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Editorial Section

COVID-19: Brings Geriatric Emergency Care to the Frontlines

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INTRODUCTION

COVID-19 has changed the trajectory of our daily lives, by both the direct disease effects, and the impacts of mitigation. Although this corona virus does not discriminate by age,¹ the older adults we love are especially vulnerable to COVID-19 disease, and social distancing disproportionately harms older adults. Challenges in older adult COVID-19 care now consumes many aspects of our professional and personal lives.

EMERGENCY DEPARTMENT & HOSPITAL TREATMENT OPTIONS

Treatment options for older adults with suspected or proven COVID-19 include discharge to home with quarantine, or admission to observation, general medicine, or ICU settings. Choosing one may depend on the availability of testing, the patient's current or likely disease trajectory, complications, ventilatory requirements, and the availability of local and regional resources for oxygenation, ventilation, and ICU care.² As the COVID-19 pandemic spreads in the US, discussions between older adults, family members, and primary care physicians, are needed to help direct these emergent decisions.

As of this writing, the median age for COVID-19 ICU care is 60 years old, and of those, 40% have comorbidities.³ In Lombardy, Italy the average ICU stay lasted 15 days.² Progressive multi-organ dysfunction and respiratory failure were the major causes of mortality.³ Patients ≥ 65 years with heart disease and hypertension experienced higher infection rates and more serious disease.⁴ The inflammatory burden of COVID-19 disease can cause vasculitis, myocarditis, and dysrhythmias in the short term, while the longer-term effects in survivors are unknown.⁵

Calculators and guidelines assessing clinical severity, and trending and treatment recommendations are especially important in older adults. The Brescia-COVID Respiratory Severity Score (BCRSS) and a number of other calculators are being developed, although external validation maybe many months

away.⁶ The National Institute for Health and Care Excellence (NICE, www.nice.org.uk) has issued COVID-19 Critical Care Guidelines to help guide admission disposition decisions.⁷ Importantly frailty should take precedence over biologic age in predicting outcomes.⁸ In summary, the guideline states that on admission all patients should be assessed for frailty, and the decision to admit to ICU should take into account the likelihood that the patient will recover to an outcome that is acceptable to them. NICE guidelines also advise specific admission considerations for patients with cancer, and those on dialysis.

One hospital in Spain has developed admissions plans based upon a discussion of patient values and preferences. Further they use biologic, not actual, age as a criterion for treatment. Their guidelines have also provided for the institution of comfort care. (Personal communication, Oscar Miro, MD).

The application of COVID-19 critical care guidelines to the emergency department (ED) setting will direct some critically ill patients away from the ICU and into an ED-based end-of-life pathway. These guidelines differ significantly from prior comfort care protocols in important ways, such as lack of family presence, type of respiratory support, use of personal protective equipment (PPE), safe suctioning, and the safety of ED extubation. The Ottawa "End of Life Care in the ED Related to COVID-19" pathway is a very useful tool for the practicing emergency provider.⁹

ED providers will be discerning goals of care for critically ill older adults, often under time pressure, without family present, and limited or no primary care provider input. ED providers need not assume this task alone. Tertiary care centers are developing emergency telehealth palliative care options.¹⁰ Additionally, nursing home-based clinicians may guide these conversations remotely, as they know their patients and families well, and practice palliative principles on a daily basis. Open access resources for ED clinicians to hone palliative skills and language specific to COVID-19 are available at Vitaltalk.org and CAPC.org.

OLDER ADULTS IN SPECIAL LIVING ARRANGEMENTS

It is difficult to isolate residents in nursing homes, assisted living, and skilled nursing facility settings. The incidence of COVID-19 is therefore skyrocketing in these facilities.¹¹ Care for many of these patients requires very close patient contact. Close physical contact with health care workers and visitors increases the disease transmission. Lack of PPE is particularly critical in these settings, as is lack of staff training in isolation/communicable disease care. Facilities have responded to the crisis by restricting visitors and family, and stoppage of group activities. Some facilities are encouraging family members to take patients home if possible.¹² For most families juggling family and work responsibilities, financial devastation from COVID-19, the need to substitute home health care for facility care,¹³ is not a realistic choice.

Some facilities have encouraged or enabled the use of telecommunication models to maintain essential social communication.¹³ Primary Care Provider case coordination, and direct care delivery are other telecommunication options.¹⁴ Such technological innovations are welcomed but are insufficient to stem the growing burden of COVID-19 in assisted living and nursing facilities. We should be prepared for disaster-like spread of illness in nursing facilities, while rapidly developing innovative solutions to limit this spread within facilities and from these facilities to the hospitals and the community. Assistance for nursing homes is forthcoming in the form of National Guard staffing in some states¹⁵ and waived certification requirements allowing care delivery from not fully Certified Nursing Assistants.¹⁶ Some long-term care facilities are initiating enhanced COVID-19 testing, segregating residents, and changing staffing models.¹⁷ Such efforts are extremely taxing but are worthy of adoption.

