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# Aging and Health Research

# Identifying the needs of our older community-based patients in the COVID era: A telephone survey

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## ARTICLE INFO

## ABSTRACT

*Background:* Older people's vulnerability during a pandemic may extend to social connectedness, access to healthcare, and information delivery. We sought to identify whether and how older community-based patients are maintaining connections and accessing information during COVID-19.

*Methods:* We administered a telephone questionnaire to all patients (or carer/proxy answering 'on patient's behalf') who previously attended our Geriatric Medicine clinic, May-December 2019.

*Results:* Response rate was 58.8% (151/257), carer respondents comprising 23.8% (36/151). Mean patient age was 81.8 years (SD 8.6); 59.6% were female, 15.2% lived alone. English was the preferred language for 72.9% (110/151). Almost half (46.4%, 70/151) felt COVID-related restrictions had impacted them. Thirty-eight percent (58/151) reported feelings of social isolation, most (38/58) reporting this new since COVID. Nonetheless, 92.1% (139/151) reported maintaining social connections, all with family (139/139), less often with friends (69.8%, 97/139). COVID-related information sources included television 68.9% (104/151), family/friends (54.3%), healthcare providers (24.5%), and written sources (21.2%, 32/151); 12.6% used online resources. Increasing age lowered likelihood of accessing online information, while having smartphone/computer increased. Most (82.6%) believed their healthcare needs were being met, and 76.1% had accessed their GP, 87% (100/115) in-person. Only 33.1% (50/151) agreed telehealth acceptable, more often those with smartphone/computer (OR 2.15, p=0.04).

*Conclusions:* Interventions to reduce isolation and optimize connectedness and healthcare- despite physical distancing- are important during COVID-19. During a rapidly evolving pandemic, healthcare delivery and information provision to our older population is likely best served by a multifaceted approach which acknowledges identified preferences, practices and barriers.

## Introduction

In March 2020 the News South Wales (NSW) state government in Australia issued a stay home order, advising older people over the age of 70 to distance themselves from other people. [1] Despite a significant focus on the impact of COVID-19 on residential aged care in Australia, [2] its impact on the lives of older people living in the community is less-well explored. [3] Policies created in response to COVID-19 that might increase social isolation and loneliness amongst older adults, [4,5] and engagement via digital or telehealth alone may be insufficient. [6] Telephone contact may be a suitable replacement to face-to-face contact as a means to maintain social connections. [7–9] Some older people may

have difficulty accessing or understanding information, due to a variety of reasons. [10] However, in a recent UK telephone survey on the impact of COVID-19, older respondents largely reported good health and low levels of anxiety. [11]

As COVID-19 lockdown commenced in NSW, as elsewhere, [12] many out-patient departments rapidly shifted towards 'virtual' consultations to provide remote care to patients. However, data are limited on how older people were accessing resources, staying socially connected, and how restrictions and changes in delivery impacted on healthcare access. Our hospital located in south western Sydney serves a culturally and linguistically diverse population; 43% of the population are born overseas, with 62% speaking a language other than English at home. [13]

We sought to explore if the health information, social and health needs of our older community-based patients were being met in the COVID era, aiming to better informing service and care planning.

## Materials and methods

In May/June 2020, we administered a telephone questionnaire (Appendix A) to all patients (or carer answering 'on patient's behalf') who previously attended Liverpool Hospital geriatric medicine clinic, May-December/2019. Survey development was guided by literature review and stakeholder consultation with aged care clinicians (medical, nursing, consumer representative). Pilot testing was conducted with a small number of consumers prior to finalization.

The list of eligible patients was identified through the clinic database. Patients were contacted by telephone, and offered the opportunity to participate. Researchers obtained verbal consent to proceed. If the patient themselves was unable to partake, and did not decline participation, the carer was asked if they might answer questions on the patient's behalf.

We anticipated that some respondents may need additional supports during COVID-19 and provided a contact number for the clinical research team in case they had concerns. Data were deidentified.

