Published in final edited form as:

Arch Intern Med. 2011 February 28; 171(4): 359–360. doi:10.1001/archinternmed.2011.17.

Fulfilling Our Obligation to the Caregiver: It's Time for Action

Eric Widera, MD^{1,2} and Kenneth E. Covinsky, MD, MPH^{1,2}

¹Geriatrics and Extended Care, Department of Veterans Affairs Medical Center, San Francisco, CA

²Division of Geriatrics, University of California at San Francisco, San Francisco, California

Family caregivers are relied upon by health care systems, yet, at the same time, neglected. They provide the bulk of care given to the more than 5 million persons diagnosed with Alzheimer's disease in the United States. They are expected to take on increasing amounts of complex care in the home, a task that requires entire health care teams in institutional settings. Their work keeps people out of nursing homes while providing high quality care at minimal cost to public and private health care systems. In return, their efforts and their wellbeing too often go ignored.

Family caregivers are often thrust into this position, with no training and little support, resulting in increased prevalence of adverse physical, social, and psychological outcomes. Caregivers are at greater risk for depression and anxiety. They are less likely to engage in preventative health measures, and there is some evidence suggesting increased risk of mortality. Although caring for those with dementia requires significant out-of-pocket costs, many family caregivers stop working in order to care for their loved ones. In real word settings, little has been done to decrease these risks to caregivers.

What can public and private health care systems do to foster healthy caregiving? Providing family caregivers information, skills, and support systems to help care for dementia patients is one way to approach this problem. Several different caregiver interventions have now shown improvements in caregiver wellbeing in randomized control trials. One intervention took the form of a collaborative care approach led by advanced practice nurses who worked with caregivers and were integrated within primary care.¹ Another was REACH II , an individualized multi-component home and telephone based intervention designed to enhance the caregiver's coping skills and management of dementia related behaviors². The REACH II intervention significantly improved caregiver quality of life in terms of burden, depression and emotional well-being, self-care and healthy behaviors, social support, and management of care recipient problem behaviors. It also resulted in an hour less per day that caregivers were required to provide direct care, giving much need respite in their busy day.

Corresponding Author:, Eric Widera, MD, VA Medical Center 181G, 4150 Clement Street, San Francisco, CA 94121, Phone: (415) 221-4810 x4614, Fax: (415) 750-6641, eric.widera@ucsf.edu.

Disclaimer: The opinions expressed are those of the authors and not necessarily those of the funders or the Department of Veterans Affairs.

Financial Disclosures: Dr. Widera and Dr. Covinsky have no conflicts to disclose.

A remaining question is whether these caregiver interventions can be implemented in real world health care settings outside the randomized controlled trial environment. In this issue of the Archives, Nichols and colleagues show with the REACH VA study that the answer is a resounding yes. Twenty-four Home Based Primary Care programs within the Veterans Health Administration (VHA) were able to put into practice a modified REACH II intervention. As in REACH II, the results improved caregiver outcomes including reductions in caregiver frustration, burden and depression.

Some may argue that health care systems do not have a duty to provide caregiver support as their contractual obligation is with the patient and not the caregiver. However, if health systems are going to increasingly rely on family caregivers to deliver complex care, then they have the obligations to aid caregivers in this task and reduce the personal costs associated with it³. We now have compelling evidence that interventions focused on the caregivers are beneficial and can be practically implemented in existing health systems like the VHA. It is time that we fulfill our obligations to caregivers.

The REACH II model should not suffer the same fate as many other proven geriatric models that were not disseminated widely, and there are hopeful indications that it may not. Congress has already passed a law providing supportive services such as training, education, and counseling assistance for caregivers of veterans (Public Law 111-163). The VHA should now take the next step by ensuring these services are universally available and based on proven multi-component caregiver interventions like REACH VA. Other health care systems should follow in its lead.

Acknowledgments

Funding/Support: Dr Widera is supported by a Geriatrics Academic Career Award from the Health Resources and Services Administration, and by the Hartford Foundation as a Center of Excellence Faculty Scholar.

References

1. Callahan CM, Boustani MA, Unverzagt FW, et al. Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: a randomized controlled trial. *JAMA*. May 10; 2006 295(18):2148–2157. [PubMed: 16684985]
2. Belle SH, Burgio L, Burns R, et al. Enhancing the quality of life of dementia caregivers from different ethnic or racial groups: a randomized, controlled trial. *Ann Intern Med*. Nov 21; 2006 145(10):727–738. [PubMed: 17116917]
3. Levine C. The loneliness of the long-term care giver. *N Engl J Med*. May 20; 1999 340(20):1587–1590. [PubMed: 10332025]