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Editorial

A Caregiver Must Be Healthy to Be Able to Care

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The impact of Alzheimer's Diseases and Related Dementias (ADRD) among older adults and their families has been well documented.[1,2] Perhaps the group that is most affected are the spouses of older adults with ADRD, who often act as primary caregivers, living in chronic stress that can lead to a higher risk for adverse physical and mental health outcomes.[1] One relevant issue of concern among spouses of older adults with ADRD is self-care—the activities and strategies used to cope with the stresses of caregiving and maintain their health in order to continue performing their role as caregivers. There are several points to considerer when we discuss the concrete actions that contribute to the health of spouses of ADRD patients (e.g., access to care, use of health services, related expenditures, etc.). Among racial/ethnic minority groups, this could be particularly relevant due to health disparities.

In a recent publication, Chu et al.[3] provided an initial step regarding how specific demographics such as race/ethnicity and coverage mediates the effect between expenditures associated with healthcare services use and having spouses with ADRD. This study determined the adjusted incremental healthcare expenditures of having a spouse with ADRD after controlling for a comprehensive list of demographics, socioeconomic status, and medical conditions. Understanding the factors that lead to excess expenditures associated with healthcare use is relevant to improving the design of the delivery model to reduce costs and increase care efficiency in this population.[2]

This study's main results showed that spouses of older adults with ADRD had significantly higher home healthcare expenditures but significantly lower outpatient expenditures compared to spouses of older adults without ADRD.[3] Differences in in-home healthcare expenditures were attributed to a higher rate of morbidities, functional limitations, and older age. Likewise, racial and ethnic characteristics also played a relevant role. For example, to belong to a racial/ethnic minority group and lack private insurance coverage and Medicare were negatively

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associated with total medical expenditures.[3] Latino and African American spouses had lower total healthcare expenditures than their white counterparts, with lower prescription drug cost and out-of-pocket expenditures.[2] These results suggested the relevant role of race/ethnicity as a contributor to access and expenditures associated with healthcare services among racial/ethnic minority groups.

We have shown that older racial/ethnic minority adults are also less likely to use healthcare services, including mental health services,[4] among those without physical or mental conditions.[5,6] This is particularly relevant to spouses of older adults with ADRD because unique aspects of ADRD caregiving are risk factors for the onset of mental, neurodegenerative, and physical disorders.[7] In this sense, the study done by Chu et al. gives some insights regarding the role of in-home interventions to reduce health disparities among minority spouses of older with ADRD.[3] In other words, interventions should be culturally tailored to specific minority groups, but also take advantage of in-home services and make them a tool to increase healthcare use engagement, especially now during the COVID-19 pandemic.

Currently, the COVID-19 pandemic presents new and unique challenges for individuals diagnosed with ADRD and the family/friends providing care for them. Providers and health plans can play a key role in supporting older adults with ADRD and their caregivers. The pandemic has highlighted the need to adapt interventions and be innovative in how to deliver these interventions. Health plans and providers can help to assist caregivers of adults with ADRD in their response to COVID-19 by providing support to ease caregiver burden, supporting unique health needs, and helping to develop daily routines and measures to prevent COVID-19.

Furthermore, Chu's study discusses that spouses of older adults with ADRD can be affected by mental health issues derived from the COVID-19 pandemic, including feelings of loneliness, anxiety, depression, and higher burden caregiver.[3] As mental health can be a sensitive topic, it is relevant to considerer how to deal with it among older racial/ethnic minority adults during the pandemic. The lack of exposure to the healthcare system, and the stigma of mental healthcare, can contribute to a low rate of mental health services among Latinos and African American groups.[4–6,8] In this sense, health promotion interventions—defined as behavioral interventions that use counseling strategies to equip participants with the necessary knowledge and skills to modify and sustain a healthy diet, increased physical activity, and/or healthy weight—could appeal to spouses of older adults with ADRD from racial/ethnic minority groups as nonstigmatizing and culturally acceptable alternatives to traditional mental health services. In addition, health promotion interventions can be delivered in home by home health aides, thereby increasing the scalability and sustainability. Lastly, expanding mental health services to home may facilitate informal emotional support provided by other family members.

One of the strengths of Chu et al.'s study[3] is the data set used. The Medical Expenditure Panel Survey (MEPS) is a set of large-scale surveys of individuals and healthcare providers across the United States. It represents a national sample of noninstitutionalized civilian population regarding several health variables. The data used were from 2003 to 2017, including a sample of 28,356 community-dwelling and married older adults. MEPS is the most complete data source regarding the cost and use of physical and mental healthcare and insurance coverage. Furthermore, sources like the MEPS allow researchers to provide policymakers insights to improve physical and mental health services and minimize gaps in these areas.

DISCLOSURE

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