

AHA COVID-19 Clinical Guidance Series
Vulnerable Populations

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Speaker 1:

Welcome and thank you for joining us for this podcast brought to you by the American Heart Association. This podcast is part of a series focused on sharing information with healthcare providers who are caring for patients during the COVID-19 pandemic.

Dr. Barbara Lutz:

This is a power byte of what will be learned in this podcast, where we discuss the impact of COVID-19 on the LGBTQ population, patients with HIV and older adults with cardiovascular disease. In the podcast, we address risk factors for these groups, prevention strategies and other special considerations that are important for these populations. So we encourage you to stay tuned and learn more about the needs of these vulnerable groups.

Dr. Barbara Lutz:

Hi, my name is Barbara Lutz, and I would like to welcome you to this podcast on the impact of COVID-19 on vulnerable populations. Today we will be discussing the COVID related issues and concerns for members of the LGBTQ community, patients with HIV, and older adults and their concerns about COVID. And joining me today, we have Dr. Billy Caceres and Dr. Matt Feinstein. Billy is a cardiovascular neuroscientist and assistant professor at the Columbia University School of Nursing. His research focuses on examining the social determinants of cardiovascular health in LGBTQ populations, and he is the writing chair of the American Heart Association's upcoming scientific statement on the cardiovascular health of LGBTQ adults.

Dr. Barbara Lutz:

Matt is a cardiologist and assistant professor at Northwestern University with a joint appointment in the department of medicine, division of cardiology, as well as the department of preventive medicine. He is a clinician and scientist with a focus on the intersection of infection, immunity, and inflammation with cardiovascular disease. And he has a particular focus of expertise in HIV related cardiovascular diseases and served as writing chair of the recent AHA scientific statement on HIV and cardiovascular disease. He is the current vice chair of the American Heart Association Prevention Science Committee.

Dr. Barbara Lutz:

And I'm the McNeil Distinguished Professor at the School of Nursing, the University of North Carolina, Wilmington. I'm a certified rehab nurse and an advanced public health nurse, and I'm the current president of the Association of Rehabilitation Nurses. I also chair the American Heart Association Cardiovascular Disease in Older Population's Committee and an incoming member of the leadership committee of the Council on Cardiovascular and Stroke Nursing. I also serve on an AHA committee to develop quality standards for post-acute stroke care for inpatient and subacute rehabilitation facilities. And my researches focuses on addressing the post discharge needs of stroke patients in their family caregivers.

Dr. Barbara Lutz:

So we thought we would open the podcast talking with Billy, and then we'll follow that by talking with Matt about his population, and then I'll end it from talking about my population. So Billy, we wanted to hear your perspectives on the needs of the LGBTQ population. Thanks for joining us today. And I'll start with a question about why this population might be particularly vulnerable during the COVID-19 pandemic.

Dr. Billy Caceres:

Sure. Thanks Barb. There are several reasons for why LGBTQ people might be at higher risk or particularly vulnerable during this pandemic. And these include LGBTQ people have higher rates of certain risk factors that can complicate the prognosis of COVID-19 such as higher rates of smoking, asthma, diabetes, as well as HIV/AIDS among gay and bisexual men and transgender people. There's also some evidence that LGBTQ people, specifically lesbian and bisexual women, are more likely to have multi-morbidity, which further complicates both treatment and management of COVID.

Dr. Billy Caceres:

Even under normal circumstances, LGBTQ adults are more likely to be uninsured, and they also report delaying their healthcare due to fears related to medical costs and potential discrimination from healthcare providers. So, at a time when family members aren't allowed to visit patients in the hospital, there are also concerns regarding denial of same-sex spousal rights and to access healthcare information, particularly in certain hospitals that might have, it might be have religious affiliation, and combined I think that all of those challenges really present unique challenges for LGBTQ adults.

Dr. Matt Feinstein:

Well, thanks for going through that, Billy, that is quite a set of unfortunately of challenges. What do we know up to this point regarding how COVID has actually affected the LGBTQ community?

Dr. Billy Caceres:

That's a really good question. The LGBTQ community includes many different groups of people that likely have different levels of vulnerability depending on their age, race, ethnicity, socioeconomic status, and even medical history. Although we do not have much data on COVID-19 rates among LGBTQ people, based on what we know about existing health disparities, lower insurance rates and higher poverty in this group, we can assume that they experience many of the same concerns that we see in other marginalized groups. Really one of the main issues in understanding how COVID-19 has impacted the LGBTQ population continues to be the invisibility of LGBTQ people on the data that is collected.

