

mask on the affected resident. Isolation is likely most important and should be done promptly, as the stakes are high. We know that there are atypical presentations to this infection in older people, and a cough even without fever should raise suspicion.⁸ Every attempt should be made to accommodate these residents in a different area of your facility. If your facility is unable to physically isolate, it may be appropriate, whenever possible, to request that residents and patients wear masks or facial coverings.⁹

If testing is limited, consider coordinating with your laboratory to safely arrange pooling samples by using one assay for multiple people to identify that your facility has COVID-19 circulating.¹⁰ For example, use one assay to test four people. If the test returns negative, you can be reassured. If it returns positive, likely further testing and aggressive isolation would be necessary.

If testing is more readily available than PPE, testing of residents and staff should be done as frequently as possible, ideally every week. If you can establish through testing and isolation a COVID-19 free facility, staff testing may be more important than resident testing. Recommendations for isolating should also include, wherever possible, partnering with neighboring LTCFs to cohort confirmed patients. COVID-19-specific units can be set up, which would minimize rotating staff, reduce training time and allow for limited reuse of face shields, gowns, and other equipment.

In summary, in these fast-changing circumstances, the authors would like to stress that in the absence of treatment, isolation should be the fundamental guiding principal and that whatever tools are available to a LTCF to achieve that may be variable and should be optimized to that end.

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Caregiving at a Physical Distance: Initial Thoughts for COVID-19 and Beyond

To the Editor:

Most older adults with physical or cognitive disabilities require physically close caregiving to perform activities of daily living (ADLs). This presents a unique challenge in this time of physical and social distancing necessitated by the COVID-19 pandemic. Where is the balance between physically close caregiving and physical distancing at home and in care settings? We survey scenarios by setting and provide preliminary thoughts on caregiving at a physical distance, drawing from public health and telehealth.

LIVING AT HOME, PHYSICALLY TOGETHER

Physical distancing must be maintained to minimize unnecessary COVID-19 exposure between caregivers and

disabled individuals living together. Although health agencies recommend reducing exposure through wearing cloth masks outside homes,¹ this policy should be extended to inside homes, so members living with disabled individuals wear personal protective equipment (PPE; ie, gloves/masks) during ADLs.

Importantly, partnership between caregivers and clinicians must be supported as an essential step in developing “dementia-capable healthcare systems.”² Caregiver training and support forums can move to digital videoconferencing platforms. However, demand for limited programs may exceed supply. Additional funding to memory centers might allow training for caregivers to improve quality of life and minimize unnecessary hospital visits. Training might include assessing orientation and redirecting individuals who become delirious. Studies indicate that educating caregivers improves recognition of delirium and reduces incidence.³ These measures will continue to impact individuals and caregivers beyond COVID-19.

LIVING AT HOME, VIRTUALLY TOGETHER

Modifying existing programs and technology can better serve individuals living alone when caregivers cannot visit regularly. During health emergencies, eligibility for meal assistance and support programs should be expanded. To accommodate for limited resources, services can transition from daily to weekly delivery and from warm meals to frozen/nonperishable food preparation. However, programs should continue to abide by nutritional recommendations and train and screen food handlers, enabling stable food sources during crises.

Physical distancing relies on existing technology for communication and access to healthcare. Disabled individuals must have access to broadband and telephone connections. Hundreds of companies have already signed the “Keep Americans Connected Pledge” to provide 2 months of uninterrupted access to individuals and businesses.⁴ However, clear pathways must be established for disabled individuals to request and maintain access beyond COVID-19. Reliable broadband enables individuals and caregivers to set up audio/video communication to promote preparedness and utilize mobile health apps associated with improved outcomes, that is, increased exercise and reduced agitation.⁵

LIVING IN LONG-TERM CARE FACILITIES

Long-term care facility staff may be encouraged to work remotely/reduced hours. Virtual communication is a viable solution for staff, family, caregivers, and residents to check in with disabled individuals. Residents who can communicate might utilize tablets to indicate needs and safety. Although most staff may assist from afar, a subset of staff/caregivers with appropriate PPE should provide direct care for residents, especially those with dementia. Additional resources are already being procured from community collection drives organized by local students.

Disabled residents are at risk for complications during pandemics and may benefit from additional tiers of care. Telehealth is generally gaining financial support, and studies suggest mobile technology is useful for disabled patients.⁵⁻⁷ Telehealth for care facilities could be driven by clinicians

and students, now and beyond. As liaisons, medical students might initiate virtual check-ins, monitor activity on patient portals/records, and flag pertinent information for onsite staff to address. Subsequently, patients requiring hospitalization could be routed to virtual triage centers staffed by clinicians in training and overseen by self-quarantined physicians. These activities match medical education initiatives, empowering students to fulfill clinical course credits/requirements.⁸

STAYING IN HOSPITALS

Hospitalized individuals with disabilities are at risk for delirium, impacting individual and hospital outcomes.⁹ Increasing interactions between patients and caregivers significantly reduces delirium duration and mortality.¹⁰ As hospitals restrict visitation, accommodations must be made to promote the physical/virtual presence of caregivers. For patients susceptible to delirium, caregivers should physically assist or virtually orient patients via audio/video chats. Additionally, temporary housing for essential providers/caregivers could be obtained from dormitories/apartments left vacant because of distancing.

