

RESEARCH

Negative Age Stereotypes Associated with Older Persons' Rejection of COVID-19 Hospitalization

INTRODUCTION

During the pandemic, excess deaths (the difference between observed and expected deaths, based on mortality rates from previous years) have far exceeded the number of deaths officially attributed to COVID-19.¹ This is partially due to older persons with COVID-19 avoiding hospitals and dying at home without an official diagnosis.^{2,3} We examined a potential explanation for this avoidance.

Specifically, the current study considered for the first time whether resistance to hospitalization can be explained by a psychosocial factor among older persons: stress-inducing negative age stereotypes (disparaging characterizations of older persons as a category) that are assimilated from society. A prevalent-negative-age-stereotype theme is inevitable debilitation.^{4,5} Previous research demonstrated that these stereotypes, which engender a sense of futility, lead to risky health behaviors, delayed recovery from disability, and low will to live among older persons.⁴⁻⁶ According to stereotype embodiment theory, and its supporting research, negative age stereotypes have a greater impact on older persons, for whom the stereotypes are self-relevant, compared to younger persons, for whom the stereotypes are self-irrelevant.⁴

We expected that, compared to older persons with positive age stereotypes, older persons with negative age stereotypes would be more likely to oppose older individuals going to the hospital when extremely sick with COVID-19. We also conducted two specificity analyses. First, we expected that the age stereotypes of older persons would not be associated with their view of whether younger persons should go to the hospital when extremely sick with COVID-19. Second, we expected that among younger persons, age stereotypes would not be associated with their view of whether older or younger individuals should go to the hospital when extremely sick with COVID-19.

METHODS

To examine these hypotheses, we assessed 1,590 participants drawn from two online platforms: Amazon Mechanical Turk and Lucid.⁷ Both platforms provide data validity and reliability similar to that collected through in-person

settings.⁷ Inclusion criteria were 18 years or older, English fluency, and U.S. residence. Forty-eight percent of the participants were in the older group (age 65 or greater). The cohort, similar to the U.S. population, was 55% female, 70% white, 19% African-American, 14% Hispanic, and 7% Asian. Participants were surveyed between April 23 and May 5, 2020, during which 28% of excess deaths were not officially reported as due to COVID-19.^{1,8}

Negative age stereotypes were measured with the reliable and valid 18-item Image of Aging scale.⁹ Views of whether hospitalization was appropriate were measured by asking participants how much they agreed with the following statements: "If older persons are extremely sick with COVID-19, they should stay at home and not go to the hospital;" and "If younger persons are extremely sick with COVID-19, they should stay at home and not go to the hospital." Covariates included: age, sex, race, self-rated health, education, marital status or financial stress (measured by asking, "How much has the pandemic affected you financially?").

RESULTS

As hypothesized, negative age stereotypes significantly predicted a rejection of hospitalization for older persons who are extremely sick with COVID-19, among older participants $\beta = .20$, $P = .04$, but not among younger participants, $\beta = .14$, $P = .24$. Also as hypothesized, negative age stereotypes did not predict views of whether younger persons who are extremely sick with COVID-19 should be hospitalized, among older and younger participants, $\beta = .17$, $P = .09$ and, $\beta = .19$, $P = .09$, respectively.

DISCUSSION

Despite widely-disseminated media reports about the relatively high risk of older persons for COVID-19 mortality,¹⁰ the saliency of negative age stereotypes still led to its association with their view that they should avoid hospitalization when extremely sick with COVID-19. It is notable that this association was greater than the one found among younger persons holding negative age stereotypes. Future research is needed to determine the extent to which the negative age stereotypes of older persons are among the risk factors contributing to pandemic deaths and how to best mitigate these societal-based stereotypes.

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The Adoption of Video Visits During the COVID-19 Pandemic by VA Home Based Primary Care

INTRODUCTION

The Department of Veterans Affairs (VA) Home Based Primary Care (HBPC) program delivers in-home care to chronically ill geriatric veterans.¹ During the COVID-19 pandemic, older adults were required to minimize in-person contact, and the home-based care delivery model became untenable.^{2,3} National VA leadership encouraged replacing in-person visits with videoconferencing. This posed challenges for HBPC, for which video visits represented only 0.3% of over 1 million national HBPC visits from January 2019 to February 2020 despite efforts to promote adoption. Before the pandemic, national VA and HBPC leadership had developed structural changes, defined as changes related to resources, management systems, and policy

guidelines,⁴ which laid the groundwork for video visit adoption. This included development of the VA Video Connect (VVC) videoconferencing software, investment in support lines to troubleshoot software issues, creation of a health record provider note template, and provision of government-issued laptops and cell phones to providers. Providers could enroll patients in a program distributing video-capable tablets to veterans with need.⁵ National leadership developed VVC training modules and incentivized replacing in-person visits with videoconferencing. Nevertheless, it was not until additional key local and national changes occurred around the time of the pandemic declaration that adoption rapidly increased in the San Francisco VA Health Care System's (SFVAHCS) HBPC from February to June 2020. We highlight key changes facilitating this increase.

METHODS

We developed a timeline of changes and categorized changes guided by the COM-B model of behavior change, a framework used to demonstrate how behavior (B) change occurs when individuals have the physical and mental capability (C) to seize available opportunities (O) if there is sufficient motivation (M) for change.⁶ Utilizing VA national (Corporate Data Warehouse) data, we trended video visits as a percentage of total visits between January 2020 and June 2020 in relation to the timeline. We trended percentages of providers who became video visit capable. The SFVAHCS with the University of California San Francisco IRB granted this project quality improvement exemption.

RESULTS

Changes involved augmenting provider *capability* (leadership encouraging providers to upgrade computing hardware and complete training modules, temporary expansion of allowable videoconferencing platforms besides VVC), *opportunity* (large group didactics as well as individual tutorials and biweekly virtual office hours for VVC training, encouragement of peer education, triage changes to favor VVC visits), and *motivation* (local mandate for all clinicians to become VVC capable, heightened desire to keep patients healthy during the pandemic) (Figure 1). *Behavior change* occurred rapidly, as clinician video visit capability increased from 12% to 94% from March 1 to 27 and video visits increased from 0% to 2% of total visits from February to March and to 8% in April onward. This surpassed the regional Sierra Pacific Network to which SFVAHCS HBPC belongs, where video visits similarly increased from 0% to 2% from February to March but increased to only 6% to 7% in April onward.

DISCUSSION

This project showed that improving video visit adoption required multiple domains of change. The combination of national structural changes and local changes addressing provider capability, opportunity, and motivation led to increased adoption. Given the diverse organizational, technological, and social barriers impacting telemedicine adoption,⁷ a multi-dimensional approach to change is vital.