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1We appreciate the wide-ranging comments regarding the importance of
2caregiver assessment in home-based medical care (HBMC) and the writer's
3appreciation of our initial steps to develop a quality of care framework¹ ,
4quality indicators², and a culture of quality improvement to the field of
5HBMC.³

6

7We completely agree that the role of caregivers for persons receiving HBMC
8is of critical importance and that the Veterans Affairs home-based primary
9care (HBPC) program's robust interdisciplinary care team and associated
10programs are currently better suited to address the needs of caregivers than
11many or most non-VA HBMC practices. In fact, the VA's approach to home-
12based interdisciplinary care is the current gold standard.

13

14While the VA model is one to which all HBMC practices should aspire, for
15many the model is not feasible. The underlying economics of the model
16allows the VA HBPC to provide primary care as part of what is essentially a
17community-based long-term care model; provision of robust interdisciplinary
18care and social support for caregivers are therefore supported for this
19purpose.

20

21By comparison, non-VA HBMC practices do not live squarely as community-
22based long-term care and have not routinely been a part of an integrated
23care delivery system. Home-based primary care and palliative care practices
24have historically relied on the mostly fee-for-service reimbursement
25environment of non-VA HBMC. In this non-VA setting (with overlapping but
26not identical target populations) there have been far fewer available
27resources to underwrite interdisciplinary care, attend to caregiver
28assessment, and offer the array of social support mechanisms that are
29available in the publicly-funded VA system. There is significant heterogeneity
30among HBMC practices in the US. In national survey data, we found that
31most HBMC practices are small and are predominantly comprised of billing
32providers without an interprofessional team.⁴

33

34That said, non-VA HBMC practices commonly focus on both the medical and
35social needs of their patients. We believe integration of social and medical
36care will improve and become the norm for all HBMC practices given an
37increasing emphasis on social determinants of health and the evolution of
38appropriate payment models, such as Independence at Home and
39Comprehensive Primary Care Plus. As that evolution occurs, we expect and
40hope that caregiver assessment and support, and use of robust
41interdisciplinary care teams will become the standard for non-VA HBMC as
42well as VA HBPC, rather than a feature of exemplar practices.

43

44We are currently engaged in a PCORI-funded project to develop approaches
45to engage caregivers and homebound older adults receiving HBMC to
46provide advice to researchers on a patient and caregiver-centered HBMC

47research agenda.⁵ We will be curious to see if caregiver assessment and
48support emerges as an item on that research agenda. Our hope is to use
49this project as a foundation to develop a national network of caregiver and
50patient stakeholder groups to provide advice on research, appropriate
51quality indicators for HBMC, and HBMC model development to best meet the
52needs of patients and caregivers.

53

54Christine Ritchie, Bruce Leff & Krista Harrison

- 1¹ Ritchie CS, Leff B, Garrigues SK, Perissinotto C, Sheehan OC, Harrison KL. A Quality of Care
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- 7³ [https://www.commonwealthfund.org/blog/2017/opportunities-and-threats-home-based-medical-](https://www.commonwealthfund.org/blog/2017/opportunities-and-threats-home-based-medical-care-under-macra)
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- 9⁴ Huber K, Patel K, Leff B, Garrigues S, Ritchie C. Interdisciplinary teams and home-based medical
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- 11⁵ [https://www.pcori.org/research-results/2017/engaging-invisible-homebound-and-their-caregivers-](https://www.pcori.org/research-results/2017/engaging-invisible-homebound-and-their-caregivers-development-home-based)
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