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## Editorial

# Providing Simultaneous COVID-19–sensitive and Dementia–Sensitive Care as We Transition from Crisis Care to Ongoing Care



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As of April 29, 2020, more than 3 million COVID-19 cases and 217,183 associated deaths have been counted worldwide.<sup>1</sup> Entire national populations are still under restrictive measures for social distancing and self-isolation. Encouragingly, recent epidemiological data show that the epidemic curve seems to have entered into a plateauing/descending phase in most of the affected countries. Accordingly, national and local administrators have started reasoning about the post-emergency phase (or the so-called “phase 2”), that is, the set of measures that should allow the country to gradually return to a condition of “normality” after the lockdown is eased.<sup>2</sup> It is, however, very likely that nothing will be as before this experience, and it is expected that the coronavirus crisis will cause major social and economic issues for a long time.

From a public health perspective, one of the main challenges that health care systems will probably face is how to progressively move from a COVID-19–centric organization (built up for combating the emergency) to models of care that reflect the “ordinary” health needs of the population. During these last weeks, many hospital and nursing home units have been converted into COVID-19 units to provide care and support to the huge number of patients infected by the SARS-CoV-2. Traditional clinical units have been transformed to host intensive care beds.<sup>3</sup> Several health care professionals have temporarily been relocated, sometimes outside of their qualifications and specialties, to tackle the contingent needs caused by the epidemic. Elective clinical activities have largely been suspended and/or postponed *sine die*. All these measures, urgently needed during the period, will have to be gradually reconsidered as the emergency comes to an end.

Older, frail people are paying the highest toll in the ongoing pandemic, being at higher risk of more severe infections and mortality. Moreover, due to the COVID-19 outbreak, their complex health needs have somehow been forgotten and relegated to the background, as if they do not exist. However, they are still there and have often been left apart, untreated, and not monitored by the fragmentation of care!

Frail individuals with chronic conditions have been especially recommended to adhere to social distancing and self-isolation because they are at particularly high risk of adverse events in case of infection. The segregation of these persons at home, the difficulties at adequately monitoring their clinical conditions, and the reduction of social support are negatively affecting their precarious health status. For example, many had scheduled appointments to perform routine clinical checkups and diagnostic examinations that have been canceled at the coronavirus outbreak. Even the mere forced sedentaryness and social isolation will probably show their dramatic consequences in these persons when everything will be over.<sup>4</sup>

As we move beyond a singular focus on COVID-19, the management of dementia will probably assume special relevance in light of its high prevalence and specific features. It is likely that, during the COVID-19 outbreak, the clinical conditions of patients with dementia might change. Beyond a possible decline of cognitive and functional capacities, the worsening of preexisting neuropsychiatric symptoms (eg, agitation, aggression, depression, sleep disorders) and/or the onset of new behavioral disruptions may have occurred. These disturbances are highly fluctuating and are strongly influenced by environmental and social determinants. The adopted isolation and social distancing measures might contribute to generate feelings of loneliness and abandonment, potentially triggering behavioral modifications in people with dementia.<sup>5</sup> Moreover, these preventive strategies against the SARS-CoV-2 might have hindered the implementation of those nonpharmacological strategies that are used daily by family members and caregivers to tentatively manage the neuropsychiatric symptoms (eg, distraction, diversification of the living environment, involvement in stimulating activities, going out for a walk).<sup>6</sup> This might result in greater use of psychoactive pharmacological treatments and consequent side effects. The dynamics of the caregiving process have also been changing in these past weeks. Several adult daycare centers are closed to avoid the gathering of people. Patients' care has increasingly been entrusted to family members because many formal caregivers have temporarily left the profession for family reasons and concerns about COVID-19 exposure.