Dr. Billy Caceres:

We right now have a much better understanding of differences in rates of infection based on sex, age, race, and ethnicity, but really few sources of information provide data on sexual orientation and gender identity. Estimates of the impact of COVID-19 across the vulnerable communities we are discussing today is really important to establish policies to reduce the spread of this virus in these groups. Another concern is the high rates of poverty in LGBTQ adults, specifically bisexual and transgender people. LGBTQ people are also more likely to work in industries that are affected by COVID like retail and restaurants. And these groups may be more vulnerable to the economic ramifications of COVID-19, including unemployment and homelessness.

Dr. Barbara Lutz:

So those are a lot of challenges and I think we can see how this might affect them more. Billy, do you have any information about how COVID has affected the LGBTQ population or adults with cardiovascular disease?

Dr. Billy Caceres:

Well, the answer is no, and it's a complicated answer because of the lack of data on that particular group. We currently do not know much about the experiences of LGBTQ adults living with cardiovascular disease. And it is unclear if COVID-19 has affected them differently. But because of some of the reasons we have already discussed, like the higher rates of poverty, worse mental health, they may be particularly vulnerable during this time as they seek and access care for COVID.

Dr. Matt Feinstein:

That makes a lot of sense, Billy. And then my next question really related to that is, we may not have really precise estimates yet of how COVID is affecting the LGBTQ community, but we have an idea of, they are being affected adversely. So then the next question is, what can we do about it and what strategies are there to support the health of these populations right now?

Dr. Billy Caceres:

Well, I think that more than ever LGBTQ people need to know that their healthcare settings are open in supportive spaces where they don't have to fear receiving inferior care because of their sexual orientation or gender identity. We see many discussions in the media about limiting treatments and supplies for certain patients. And this may increase fear among vulnerable groups, not only LGBTQ people but also other populations regarding the type of care that they will receive if they actually do seek care. I think whatever we can do as healthcare providers, even taking small steps to help LGBTQ people know that they will be supported and receive the same quality of care provided to other patients is really important.

Dr. Billy Caceres:

And I think this can be done in a number of different ways, including having intake forms that collect data on sexual orientation and gender identity. Also, particularly for transgender and gender diverse people, having forums that allow them to indicate their preferred pronouns during clinical encounters. And also in making sure that forms do not assume that people that say they're married are only exclusively married to opposite sex individuals, and they're having more inclusive language is really important.

Dr. Billy Caceres:

These are just really small steps that can make LGBTQ people feel more welcome in clinical spaces in general, but particularly during the pandemic. I think the people that are probably most vulnerable during this time are those that are the oldest and youngest members of the LGBTQ community who may lack support from their biological families during this difficult time. And this combined with higher rates of poor mental health, suicidal ideation, and even higher rates of self harm that we see among transgender people, really creates a situation of heightened risk.

Dr. Barbara Lutz:

Thank you, Billy, for your interesting perspectives on the LGBTQ population. I know there are a lot of challenges and I think all the populations we're talking about today are facing some similar challenges. So now we're going to turn to Matt. Matt, thanks for joining us to talk about the impact of COVID on patients with HIV. Can you tell us a little bit about patients with HIV, do they have higher risks for contracting COVID or do you think they're more protected?

Dr. Matt Feinstein:

A lot of what we're talking about related to COVID and HIV, there are certainly some insights from Billy's conversation that can help inform us as well given the disproportionate representation of the LGBTQ community among people who have HIV. But Barbara, regarding your question specifically, it's a good question, and we don't really know. So far the data aren't necessarily suggestive of an increase or a decrease in risk for contracting COVID associated with HIV. Really at best what we have is mechanistic speculation, which is... It hasn't been born out in the epidemiology yet, but we do know that a lot of this could have to do with the immune progression if there is an increase in risk. And the general idea of that is in immune progressed HIV, there are dampened cell-mediated immune responses and some immune senescence.

