VIEWPOINT

Meeting the Care Needs of Older Adults Isolated at Home During the COVID-19 Pandemic

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The dramatic shift toward social distancing measures presents important challenges to the health and well-being of community-dwelling older adults, particularly those who are frail, very old, or have multiple chronic conditions. Such older adults are at high risk of dying from COVID-19.[1] Yet they also have high rates of morbidity and mortality from other acute and chronic conditions—and may adapt poorly to aggressive physical distancing and the changing health system structures that accompany it. In this Viewpoint, we highlight the health challenges for community-dwelling older adults and offer targeted suggestions for actions clinicians can take to mitigate these threats.

Although loneliness and depression may result from or coexist with social isolation, they only represent the tip of the iceberg of potential harm. For many older adults, health is influenced more by their daily lives than by medical interventions. Changes in the types of foods eaten due to changes in food availability during shelter-in-place orders may precipitate the exacerbation of heart failure, for example. Lack of exercise due to isolating at home may lead to deconditioning with subsequent weakness and falls. Reduction in the cognitive stimulation that comes with socializing and engaging with the wider world may worsen cognitive and behavioral symptoms of dementia.[2] Older adults with medical, cognitive, or social frailty have less reserve to compensate when their homeostasis is threatened. When facing the challenges of social isolation, they are particularly vulnerable to rapid declines.

Withdrawal of the formal and informal functional supports on which many vulnerable older adults rely may compound these problems. These supports can make all the difference between staying in their home or ending up in a hospital, residential care, or long-term care facility. Although policies and practices for those who provide professional services for older adults continue to evolve, many have substantially cut back on in-home supportive services, adult day health care, and other programs. Family and friends who have served as caregivers may be afraid or unable to visit. While it has been heartening to see voluntary networks spring up to help older adults buy groceries and the like, other basic needs such as assistance with bathing, basic home cleaning, and dementia supports may be unmet.

Finally, when declines in health occur, fear of going to medical facilities may prevent people from receiving the care they need—a likely contributor to anecdotal reports of marked declines in hospitalization for non-COVID serious illness that have been observed in some hospitals. Moreover, the telephone and video substitutes for in-person evaluation pose special challenges for some older adults. Hearing loss, cognitive impairment, and unfamiliarity with new technology may compromise their ability to effectively use these modalities. These technology platforms have not been rigorously evaluated in older adults and may not be configured for easy use.[3] Yet for many older adults they have become the sole source of connection with the health care system.

All is not doom and gloom, however. Although social and health system realignments in response to COVID-19 are unavoidable, clinicians can help reduce their potentially negative effects on the health of older adults by identifying and addressing the risks and helping patients compensate.

First, telephone or video visits may be improved with simple, common sense interventions. Ensure that vulnerable patients are wearing their hearing aids (or using telephonic adaptive devices, if they have them). Enlist the help of a family member, friend, paid caregiver, or staff member in advance of the visit to familiarize older adults with video-call technology. By practicing ahead of time, the UCSF Care at Home program has rapidly increased utilization of such technologies. It may also be useful to engage caregivers in a visit through a 3-way call, which can be done using apps such as Facetime or Skype, which can be used during the COVID-19 national health emergency as part of the expanded Medicare telemedicine services.[4]

Telemedicine only goes so far, however. There is a risk that reflexive thinking and fear among both clinicians and patients may override clinical common sense about which in-person visits are in fact essential. Clinicians should be mindful of this potential cognitive trap and advise their patients to avoid it as well. When a trip to the clinic or lab may be particularly risky or challenging, creative solutions such as home health nursing evaluation, phlebotomy, or a house call (while maintaining stringent infection control safeguards) should be considered.

Second, when meeting with older patients face-to-face or virtually, clinicians should inquire about unmet social or functional needs. Have informal or formal services and supports been withdrawn, and, if so, how is the person managing? How is the person getting food and staying active? If answers are concerning, additional or novel supports such as home meal delivery or emergency on-call home care services should be considered, with health system social workers and Area Agencies on Aging often having the best knowledge of options.[5] Early identification of these issues may help prevent hospitalizations. Where appropriate, patients should also be encouraged to accept available home care services, which may be essential to preserve their health, but which they may have previously declined because of concerns about exposure to COVID-19. Health sys-

tems and local agencies that assist older adults should coordinate their efforts to identify and proactively reach out to help those at the highest risk of poor health outcomes.

Third, a focus on COVID-19 should not short-circuit diagnostic reasoning. Some people with fever and cough will have bacterial pneumonia. And, although there are concerns about COVID-19–related myocarditis masquerading as non–ST elevation myocardial infarction, many people with troponin elevations and characteristic electrocardiographic findings will have coronary disease. When seeing a patient in whom COVID-19 is being considered, a "COVID time-out" should be taken, to consider alternative diagnoses. Conversely, because older adults can present with atypical symptoms of infection such as delirium and fail to show classic symptoms such as fever, it is important to keep infections, including COVID-19, on the differential diagnosis until a clear cause of symptoms emerges.[6] As the prevalence of COVID-19 increases, some patients may also present with both COVID-19 and another problem, for example heart failure or chronic obstructive pulmonary disease exacerbated by COVID-19 infection.

Fourth, as health systems prioritize the care of patients with COVID-19 by delaying elective procedures, administrators and the leaders of these systems should recognize that a procedure considered elective in a young person may be urgent or an emergency for an older adult. An example is a patient who has dementia and a percutaneous biliary drain and who is waiting for definitive endoscopic treatment for choledocholithiasis. If such a patient were to repeatedly pull on and dislodge the drain, despite the efforts of the family and visiting nurse in the face of physical distancing, definitive treatment with a procedure that in other circumstances is elective would be preferable to multiple visits to the emergency department. Moreover, caregiving and transportation difficulties, complex decision-making about goals of care and the appropriateness of interventions, and related challenges can put older adults at a disadvantage when "getting in line" as capacity for medical procedures becomes available.[7] There are no easy answers, and difficult decisions need to be made about the use of scarce medical resources and the challenges for postprocedural care. Greater attention to issues of aging can be facilitated by including in the decision-making geriatricians and other clinicians who have assumed greater responsibility for the care of older adults. Improved decision-making should reduce the risks of unfairly disadvantaging or misaligning care for older adults.

Although older adults living in the community are highly susceptible to death from COVID-19, their non–COVID-19 care should not be forgotten. Physical distancing and social isolation may take a heavy toll not only on their mental health, but also on their physical health and functioning. In responding to the pandemic, it is essential to be mindful of the challenges that physical distancing is creating for vulnerable older adults and to address these challenges head on.

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