This Quality Improvement project was approved by the district Human Research Ethics Committee (LIV114/2020/20).

### Statistical analysis

In addition to descriptive summary statistics, we investigated whether patient characteristics were associated with pre-determined outcomes of interest: information sources, finding telehealth acceptable, and feeling socially connected/isolated. Rather than employ a more restrictive model, factors that were potentially associated with outcomes of interest on univariate analyses ($p<0.10$) were included in the initial multivariable logistic regression models, but excluded from subsequent models if statistical significance ($p<0.05$) was then not observed. Numerical data were analysed using Stata® v13.0 (StataCorp®, USA). Additional thematic analysis of open free-text answers captured frequencies of terms used. [7]

## Results

### Response rate and patient characteristics

Amongst 257 patients potentially eligible for inclusion, final response rate was 58.8% (151). Of 106 excluded, commonest reasons were failure to contact (67%, 71/106), and patient declining participation (11%; 12); at least 9% (10) had died.

Respondents comprised patients (76%; 115/151), or carer answering on patient's behalf (36/151; 33 family 'carer', 3 'other carer'). Patient mean age was 81.8 years (SD 8.6 years); 60% (90/151) were female, 15% (23) lived alone, 19% drive. Preferred language was English for 73% (110), followed by Spanish, Vietnamese (both 9/41) and Italian (7/41); 85% (128) were able to answer in English, the remaining 15% (23) having an English-speaking carer assist.

### Information resources

Where were older people accessing information relating to COVID-19? Television was commonest, followed by family/friends (Table 1). Older persons were less likely to access online information (OR/year increase 0.93, CI 0.88–0.98, p=0.006), while having smartphone/computer increased odds (OR 4.44, CI 1.164–12.01, p=0.003). Men less often sourced information from healthcare professionals (OR 0.38, CI 0.17–0.88, p=0.025) than women.

Overall, 86.7% reported the level of information was 'just right' (Table 1). In terms of difficulty understanding information, amongst

**Table 1**

Sources of information, and respondent opinion regarding level of information provided.

| Sources of information | N (%) |
|---|---|
| Television | 104/151 (69) |
| Family/friends | 82/151 (54) |
| Written resources | 32/151 (21) |
| Newspapers (English or other), | 18/32 (56% of this subgroup) |
| Government flyers | 4/32 (13% of this subgroup) |
| Information from aged care providers | 4/32 (13% of this subgroup) |
| Unspecified | 4/32 (13% of this subgroup) |
| Other | 2/32 (6% of this subgroup) |
| healthcare providers | 37/151 (25) |
| GP | 23/37 (62% of this subgroup) |
| Other | 14/37 (32% of this subgroup) |
| Radio | 28/151 (19) |
| Online resources | 19/151 (13) |
| Named specific site | 8/19 (42% of this subgroup) |
| News website/app | 5/19 (26% of this subgroup) |
| Facebook/social media | 2/19 (11% of this subgroup) |
| Government website | 1/19 (5% of this subgroup) |
| National helpline | 1/151 (<1) |
| Level of information | |
| 'Just right' | 130/151 (87) |
| Too much | 16/151 (11) |
| Too little | 5/151 (3) |

**Table 2**

Means of maintaining social connections. Total N=151. Participants may select >1 option.

| Means of maintaining social connections | N (%) |
|---|---|
| Telephone | 113 (75) |
| In-person | 100 (66) |
| Video-conferencing | 32 (21) |
| Other social media was infrequent | 3 (2) |
| Shopping | 11 (7) |
| Exercise | 5 (3) |

47 free-text responses, 19 reported (impaired) cognition contributing to difficulties; other themes included lack of clarity in information especially regarding quarantine/restrictions, misinformation/speculation, language barriers and medical jargon.