Dr. Matt Feinstein:

And this is really something that actually happens naturally with aging as well as our sinus or our sinuses involute and we have less robust and effective T cell responses. You get a little more reliance on innate immunity and innate immunity can be a little more broadly pro-inflammatory. So whether this increases risk of getting the infection we don't know, but whether this could increase the risk of severe pro-inflammatory responses and then systemic inflammation in the setting of infection, it's certainly possible. But again, this is all purely speculative based on mechanisms, and we just really don't have the data almost yet.

Dr. Billy Caceres:

So that's really interesting Matt. I think that one of the questions that many people have had lately is whether antiretroviral medications help in combating COVID-19?

Dr. Matt Feinstein:

There's still a lot that's to be determined here. One thing we do know, they did try certain antiviral medications really on their own. So recently, for instance, so looking at the Lopinavir–Ritonavir trial demonstrated no benefit. But there may be some benefit in combination with antivirals and interferon, at least based on a Lancet paper recently that demonstrated that early triple therapy in the setting of COVID with lopinavir–ritonavir interferon and ribavirin was superior than to just lopinavir–ritonavir in terms of alleviating symptoms and shortening the duration. But two of those three meds are not antiretroviral, so there's not really reason necessarily to think that standard antiretroviral therapy alone here is going to prevent or treat COVID.

Dr. Barbara Lutz:

So the jury's still out on a lot of this. I think we're learning so much as we go along. We do know some populations are more likely to have more severe symptoms if they do get COVID. For people with HIV, is that the expected course or do we know about that yet?

Dr. Matt Feinstein:

Yeah, it's a good question. We don't know fully in the sense of we don't have robust clinical or epidemiologic data. But we do know about general comorbidities that tend to often dovetail with HIV. We know people with HIV are more likely to smoke and are at higher risk for cardiovascular disease and cardiovascular disease-related risk factors. And certainly given the intense pulmonary involvement of SARS-CoV-2, the virus underlying COVID, and difficulty patients with diminished lung function have in the setting of COVID, the high rates of smoking in the HIV population are certainly a concern. Not necessarily HIV on its own is increasing the risk, but some of the concomitant comorbidities may be.

Dr. Matt Feinstein:

And we also know that there's a high prevalence of HIV in populations that have housing vulnerability who are also at high risk for COVID and don't really have the luxury of the social distancing that we are really hoping most people can be pursuing now. And then finally, the point that I brought up a bit earlier about impaired immune regulation and sort of a longer term shift to less targeted more broadly pro-inflammatory immune activation for people with HIV, which in the setting of the robust inflammatory response of the lungs, it's really creating an ARDS-like picture for a lot of the people contracting COVID. That's certainly a concern. That's a long way of saying the answer to your question is, will the symptoms of people with HIV who get COVID be more severe? On a population level, probably, but not necessarily because of the HIV, but rather mainly because of the comorbidities that go along with it.

Dr. Billy Caceres:

Matt, that was really interesting. And I think something to think about is because of the pro-inflammatory elements that we see in COVID, is there any evidence of heightened CVD risk among those with COVID-19 that might be similar at least mechanistically to what we know about HIV in relation to CVD?

Dr. Matt Feinstein:

It's something we don't fully know the answer to yet as with everything, but here there may be a little more clarity about potential mechanisms in common. First I obviously have to say there are clearly differences in terms of the viral mechanisms and its presentation, right? People with HIV right now, in general, we're talking about more of a chronic controlled picture of viral reservoirs, but not severe

viraemia in the blood, not often having acute presentations or at least as frequently as it did in the past. Whereas with COVID, it's quite different, right? We have an acute short course. But that said, there are some potential mechanistic similarities and a lot of this seems to revolve around endothelial involvement.

Dr. Matt Feinstein:

Some of this really being induction of pro-inflammatory and pro-clotting mechanisms, all of which can make people who are acutely infected with COVID at higher risk for clotting complications, whether they're lung clots, or even clots in the heart leading to the heart attack. And we've had some reports of this incumbent. We also know this tends to be the case in HIV, even though acute HIV is less common now. But in the setting of, for instance IRIS immune reconstitution, when that happens for people with HIV who have other co-infections and then actually have a robust increase in immune response and inflammatory response, some of their pro-inflammatory pro-coagulable sequelae may be similar to COVID. So, that's a way of saying there's probably something we can learn here, but I'm also reluctant to kind of over generalize on potential similarities between the two.

