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BREAKING SOCIAL ISOLATION AMIDST COVID-19: A VIEWPOINT ON IMPROVING ACCESS TO TECHNOLOGY IN LONG-TERM CARE FACILITIES

To the Editor:

In addition to large-scale initiatives that have been implemented to prevent international spread of the coronavirus disease 2019 (COVID-19) pandemic, we should advocate for local action targeted at preventing the deleterious health effects of social isolation as a consequence of contingency measures.¹ As a frontline physician involved in the care of older adults living in long-term care (LTC) facilities, I have witnessed profound isolation in this population; my patients have become prisoners in their one-bedroom homes, isolated from each other and the outside world. This extreme loneliness should raise concern as it is a known risk factor for poor health outcomes, including anxiety, depression, malnourishment, and worsening dementia.^{2,3} One way of palliating social isolation would be to integrate technological advances in the care of populations at risk of being further secluded during health outbreaks.

From the encounters I experienced, many older individuals in LTC facilities lacked access to common devices (eg, a smartphone that would have allowed them to "facetime" with family members). Such network-connected devices would also allow patients to freely access health information in the wake of the pandemic, in addition to giving them the opportunity for telecare. More advanced technology, for instance augmented reality, could as well prove beneficial in this patient population, by reducing the burden of frailty, increasing well-being and social participation, and thus promoting successful aging.^{4,5} From the safety of the patients' own home, a device like a wireless virtual

reality (VR) headset could provide the patient with immersive experiences, ranging from connecting with loved ones in a common simulated space to visiting environments not otherwise accessible (eg, a music concert or a nature expedition that could include interaction with virtual animals). For older patients isolated in LTC facilities, providing them with these technology-dependent amenities and social contacts could potentially decrease their sense of loneliness and increase their self-perceived health, similarly to the benefits seen with physically going outdoors.^{6,7} These VR applications have shown positive impact, even in individuals with physical and cognitive impairment.⁸

Yet, none of these technologies was available in the centers I visited and making them available at present time would be impossible given the risk of disease exposure. I believe there are two reasons we have deprived the older population of technological advances: our inherent bias of assuming the aging population is passive and lacks the ability to learn, combined with the fact that this is a population who does not advocate for itself. However, as healthcare providers who strive to constantly improve the care we offer to our patients, we must update our practice of medicine and integrate assessment of technology use as part of the preventative healthcare we offer to vulnerable populations. We must structure our comprehensive assessment to dedicate time in asking our patients questions about concerns and barriers to accessing technology, while redirecting them to educational community resources when necessary. Whether it be in the context of social isolation to control a local gastroenteritis outbreak to a large-scale pandemic, giving older adults in LTC facilities the opportunity to access technology would enable them to maintain social contact and communication. Furthermore, it would allow physicians to virtually connect with these patients and increase frequency of medical contact. It is our duty as a society not only to address but also to prevent the long-term sequelae of a pandemic contingency planning, especially when health outcome entails experiencing invisible mental health illness.

In regards to policy-making decisions and resource allocation, the success of making technology more accessible to the marginalized older population should not be measured solely on the outcome of avoiding acute care services; its benefits should rather be assessed with functional health as the focus of intervention, including measures of psychophysical well-being and life satisfaction.⁹ Higher-end immersive technologies could be installed as a private expense in a patient's room; they could also be made available in common recreational areas within a leisure and/or fitness room, provided by the LTC facility through support of government subsidies and incentives aimed at promoting health of its aging population. However, more popular interactive devices, such as smartphones and computer tablets, must be made available as an affordable commodity for the means of every patient at risk of social isolation, while providing all the necessary ergonomic adjustments to those with impaired physical and sensory function. Finally, just like the pharmaceutical industries should not be allowed to simply sell to the highest bidder during a pandemic, big tech corporations should be required to collaborate with governmental social initiatives to ensure access to

technology for marginalized populations in times of public health crisis.¹⁰

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WHY AM I, AS A GERIATRIC MEDICINE FELLOW WITH SYMPTOMS, UNABLE TO GET TESTED FOR COVID-19 WHILE POLITICIANS, OIL EXECUTIVES, AND NBA PLAYERS ARE?

To the Editor:

I am an integrated geriatric and palliative medicine fellow physician in the time of COVID-19. As the virus began to tear through my greater community, and as my hospital prepared for an enormous surge of patients, I spent time off work with symptoms that were consistent with a mild case

of COVID-19. After going through the proper channels, I was denied viral testing and had to sit out of clinical duties, unsure whether I had picked up a standard respiratory infection or whether this was mild COVID-19.

Around the country, physicians, nurses, and other critical providers are being denied testing for SARS-CoV-2 while stories abound of political, economic, and social elites getting tested who are equally or less symptomatic.¹⁻³ As providers in the time of COVID-19, if we ignore symptoms of a mild respiratory infection and continue to work (historically considered a point of pride in much of medical culture), we now risk becoming superspreaders of a deadly disease, putting not only our most vulnerable patients but also scores of our colleagues (and all *their* patients) in serious danger. This is particularly the case in geriatrics and palliative care, where our patients carry disproportionately high risk of morbidity and mortality from infection with SARS-CoV-2. If providers go untested, we will undoubtedly worsen this pandemic by unwittingly seeding the same communities that we care for and live in. We do not have the ability to socially distance to the same degree as the rest of society; we still go to work after all. Finally, even after sitting out from work, providers like me who go untested still do not know if we have been infected, and at least until the rollout of an accessible antibody test, we will not know if we have developed immunity. So the next time we develop concerning symptoms, we are out again, even as the healthcare system strains to the breaking point.

Given that I had relatively mild symptoms and there is a critical shortage of COVID-19 testing supplies, I do not feel I should have been tested over sicker and more vulnerable patients, especially those in need of hospitalization. In fact, my organization was following the most recent Centers for Disease Control and Prevention guidance regarding proper use of testing, and I am glad I was not shuttled past those who needed it more. But in comparison with some of those with higher socio-economic/political capital and equal or lesser symptoms who did receive testing, I feel this reflects a deeply troubling and dangerous misallocation of resources, one firmly rooted in the profound inequality that has come to pervade our society.

It is difficult to see much silver lining to this pandemic from our current vantage point, and the totality of the fallout is far from certain. In addition to the known risks to older adults and those with chronic conditions, we are already seeing evidence that people with lower socioeconomic status are disproportionately affected by this virus^{4,5} (higher burden of chronic medical conditions leading to higher risk of morbidity and mortality; less ability overall to socially distance leading to higher risk of infection; less financial cushioning leading to worse financial distress, etc).

One fact that I hope this pandemic makes glaringly clear is that we are all in this together. SARS-CoV-2 anywhere is a threat to human health and prosperity everywhere. I hope that in the wake of this crisis we finally rebuild a fully inclusive and just healthcare system, one that ensures *all* of us, whether rich or poor, young or old, CEO or CNA, is given the right to quality, compassionate, and equitable care. This virus has exposed that we are immensely interdependent, and as the dust settles on this crisis, we will have the opportunity to rebuild our healthcare system to reflect this truth. As we can now see more clearly than ever before, the health of every individual depends collectively on the health of each and every one of us.