental office. They are proficient in dealing with Alzheimer's and Dementia patients, and this has led to Stu being named to the Board of Directors of Alzheimer's New Jersey.

During the COVID-19 pandemic, Dental Home Services overcame some unique challenges to continue performing house calls. Their volume of patients grew as people could not leave their homes or ALFs to see a traditional dentist for their dental emergencies. Each ALF would test the dentists before entry and wouldn't accept the tests from other ALFs. This became a significant challenge as the dentists were being tested four to five times a day, reducing the time they had to see all of their patients. Another challenge was procuring PPE. They were steadfast in using one disposable gown per patient. In desperation, rain ponchos were used and disposed after each patient. The providers of Dental Home Services were extremely fortunate to be able to partner with other capable and caring providers during the crisis.

Stu Rubin, DMD

Executive Director of Dental Home Services, LLC,
Certified Dementia Practitioner

Interest in primary and specialty home care has exploded due to COVID-19, and so many health care companies are now delving into this space. There is opportunity to improve the care of these patients and families so that they do not feel marginalized in our health care system but instead feel embraced. [Accolade Health](#) as well as [Landmark Health](#) and many others have found ways to innovate in this space by providing telehealth services and other novel innovations to help address access and impact. We hope we have provided some insight into how house calls can be modified to your unique practice and how innovation and creativity can take care to the next level for our vulnerable patients. //

ACADEMY NEWS

Welcome, New Members

The Academy welcomes the following new members who joined AAHCM between May 12, 2021 and August 20, 2021:

Arizona

Erin Collins
Kim Herman
Rachel Langland
Cristine Oropez
Zuleikha Vellani

California

Manish Saha
Nicole Schwartz
Vanessa Vinn

Colorado

Christine Lum Lung

Connecticut

Holly Penkacik

Florida

Anabel Cento
Darlene Davis
Tamara Dukes
Vanessa Lewis
Aliex Perez-Perdigon
Alexandra Ristow

Georgia

Kristal Brooks
Michael Gonzalez
Robert Killough
Exie Lamar

Illinois

Sylvia Coleman
Elizabeth Davis
Cory Dehnee
Linda Kunicki
Alexander Sasha
Rackman

Indiana

Sheilah Adams
Sandra Nixon

Kentucky

Sabrina Dycus

Massachusetts

Julia Carson

Maryland

Jessica Colburn
Matt Lambert
Kristen Seabrease

Michigan

Susan Brewer
Catherine Burton
Madeline Del Valle
Vanessa Delgado-
Ramirez
Patrice Griffin
Grace Jenq
Kim Mitchell
Jennifer Powell
Laurene Sanders

Minnesota

Candice Levy

Missouri

Natasha Shelton

New York

Andrew Dunn
Kerriane Page
Manuel Vazquez
Tao Xu

Ohio

Michael Adams
Deidre Arch
Matthew John
Baessler
Michael Bennett
Elizabeth Bigrigg
Jamie Bole
Hailey Brogan
Elizabeth Burchfield
Daniel Fial
Jessica Gorski
Nathan Hart
Krista Hodges
Gwynne Ingram
Ashley Kerney
Kristine Kocin
Marianna Lanigan
Sarah Mcculloch
Howe
Jenna Molnar
Lisa Robinette
Wanda Simmons
Nicole Spellacy
Mary Steiber
Danielle Stewart

Brittanie Svoboda
Natalie Sykuta
Stephanie West
Christine Wichert
Andrew Wrobel

Pennsylvania

Ryan DeLong
Keith Lagnese
Eliza Thornton
Timothy Trotter

Rhode Island

Anna-Rae Montano
Michael Ross

Texas

Nelson Achu
Luz Amar Verma
Paul Bourland
Casey Divin
Jennifer Gonzales
William McKinney
Diane Perritano
Breion Scott
Karen Wallen
Dottie West

Virginia

Dawn Alexander
Dana Colvin
Autum Simmons

Washington

Maria Luisa Jabido

West Virginia

Tanya Call

International

Carmen Izquierdo
Henn
Taehoon Lee

**Become a
member today!**

Introducing the National Home Care Medicine Practice Directory

We are thrilled to announce that thanks to funding from The John A. Hartford Foundation, we went live with the searchable National Home Care Medicine Practice Directory earlier in August.

The online Directory helps patients and their families connect to trusted, local home-medicine providers. Healthcare organizations and payers can also use the Directory as a resource for referrals and new care-team relationships.

Throughout this month, we have conducted a broad outreach to other home care-focused associations, payers, hospitals, and health systems. Most importantly, we reached out to consumers via Facebook to let them know this critical resource is available.

Please take a moment to review your information in the Directory to ensure its accuracy. Most importantly, please make sure that your NPI number is up to date in your AAHCM member profile. Criteria for inclusion in the Directory is 100 home/domiciliary visits per practice in 2018 and is based on 2018 Medicare claims data identifying appropriate E/M codes.

Please reach out to [Stacy Warkentine](#) if your practice is not in the Directory and you believe it should be included.

[BROWSE THE DIRECTORY »](#)

Applications Close September 10 for Robert M. Kaiser Scholarship

The scholarship covers the cost to attend the Virtual Annual Meeting October 29 – 30, 2021.

Eight scholarships will be awarded this year to students, residents, and fellows in good standing enrolled in school or completing training.

[APPLY TODAY »](#)

Board of Directors Voting Open Through September 17

Take a few minutes to help shape the future of AAHCM and vote for your 2021–2022 Board of Directors, open now through **Friday, Sept. 17, 2020**.

Use the button below to access the voting site. Your username is your AAHCM member ID (1, 2, or 3 numbers) preceded by 1 + 0s to make a total of 8 digits. For example,

1 + 0000 + 123 Member number

Your password is your last name.

username: 10000123 **password:** Smith

AAHCM bylaws require a quorum of voting members—your vote is critical for a successful election!

[VOTE NOW »](#)

Join AAHCM and make home-based primary care a reality for all in need.

Since 1987, AAHCM has been the premier association for healthcare professionals who deliver or manage comprehensive primary care services to patients in the home by removing barriers, setting standards, providing education, facilitating networking opportunities, and fostering the development of legislation to facilitate growth.

[MEMBER BENEFITS »](#)

[JOIN NOW »](#)



AAHCM 2021 Virtual Annual Meeting

HOME-BASED MEDICAL CARE: LEADERSHIP ACROSS THE LANDSCAPE

Friday and Saturday, October 29 – 30, 2021 Pre-conference sessions October 28

REGISTER NOW »

2021 VIRTUAL ANNUAL MEETING

Thank you to our premier sponsors!

For a full list of sponsors and exhibitors, [visit the Annual Meeting site](#).

Platinum Sponsor

U.S. Medical Management



Silver Sponsors

Home Centered Care Institute

Smith + Nephew



Smith+Nephew

Bronze Sponsors

Dispatch Health

Healthspieren

Iris Healthcare



Become an Annual Meeting sponsor: email [Stacy Warkentine](#) for more details.