Dr. Barbara Lutz:

Given all this, what we're hearing, of course we don't know a lot of this, as we go along we're learning, but what are some strategies that we should recommend for people with HIV? And should we be considering them a higher risk population? It sounds like maybe we should, but I'll be interested to hear your thoughts on that.

Dr. Matt Feinstein:

Yeah. I mean, I agree with you, maybe we should. I don't think we have clear enough data to say certainly we should, but given the heightened risk for severe complications in theory among people with HIV of COVID, it can't hurt to be more cautious, especially when a lot of what we're talking about for exercising caution, there's not a huge downside in many cases to increasing social distancing, avoiding crowded spaces as possible, and really minimizing these types of high risk exposures for transmission. At the same time, we know this is really challenging in vulnerable populations, especially when there's housing vulnerability. So from our end, as clinicians and people involved in disease prevention and early diagnosis and treatment, for us it's really all about keeping a high index of suspicion and a low threshold to accelerate care in people with HIV who have COVID or we suspect may have COVID.

Dr. Billy Caceres:

Thanks, Matt, for your insights into the important issues related to COVID-19 and patients with HIV. Now, we're going to turn to Barb to talk a little bit about issues and concerns of older adults with CVD during the COVID-19 pandemic. And interestingly, all three of us are members of the American Heart Association CVD and older population's committee. So this is a topic that I know we all care about deeply. So Barb, given the impact of COVID-19 on older adults, especially those with comorbidities like CVD, what are the most important recommendations that you think we should be sharing with our older adult patients?

Dr. Barbara Lutz:

Well, we know older adults, and especially those with cardiovascular disease and other comorbidities are more susceptible and at higher risk of getting really sick with COVID and even dying from COVID. So we really need to be concerned about this population. We also know that people who live in congregate

sites or congregate housing such as assisted living or nursing homes are at the highest risk due to the ease with which the virus can spread throughout those populations. So we really want older adults to focus on disease prevention, to do the things to prevent from coming into contact with people who are COVID positive.

Dr. Barbara Lutz:

It's important to follow the Centers for Disease Control and Prevention (CDC) recommendations. We've been hearing about this on the news and ads on TV, but continuing to stay at home even though there's more pressure for people to go out now, using social distancing, washing hands frequently, not touching your face, wearing a mask if you do have to go to the store, go out for appointments, using FaceTime or video chats or email to communicate with families and friends to help reduce isolation while maintaining some social distance.

Dr. Barbara Lutz:

If it's absolutely necessary that you visit with family or friends, and I know people are really beginning to want to do more of this, it's better if you can do that outside and stay six feet apart at least wearing a mask and always staying away from large gatherings. I think one of the big things now for older adults, and maybe a lot of adults is wanting to go to religious services. And I think we need to continue to caution people away from those kinds of large gatherings because they can really wreak havoc on disease spread.

Dr. Barbara Lutz:

We also want to encourage really good self care, eating healthy, fresh vegetables, not snacking on high calorie low quality foods, staying hydrated, drinking water throughout the day, and staying active. Walking every day is a really good choice. The weather's getting better in most areas of the country, so that's a good way to get outside. If they can't walk or if they're mobility impaired, you can recommend chair exercises, just even maybe some exercises with some lightweights, even using a one pound can as a weight. Also they can have medications and food delivered if those services are available in their area. So there are lots of strategies they can implement.

Dr. Barbara Lutz:

They also need to develop a plan in the event that they are hospitalized either with COVID or with another issue because there's a big difference now in hospitalization and I'll talk a little more about that in a bit, but we need to encourage them to keep routine appointments and talk with their healthcare providers about special concerns they may have or special precautions they should be taking and what they should do if they're exposed to COVID or develop symptoms, who should they call and when and what the symptoms are. Many older adults are fearful of being exposed to COVID-19. So if they are, they may be avoiding routine medical care and this is really a problem.

Dr. Barbara Lutz:

It's essential that their cardiovascular health be optimized, especially to reduce the risk for a COVID-related hospital admission and potentially to even mitigate some of the vulnerability if they are exposed to COVID. And especially for high risk patients, clinicians really need to consider avoiding direct contact with these patients and using telehealth or telephone visits if they can and if those are acceptable to their patients. So there are lots of strategies we can employ to kind of minimize the potential contracting of COVID.