### Maintaining social connections

Only 22% (33) reported using a smartphone and 16% a computer (28% having ≥1 of these). Almost half (45%, 68/151) reported having felt some impact of COVID-19 restrictions. Commonest themes amongst free-text responses included limitations of social activities (29/97), visitors (23/97), and essential services (10/97), the need for 'social distancing', and loss (routine, freedom). Frequently used words indicated restriction and perhaps disempowerment: 'cannot' (go out/exercise/hug), 'stuck' (indoors/in house), 'staying' (in home/indoors).

Thirty-eight percent (58) reported feeling isolated, two thirds of these (38/58) reporting this was new since COVID-19. However, 92% felt they had maintained social connections, more often with family (139/139) than friends (70%, 97/139); Table 2 details means used. Patient characteristics or technological resources were not associated with feeling socially connected or isolated (all $p>0.1$).

### Healthcare needs

Most (83%, 123/151) believed their healthcare needs were being met, and 76% (115) had accessed their GP, 87% (100/115) in-person.

Only 33% (50/151) agreed telehealth acceptable, more commonly those with smartphone/computer (OR 2.15, 95% CI 1.02–4.51, p=0.04).

Asked why/why not, negative themes predominated (lack of rapport/physical examination, technological issues, cogni-

tive/language/sensory barriers). Within 65 free-text responses suggesting additional helpful resources needed, community physiotherapy (15/65), home services (7) and technological enhancements (7; 3/7 suggesting dementia-specific technologies) featured; 25/65 reported nil additional resources were required.

*Excluded patients*

Excluded patients were of similar age (mean 82 years; p=0.86) and sex (67% female, p=1.0) to included patients.

## Discussion

In this survey of community-based older patients during the COVID-19 pandemic, we identified that many older persons felt they had maintained social connections and that healthcare needs were being met. However, almost one fifth reported their healthcare needs were *not* adequately met, and new social isolation was not uncommon.

Telephone and in-person interactions enabled social connections more than social media or digital technology. Patients partaking in this study reported deriving COVID-19 information mostly from television and family/friends, which may be important when looking to disseminate information about COVID, vaccines and other healthcare topics. Cognitive difficulties, language barriers, misinformation and medical jargon all featured as concerns with available information. Standardised information from NSW Health and other health services has been made available not just through online resources, but also through liaison between the department's media team and journalists, and inter-departmental collaboration to deliver advertising campaigns targeting diverse NSW communities and populations. [14] However, we acknowledge that information obtained elsewhere via media or family/friends may not be subject to similar rigorous controls and quality assurance.

Telehealth was not popular, with lack of rapport, technological issues and cognitive, sensory and language barriers featuring as concerns. Telemedicine 'unreadiness' is not a specifically Australian issue- a 2018 survey of >4000 US adults indicated that, based on their data, an estimated 13 million older US adults were telemedicine 'unready' [15].

While the internet has been mooted to be a human right, [16] not all older persons may use a device, or wish to. Almost three-quarters of our respondents reported not using a smartphone/computer. This is higher than that in a large US study of adult Medicare beneficiaries, where 40% lacked access to both computer and phone, but they noted this figure was influenced by age, educational attainment, disability and ethnicity. [17] It is important that technological privilege not dictate healthcare information, access and social inclusion. While state-wide easing of restrictions has seen some return to usual out-patient clinic practices, the unpredictability of COVID-19 surges means contingency plans must ensure that older vulnerable people are not disadvantaged if the situation changes.

While most patients reported maintaining social connections, especially with family, many reported social isolation and/or negative themes in relation to the impact of COVID. Isolation is strongly linked to depression, anxiety and cognitive decline, and reduces resilience factors-self-worth, sense of purpose and feeling valued. [18] Longer term outcomes of COVID-related restrictions on the mental health and quality of life of older persons- and indeed the impact of easing restrictions and re-engagement with 'normality'- [19] are yet unknown.