To tackle these challenges, dementia associations are providing tips and resources to improve the management of patients at home and mitigate caregiver burden.<sup>7</sup>

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- Smartphones, tablets, and game consoles can offer a variety of ways to pass the time and keep engaged and stimulated. Moreover, they allow connecting with friends and relatives, thus potentially reducing boredom and the feeling of isolation.
- Activities in and around the home (eg, gardening, cooking, reading, listening to music, physical exercise) may be beneficial for patients by keeping them active and purposeful, according to individual interests and preferences. They also may help the person retain skills and functional independence.
- Developing a daily routine, based on simplified and sequential tasks, can be calming and reassuring for both the person with dementia and those around him or her. In fact, the predictability of a routine can decrease anxiety. The person with dementia may feel more comfortable and confident if knowing what to expect.
- Supermarkets and local grocers are offering special arrangements (eg, priority booking for food delivery) for older people. Similarly, local pharmacists are arranging drug deliveries, also assisted by community volunteers. These services may facilitate the provision of food, medications, and other essentials.

Hopefully, this contingent situation of forced restrictions could offer the opportunity to improve and refine home-based caregiving strategies that could be useful even when we will proceed toward a normalization of the process of care.

All the changes that occurred in the provision of care and support to people with dementia during the COVID-19 outbreak will likely result in a very high number of requests for medical help as soon as the post-emergency phase begins. This implies the serious risk of overloading the dedicated services and reducing the quality of provided care. In this scenario, it appears imperative to develop and implement triage/assignment systems that may allow referrals to be informed more in detail about the “actual” patient’s needs and care priorities. This implies a more correct allocation of resources, serving people based on their health status rather than on pure administrative models (eg, “first come, first served”) recovering missed appointments. These procedures may be implemented via the adoption of brief triage questionnaires focused on the biopsychosocial status of the person with dementia to be administered by phone or the Internet. For instance, the timing of the clinical assessment could be determined by considering some of the following parameters whose impact on the quality of life and clinical trajectories are established:<sup>8</sup>

- onset/worsening of severe neuropsychiatric symptoms
- modifications in the use of psychoactive medications
- modification of the general clinical status requiring the adjustment of existing therapies and/or hospitalization and/or access to emergency departments
- fall events during the past month
- reduction of functional capacity (eg, slower gait speed)
- weight loss
- lack of social support
- burnout of the caregiver

It is not surprising that in the rethinking of health care systems in response to COVID-19, a greater use of telehealth has also been repeatedly advocated.<sup>9</sup> The delivery of remote care could have important advantages for people with dementia and their families.<sup>10</sup> It can avoid outpatient visits in crowded hospitals, reduce the need for long travels, and minimize the risk of serious complications, such as fall events. All these aspects assume special relevance nowadays in light of the still high risk of contagion. Interestingly, data exist showing the noninferiority of clinical evaluations conducted via video conferencing compared with face-to-face assessments in memory clinics.<sup>11</sup> Moreover, telemedicine may support a more ecological assessment of the individual in his or her living environment, thus

reducing the impact of those emotional and contextual factors (eg, stigma, confidentiality, fatigue) that may bias the assessment of cognitive deficits and neuropsychiatric symptoms. Of course, this is not as straightforward and easy as it might seem. It requires that physicians assume a new mindset, become familiar with the new way of working, and prioritize the patient’s interests over the fear of mistakes due to the novel technological approach.<sup>12</sup>

Other forms of remote care for older persons with dementia could be represented by electronic diaries, applications, or other tools that can improve the monitoring of the highly fluctuating manifestations of dementia.<sup>13</sup> The period of necessary reorganization we are going to face in the future should represent an opportunity for implementing (and taking advantage of technologies) all those measures able to facilitate exchanges between caregivers and health care professionals.

In conclusion, it is now time to consider how the reopening of health care services should be arranged after the coronavirus crisis abates. Key considerations include organizing pathways to allocate persons with dementia (and others with frailty) according to their health status, providing enhanced resources to mitigate caregiver burden, triaging patients to identify needs and priorities as services open, and maximizing the electronic and telehealth resources that have developed during the crisis. If this is not done, the risk is that the most vulnerable persons will pay a high price to the coronavirus, even without having been infected by it.

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