Dr. Matt Feinstein:

Thanks, Barb. Yeah, that sounds very practical and reasonable in terms of the approach. Now, I want to ask about the last thing you mentioned, which is telehealth, and I know more and more providers, myself included, are conducting a huge portion of their visits using telehealth now, whether it's with audio or video conferencing. I want to ask, given your expertise in this area, what kind of impact are you seeing on these visits for older adults?

Dr. Barbara Lutz:

Like much of what we're hearing about COVID, we don't have a lot of data yet, but anecdotally we are hearing that older patients are not as responsive or receptive to telehealth visits, especially if it's a video conferencing or video chat, it makes it even more difficult if it has to be done through a portal of some kind. There are no standardized formats for these video conferencing or video chat calls, so different providers are using different platforms and it makes it more difficult for older patients to access those different kinds of formats if they're not familiar with them.

Dr. Barbara Lutz:

They also, these older adults may also have hearing and visual impairments which make video chats more difficult for them to understand or see what the provider may be showing them. Or if they have mild cognitive impairments that can also make video conferencing more difficult for these patients. And the end result is that these older patients may not be receiving the follow-up care that they need for their cardiovascular disease and stroke related issues.

Dr. Barbara Lutz:

So, I think we really need to be innovative and identify appropriate strategies that can help improve access to care for older adults during this time that reduces contact, especially for those who really don't want to go out or can't go out. And at a minimum, our providers should be making follow-up phone calls to patients who cancel or miss scheduled appointments to kind of have a touch base with them and reschedule those appointments either via telehealth or telephone. Medicare has eased restrictions and visits can be reimbursed for patients who can't do or don't want to use video technology so you can get reimbursed for telephone visits. I know it's not ideal, but at least it's a touch base with the patient.

Dr. Barbara Lutz:

We also need to encourage the family members to familiarize themselves with the video technology because then maybe they can assist the older adult in keeping these appointments, and making sure that we have a good contact for the older adult of somebody who's a healthy trusted point of contact, usually probably a family member, so that if we can't reach the patient, we've got someone we can call for communication so that we've got all the Health Insurance Portability and Accountability Act of 1996 (HIPAA) forms and all the things we need to make sure that we can maintain contact with these patients because people are really isolated right now.

Dr. Billy Caceres:

That's a lot of really good information about older adults that are living in the community. But Barbara, can you tell us about the impact of COVID on hospital-eligible older adults, including those with and without a diagnosis of COVID?

Dr. Barbara Lutz:

First we're seeing fewer emergency department visits and admissions for cardiac issues and stroke. And we don't really know for sure what this is about. We don't have the evidence yet, but we're very concerned that older adults who are experiencing symptoms of cardiac distress or stroke are not seeking care in the emergency department. So that fear is a huge component for this population. And there are some anecdotal reports of finding of people who die at home because they were afraid to go to the emergency department.

Dr. Barbara Lutz:

So we need to continue to stress with our patients. Again, this gets back to keeping in contact with them, the importance of seeking care quickly, especially with the onset of concerning symptoms. In stroke, we talk about time is brain, and we have the FAST acronym that's face, arm, speech, and time. And we need to continue to remind patients to be aware of what those symptoms are that are concerning and that they should seek care.

Dr. Barbara Lutz:

As I said earlier, older adults really need to have a plan. We need to be telling them now, if you were to get admitted to the hospital, how are you going to manage that? Make sure you have things together like your medical history, any comorbidities, any medications that you've been taking, really preparing for the worst. And how are you going to stay in contact with your family members because we know that there's limitations in visitation at many, many facilities right now.

Dr. Barbara Lutz:

We also need to let older adults know that if they are hospitalized, that their recovery and access to post-acute care may be challenging. Whether they have COVID or something else, they may suffer new dependencies and functional impairment as well as being subjected to these strict isolation measures. So if they're used to having somebody help them, that person may not be available to help them. And this isolation really becomes absolute when somebody is institutionalized. So again, figuring out ways to stay in contact.

Dr. Barbara Lutz:

I know a lot of the hospitals are doing a better job, I think, of helping patients and family stay in contact. But then when we talk about patients who have cognitive impairments, the impact of this isolation and change of location to a hospital or institution can have a profound impact on their cognition. So we need to be thinking about this. I would say planning ahead to help people think through what they're going to need if they are hospitalized either for COVID or for something else.