Safe disposition of nursing home residents from the ED with confirmed or suspected COVID-19 is a unique challenge. Facilities may refuse to accept return or new admission of these patients, given the internal challenges for PPE, staffing, and isolation rooms. At the same time, EDs and hospitals are hastening discharges to conserve inpatient beds. These differing incentives have created opposing recommendations from state and professional organizations¹⁸ and prompted emotional reactions. For example, one prominent geriatrician described the discharge of a patient with COVID-19 to a skilled nursing facility as “akin to premeditated murder”.¹⁹ Solutions to this complicated issue are necessarily local, informed by disease prevalence and inpatient and outpatient resources, and represent an urgent reason for EDs, hospitals, and referring nursing homes to communicate forming plans for best transfer and patient care options under difficult circumstances while facing seemingly opposing incentives.

OLDER ADULTS LIVING IN HOME PROTECTIVE ISOLATION: THE REALLY FORGOTTEN GROUP

While the world outside is struggling with COVID-19, the older adult at home for quarantine or for protective isolation faces challenges of their own. Home-dwelling older adults may be frail or cognitively impaired. Regular home health care may be a necessity, yet there are reports of home-bound patients refusing entry to home health care workers for fear of COVID-19 infection.²⁰ Older adults and their family members need to learn the home health care company policies on infection prevention, social distancing, and guidelines to prevent cross-contamination from staff making multiple serial home visits. Meals, medication refills, bathing, personal hygiene, anxiety, insomnia, social isolation, loneliness, fall risk—the list of needs for those at home lockdown is long. Community solutions such as Meals on Wheels (www.mealsonwheelsamerica.org) can provide needed nutrition. Pharmacies may prepackage drugs and deliver to the home. Families and caregivers must ensure there are contingency plans for their older neighbors, families, and friends, in case of interruptions of home care or visits. But this is only the tip of the iceberg.

Consider that in contemporary society, isolation and loneliness are themselves epidemic, or perhaps pandemic among older adults. AgeUK estimates that 2 million people in England ≥ 75 years old live alone, and more than a million people typically sustain isolation periods of over a month without speaking to a friend, neighbor or family member.²¹ In the US, about 1 in 4 people now live alone; in urban areas the percentage is thought to be higher. Living alone works well in areas that have strong social supports for older individuals.²¹

THE BIGGER PICTURE

The COVID-19 outbreak is an opportunity for our society to reset its relationship with our older population.²² This is a chance for us to work as a community. Many of us can call and ask if help is needed, pick up groceries and medications for those who are unable. Despite stigma to the contrary, older adults are increasingly familiar with digital media. Data from Office for National Statistics in the UK report that 83% of those aged 65-74 years had used the internet in 2019. This is a chance for us to share the fun of Netflix, FaceTime, and What's App with our older friends, families, and neighbors.²²

CONCLUSION

While hospitals and communities are dealing with logistical problems such as who, where, why, and when to test and treat for COVID-19, let's look at the larger societal problems facing older adults during the pandemic. From testing strategies, to making life decisions in hospital settings, to partnering with older adults in special living or home isolation settings, let's all work together!

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MISSION

Improve emergency health care for older adults by providing open access, peer-reviewed, quality education and dissemination platform giving providers in all disciplines the evidence they need to enhance emergency care of older adults.

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APPENDIX 1- ADDITIONAL RESOURCES

- 1) LeadingAge (non-profit nursing homes, SNFs, assisted living residences, home care, housing):
<https://www.leadingage.org/>
- 2) AHCA (American Health Care Association (non-profit and for-profit nursing homes, SNFs, assisted living residences, home care, senior housing):
https://www.ahcancal.org/facility_operations/disaster_planning/Pages/Coronavirus.aspx
- 3) Provider Magazine Online (provides policy and regulatory updates):
<https://mail.google.com/mail/u/0/#inbox/WhctKJVqrrFlqNwxDTzpwDdjHHqXsJpnscbXWxNwwJszZBBsXbkMnTPRLtdtJpRnflqWNIB>
- 4) Local State Health Departments or HHS Departments/Command Centers by state.

Example from Massachusetts - new Command Center is being led by HHS Secretary Marylou Sudders:
<https://www.mass.gov/resource/information-on-the-outbreak-of-coronavirus-disease-2019-COVID-19>
- 5) CDC:
<https://www.cdc.gov/>
- 6) World Health Organization:
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019>
- 7) American Geriatrics Society:
<https://www.americangeriatrics.org/publications-tools/week-review>
- 8) American Medical Directors Association/Society for Post-Acute and Long-term Care:
<https://paltc.org/COVID-19>
- 9) John A. Hartford Foundation:
<https://www.johnahartford.org/dissemination-center/view/coronavirus-disease-COVID-19-resources-for-older-adults-family-caregivers-and-health-care-providers>
- 10) Emergency Nurses Association
<https://www.ena.org/practice-resources/COVID-19>

APPENDIX 2- DISCLAIMER

The situation with COVID-19 is changing rapidly and many national and state websites are providing daily or more frequent updates. Please check those websites daily for any updated information and check the date that the website was most recently revised.

The content provided above is current as of 4/10/2020.

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