Limitations of this study include that being drawn from a single center study and that patients were recruited from geriatric medicine clinic lists, meaning that data may not be representative of all older persons. We acknowledge the possibility of selection bias. Those unable to partake may be even more vulnerable. Our response rate of 59% was modest, but telephone surveys may trump other survey types, and our response rate was higher than some groups have reported. [20] The sample size precluded in-depth investigation of subpopulations and has limited power to detect associations between variables. This study was un-

dertaken in mid-2020, a few months into the COVID-related constraints; prolonged social restrictions may have even more profound effects, and we cannot speak to practices and preferences during the most recent wave of the pandemic. Finally, while we endeavored to explore patient viewpoints, we did not delve into themes in detail. However, these data provide some insight into experiences and preferences of community-dwelling older Australians, at least within the population surveyed.

Moving forward, in addition to longitudinal follow-up of outcomes to assess longer-term sequelae, and studies sampling a broader sample of the population, further work might concentrate on overcoming difficulties with available information, and exploring concerns regarding telehealth in-depth, to investigate if acceptability to older patients can be improved and/or appropriate alternatives identified.

We conclude that in the rapidly evolving context of a pandemic, healthcare delivery and information provision to our older population is likely to be best served by a multifaceted approach, cognizant of identified preferences, practices and potential barriers. Policy responses should focus on co-designing interventions with older people to reduce isolation and maximize means to maintain social connectedness- despite physical distancing.

## Conflicts of Interest

No conflicts of interest to declare.

## Funding/financial support

## Declaration of Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## CRediT authorship contribution statement

**Danielle Ní Chróinín:** Conceptualization, Investigation, Formal analysis, Supervision, Writing – original draft, Writing – review & editing. **Carol Lu Hunter:** Investigation, Writing – review & editing. **Michaela Shaw-Jones:** Investigation, Writing – review & editing. **Esther Duruchukwu:** Investigation, Writing – review & editing. **Frank Huang:** Investigation, Writing – review & editing. **Amy Ngov:** Investigation, Writing – review & editing. **Ashley Wang:** Investigation, Writing – review & editing. **Alex Yu:** Investigation, Writing – review & editing. **É Ní Shé:** Formal analysis, Writing – original draft, Writing – review & editing.

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## Appendix A. Telephone survey

**[Introduction, consent and contact details for team if queries/concerns]**
*Respondent details*
Respondent (circle): Patient or carer (family/other)
Preferred language (circle): English/other (specify)
Able to answer questions in English (circle): yes/no
Sex (circle): male/female
[If carer answering questions, they are to answer on behalf of the patient, not themselves]
*Information sources*
Where have you been getting most of your information about Coronavirus and COVID-19 (the illness due to Coronavirus)? Online (which

websites), TV, radio, family, friends, GP, national helpline (Health Direct), other healthcare provider, written information (source)?

Have you found the level of information appropriate (right amount), or is there too little (insufficient) or too much (overwhelming)?

What, if anything, have you found difficult to understand?

### Social circumstances

Are you living alone? Yes / No? If no, with whom? Spouse / children/ grandchildren / other family / non-family (circle all as appropriate).

Do you use a smartphone?

Do you use a computer?

Do you drive?

### Impact of restrictions

How have the current restrictions (social distances, isolation, business closures) impacted on you?

Do you feel socially isolated? If yes: is this new since COVID-19/Coronavirus? Yes/No

Have you been able to maintain social connections?- with family? With friends? How? e.g. telephoning, video-conferencing [Whatsapp, Skype, Facetime]), other social media (Facebook, Whatsapp, similar), in-person visits (e.g. for family to provide necessary care), exercise, someone taking you shopping?

### Helpful resources

What resources would you find helpful at this time?

Which of the following would be helpful: More health information, better technology, structured exercise programs, transport options, improved access to health providers (in-person or tele-health), more entertainment options, other (specify)?

### Meeting healthcare needs

Do you feel your healthcare needs are being met at this time? If not, in what way?

Have you attended your GP in the past month? In-person or tele-health?

Would you find specialist tele-health consultation (talking to your specialist over the computer, with video) an acceptable alternative to in-person clinic reviews? Why/why not?

Do you have any other comments?

Do you have any questions?

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