Dr. Barbara Lutz:

We also need to make sure they've identified somebody who can assist them in their recovery if they come home or can help them continue to maintain social connections through FaceTime or emails if they were to have to go to a nursing home or skilled nursing facility after being hospitalized. So there are lots of things we could think about. It's almost having an emergency preparedness plan that's based on if I were to get hospitalized, what are the things that I need to have in place so that I can make sure I get the best care. So there are lots of things to think about.

Dr. Matt Feinstein:

Yeah. Barb, you made a number of important points there and I think one of them that's particularly interesting and maybe something we don't think about enough is the transition to post-acute care settings. So I wanted to ask, how are these post-acute care settings managing admissions of patients who have stroke and other debilitating conditions with or without COVID in the current setting?

Dr. Barbara Lutz:

First of all, the good news is CMS or Medicare has suspended many of the regulations regarding admissions to acute or inpatient rehabilitation (rehab facilities). So that really increases options for post-acute care for older adults, whether they've had a stroke or if they've become disabled or have functional limitations because of a hospitalization due to COVID or something else. So it's really important that we screen them while they're in the acute inpatient setting to identify what their rehabilitation needs are and make sure we're referring them to the appropriate level of care, which for many of these patients may be even a short stay in an inpatient acute rehab facility. Because of COVID alone, we know that these patients will need rehab. And then if you add co-morbidity and frailty that often happens with older adults, they're at much higher risk for increased functional limitations.

Dr. Barbara Lutz:

Another good thing in the planning process is to be thinking about, if your older family member ends up in the hospital where, if they can't come home because they need some rehabilitation, where might be the best place for them to go? And becoming familiar with the facilities in your area or for providers helping patients and families become familiar with facilities in the area that provide these services so that families can check them out ahead of time so they know how those facilities are managing COVID and non-COVID patients. We do know that older adults in long term care facilities, so subacute rehab and nursing home skilled nursing facilities, are at much higher risk of contracting COVID. So seeking post-acute care in an inpatient facility at least should be considered.

Dr. Barbara Lutz:

The way facilities are managing COVID patients depends really on the facility. Some are only taking patients who have had two negative COVID screenings. On the other hand, there are units in New York, I have a colleague who has a unit where they are taking COVID positive patients, patients who haven't recovered, and then I have another colleague in another state where even if they have a positive COVID screen, if they have recovered, if they no longer have symptoms, then they are taking those COVID patients but they're managing them in a variety of ways.

Dr. Barbara Lutz:

The ones that are taking active COVID patients have separate units that are managed specifically for the COVID patients. Pretty much all these facilities or most, I would say depends on the state again, have really strict visitation policy. In rehab, we typically expect family members to come in frequently to get training for the post-acute care because a lot of times these patients needs a lot of help when they get home, but they're not able to do that. So facilities are working on identifying creative ways to train family members through videos and video conferencing before the patient goes home, and then typically what they do is at least have a family member come in one time to do the training in a very structured way so that they hopefully are better prepared to take the patient home.

Dr. Barbara Lutz:

One thing I found was interesting from my colleague in New York, she said they're seeing a lot more pressure ulcers and falls in their post COVID patients. And this increases the risk for older adults because if you have a pressure ulcer and you're already compromised, healing of that pressure ulcer could be a problem. And for COVID patients, when they put them prone, they're getting pressure ulcers on their cheeks and their chin. So places we don't normally see them. So, just letting people know that some of these things may happen and that we know how to take care of them and we will take good care of them.

Dr. Barbara Lutz:

We also want to make sure if patients are discharged directly home, if they've been in the hospital, we know that older adults lose functional status really quickly when they're hospitalized and not mobile. So, it's really critical that if they go straight home, that they're evaluated for post-acute follow-up rehab at home, and this could be by tele-rehab. We know there are problems with video, but if there's a family member there, that might be a good option.

Dr. Barbara Lutz:

There also may be in-home visits available in the area. So again, being aware of what's available in your area is really important depending on what the agency standards or requirements are. And then there are some places still doing outpatient therapy. And again, being very cautious and careful in managing patients, similar to other provider offices. So there are lots of options and I can't stress enough the importance of planning ahead.

Dr. Billy Caceres:

That's a lot to consider regarding many now three different settings for older adults in their care. And another consideration is to think about strategies that we should be incorporating to assure that older adults have a clear understanding of advanced directives and treatment wishes in relation to COVID, and it's such an important topic at this time. What are your thoughts about that part?