Onsite care needs may be alleviated by redistributing nonphysical tasks via telehealth.⁶ Virtual hospital interventions including chart biopsies, history collection, and rounds can be organized by offsite or distant trainees and supervised by self-quarantined clinicians, older clinicians at risk of complications, or redirected specialty clinicians on a volunteer/need basis.

Overall, caregiving at a distance is challenging. Nevertheless, COVID-19 serves as an impetus for communication and collaboration between government, healthcare, community, and patient/caregiver groups. We hope the seeds of policy and technology are sown now so that when pandemics arise in a physically distant future, caregivers and providers will be better prepared.

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Challenges and Responsibilities in Caring for the Most Vulnerable During the COVID-19 Pandemic

To the Editor:

COVID-19 has upended our lives, our work, and our hospitals. Our colleagues have created intensive care units in post-anesthesia care units, operating rooms, and regular floors; redeployed subspecialty and nonmedical staff must rapidly acquire new skills to care for inpatients; subspecialists have become hospitalists and hospitalists have become intensivists as we have tried desperately to care for so many people whose illness can be rapidly progressive and often fatal. People are alone, deprived of family who could help them heal or be present as they die.

I have just finished my first week attending on a Geri-COVID service in a New York City hospital. Although all of us have geriatric outpatient and/or palliative care responsibilities, currently six from the geriatric/palliative care division are caring for inpatients at our hospital: two on Geri-COVID, two on a hospitalist service, and two in the newly created COVID-19 hospice unit. Our plan is to alternate weeks on service to give ourselves sufficient time to rest (physically and emotionally) and to catch up with other work. Ours is just one contribution to inpatient care; my colleagues in critical care, emergency medicine, nursing, and hospital medicine are my hospital heroes.

To cope with this pandemic, we have had to change the way we practice medicine. On the general medical floors, we decide daily which patients will be seen and by whom, usually only one house officer per patient, and sometimes no attending; exams are cursory, often visual; stethoscopes are rarely useful. We round by numbers, where the most important information about the patient is the amount of supplementary oxygen needed to maintain effective saturation. We have been encouraged to

limit the time we spend with the patient, and when we are there, gowns and goggles and masks and gloves make us look alien and remind us to stay away. And staying away violates everything we have been taught as geriatricians. Once, after I had helped a nurse walk a patient to and from the bathroom, I had to slap away the thought I had spent more time than I should have in the patient's room.

We no longer have an acute care of the elderly unit. Instead, we are the peripatetic Geri-COVID team, and the median age of our patients is in the mid-80s. Those who do not have COVID-19 have also been desperately ill; too sick to be discharged or managed at home, they too have succumbed, alone. We have spoken to families daily and have tried to use tablets so they can see their loved ones, but these are no substitute for their presence.

I suspect that our service has seen so much death not just because our patients are in a high-risk group, but also because families expect and understand the conversations about goals of care. Only a minority (three during the past week on my service) were intubated; many patients are frail and/or cognitively impaired, and most families want their loved ones spared the ventilator. Some recover, to our great joy; most we care for until they die.

I am old enough for a resident to have asked me which was harder, caring for people with acquired immunodeficiency syndrome (AIDS) (when I was a house officer in the 1980s) or people with COVID-19. It was tough question to answer, but I truly believe this is more difficult, with patients dying so quickly and so alone, in a numbing sameness. Like COVID-19, AIDS was frightening, and up to one-third of our patients had it. It was a killer of young people like us, a disease whose etiology was unknown and almost invariably lethal. But its longer time course led us to develop emotional ties to our patients. We savored small therapeutic victories, and we felt we could champion our patients when the rest of the world seemed indifferent. Of course, I will never speak for those with human immunodeficiency virus (HIV) about what they lived through then and are experiencing now; rather, I am also hoping to learn from and find new ways to support long-term survivors of HIV as they cope with a new pandemic. But we are all thinking of those years.

I would like to believe that I have chosen academic geriatrics because I love proselytizing to house staff for what it offers: small victories, intellectual challenges, collaborative care, and meaningful opportunities to help patients *and* their families. We are deprived of all of this in the pandemic. As an educator, I am impressed by the rapidity with which our house officers have embraced caring for so many people with COVID-19; they have understood and welcomed the new responsibilities asked of them. But I am also unnerved by how the practice of medicine has been altered by this disease, and I worry about permanent effects of this pandemic on doctoring in general and geriatrics in particular, both because our bedside care has changed and because we hear public pronouncements denigrating the value of the lives of older adults, asking the country to make the (false) choice between saving older people or the economy.