Dr. Barbara Lutz:

We've talked a little about patients being concerned about not getting the care that they want, right? I think Billy you mentioned that. And so my first comment is everyone, not just older patients but everyone, should have discussed and completed advanced directives. What do they want in case they can't make decisions about care for themselves? And those should be in writing and have been discussed with their healthcare provider, their primary care provider or specialist and their family members, and well-documented. There are lots of excellent sites that provide tools for this kind of advanced care planning. So if your patients haven't done that or if you are an older adult or if you're a younger adult, you should be doing this now. You should be really thinking about this. And there are a couple of good sites: Begintheconversation.org, and [The Conversation Project](http://TheConversationProject.org). But also most providers' offices have information about this.

Dr. Barbara Lutz:

And as providers, we really need to be discussing these advanced directives with patients in light of COVID to make sure that we know how their wishes might differ if they were to be hospitalized for COVID specifically. For example, some patients may have indicated that they don't want to be intubated. Maybe they say if they have a major stroke, they don't want to be intubated. But in the case of COVID, they may feel very differently about this. So we really need to know, do they have different advanced

directives if they were to be hospitalized for COVID? And we need to make sure that they understand these choices need to be clear and that everybody, as I said earlier, their providers and their families understand what their wishes are so we can make treatment decisions that are in accordance with their goals.

Dr. Barbara Lutz:

And on a health policy level, we need to assure that we're not making healthcare decisions. For example, in the case of a shortage of ventilators or medications that might help patients, that we're basing that on an individual's age and/or co-morbidities alone. We really need to understand what the family's and the patient's wishes are and goals for care are. And there is some concern that older patients are not going to have that kind of autonomy. So as much as we can, we need to make sure those things are well documented.

Dr. Matt Feinstein:

Yeah. Thanks Barbara. I think that's an important point about advocacy and the potential for vulnerability on older populations. And so along those lines, well, where do we go from here? What kind of COVID-related research topics and recommendations regarding older adults and cardiovascular diseases in the setting of COVID, what should we be thinking about for that?

Dr. Barbara Lutz:

Well, I think one of the big things that we need to know more about and figure out quickly, we know that these long-term care facilities are hotspots for COVID regardless of the surrounding region. So we have to figure out what the most effective strategies are for keeping those residents safe and reducing the risk of infection within those populations because that's where we've seen a lot of the older folks who have been the most sick and have the highest rates of death. Other potential research topics, looking at the effects of isolation and social distancing on older adults, both in the hospital and at home, because we know older adults are having to stay home more. And how do we keep older adults safe at home and in institutions, as I said, not just long-term care facilities but hospitals.

Dr. Barbara Lutz:

How do we make sure the older adults at home can get their medications that they need? That they have adequate food, that they're able to manage their self-care if they were used to having family members come frequently and now those family members can't get to them. What are the effects of reduced mobility on functional status and how can we minimize that and keep these folks active so they can stay as independently as possible. What about medication management? What issues do people have managing their medications and how do some of the new therapies like remdesivir impact COVID in older adults versus younger?

Dr. Barbara Lutz:

Finally I think we need to really develop effective telehealth strategies for older adults taking into consideration their concerns about the type of media that we're using or platforms that we're using to connect with them. I think that's really important. And I just want to add, I didn't address any of the medical management of patients. There's a lot around medical management of patients with cardiovascular disease. There are a lot of great resources on the web and I have listed some of them in the podcast transcripts so that if people want more specific information on medical management, that would be included there.

Dr. Barbara Lutz:

As we wrap up, I want to re-touch base with Billy and Matt and then I'll give some final thoughts. But Billy, can you give us some final thoughts on sort of the takeaway messages for LGBTQ population and COVID?

Dr. Billy Caceres:

Sure. Thanks Barb. I think COVID-19 has really highlighted the importance of including LGBTQ people and really people from other underrepresented groups in epidemiological and clinical research. The lack of data regarding the impact of the pandemic on LGBTQ people has really brought this issue to the forefront for many researchers and healthcare providers. And I believe there's really so much more than we can do to support LGBTQ people and other marginalized groups. And one of those ways is really understanding how to implement strategies that leverage resources like telehealth to really maximize the care that underrepresented groups are receiving and really optimize the health outcomes in those populations that we know experience these health and healthcare disparities.

Dr. Barbara Lutz:

So, Matt, how about your population with patients with HIV?

Dr. Matt Feinstein:

Billy hit the nail on the head in a lot of ways in that first one of the major barriers here to us having stronger recommendations in terms of what do we do at least medically for folks is that we don't have... our epidemiologic and clinical data are not all that clear and they're particularly unclear in underrepresented groups that haven't had as clear of a seat at the table as they should. And that's certainly the case for a substantial portion of people with HIV as well. So a lot of what Billy said applies there too. And then I think in terms of what can we do, something I keep coming back to, and this applies to all of our populations in particular because there's some vulnerability and some difficulty with self-advocacy in some cases and certainly difficulty in the healthcare systems really thinking about and advocating for a lot of these vulnerable populations.

Dr. Matt Feinstein:

It's first do no harm and in the absence of really strong safety and efficacy data a lot of the potential COVID preventive and really therapeutic strategies, I think it's really making sure that our populations that are particularly at risk are not being subjected to really poorly supported science that could actually do them harm. That's one major point which is just kind of staying humble about what we know and what we don't know and understanding that if we don't know something and if there's a reasonable risk of severe side effects without a clear benefit, we really need to be protecting our patients in this setting.

Dr. Matt Feinstein:

But at the same time we can also be really proactive about certain things. And I think Billy's points about telehealth are really important, right? Think of this as an opportunity for different ways: how do we expand our outreach? How do we do a better job of trying to really promote more equity here? And use this as an opportunity to rethink how we reach these populations and how we can promote what we know is good prevention, right? Healthy lifestyle in the case of COVID that also includes social distancing as much as possible. And for people who have some built in vulnerabilities, how do we have structural initiatives that can actually improve the built environment that can limit some of the vulnerabilities there?

Dr. Matt Feinstein:

And then of course, medically it's still having a high index of suspicion to take complaints and concerns seriously, to understand that these are populations that may be at particular risk, maybe particularly reluctant to engage healthcare providers. And so it's really on us to do both outreach but also to take any engagement really seriously, and to really be thinking about everything we can do that seems reasonably safe and is likely to have a positive benefit to risk ratio to really be advocating for that on behalf of our patients.

Dr. Barbara Lutz:

Yeah, those are all really good points. And what I hear in both of your comments is we need to figure out better ways to target based on the needs of specific populations. So telehealth works maybe really well for a younger population, but for older populations we maybe need to figure out a different kind of innovation to do virtual appointments with those folks. And for me, focusing specifically on older adults, it's really important for us to remember that all older adults are particularly vulnerable during the pandemic. They're vulnerable, not only to COVID, but to this isolation and increased functional limitations. And those with cardiovascular disease are at even more risk.

Dr. Barbara Lutz:

So we need to make sure we continue to pay special attention to their needs and not marginalize them, similar to the other vulnerable populations we've talked about. I think encouraging them, and maybe this goes for the other populations as well, encouraging them to have a plan. Think about, what are you going to do if you're hospitalized? What do you need to have with you? How do you need to connect with people? If you can't go home after you're hospitalized, how are you going to manage that? And then also really encouraging them and providing accessible ways for these vulnerable populations to seek care when they need it.

Dr. Barbara Lutz:

We need to continue to assure them that we're taking the necessary precautions to limit their exposure, and that we will listen to them. Like Matt said, that we'll hear them and we want to engage them and continue to engage them in their healthcare and their self care. We also need research to learn more about how these vulnerable populations, including older adults, can respond to these different treatments. And as I said earlier, identify innovative ways to conduct virtual appointments that meet the needs of the different populations, older adults in particular, but also the other populations we've talked about with the goal of helping them maintain their independence, because that's a big concern in this population that they may lose their independence even if they're able to recover from COVID.

Dr. Barbara Lutz:

I want to thank everybody for listening to the podcast today. Please be sure to return online to the American Heart Association Professional Heart Daily for additional podcasts that are planned for this series. These will include COVID-19 and stroke, diabetes, pulmonary hypertension, and other concurrent cardiovascular diseases during this disruptive time in healthcare delivery. Thanks Billy. Thanks Matt. It was really great to spend this time with you, and we hope everybody enjoyed the podcast.

Speaker 1:

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