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EDITORIAL

Geriatrics

Caregivers are not visitors

In this journal, Lo and colleagues[1] share their survey of hospitals and emergency departments (EDs) across the country to determine how many had posted visitor policies and exceptions during the early stages of the COVID-19 Public Health Emergency (PHE). Not surprisingly, almost all hospitals reviewed had visitor restrictions, although the majority had exceptions posted, most often for children (76%) and patients at end of life (58%). Notably, only 39% of hospitals and 32% of EDs made an exception for patients with cognitive impairment, with 14% of hospitals and 11% of EDs specifically identifying patients with dementia as eligible to have visitors. As the authors point out, keeping the caregivers of individuals with dementia out of the ED during a PHE increases the potential for bad outcomes including delirium, prolonged avoidable hospital admission, misdirected medical evaluation as a result of incomplete history of present illness, and iatrogenesis.

Paying careful attention to who is allowed into healthcare settings such as EDs during an infectious pandemic makes sense. However, although the risks of transmitting infection are obviously higher during a pandemic, the limited data that exist on visitors in care settings do not suggest increased risk from enacting policies that carefully allow visitors.[2] The risks of spreading infection, which can be mitigated through careful screening and personal protective equipment (PPE), must be balanced with the increased risks of bad outcomes from a blanket ban on all visitors and caregivers.

Caregivers are not visitors. Patients who need caregivers for daily activities of life are at increased risk of bad outcomes when in a healthcare setting alone. This is intuitively obvious for children, that is, we would not treat a pediatric pandemic by keeping all parents out of the hospitals and EDs. For patients who need caregivers, especially those with dementia, the situation is analogous. We should be just as committed to finding safe ways to grant access to the caregivers of people with dementia as we would be to grant parents access when their children are being treated. Understanding that caregivers are care partners helps physicians and nurses recognize the value these individuals bring.[3] Furthermore, caregivers often augment an overstretched workforce. Barring those who help vulnerable patients from the care setting makes the situation more difficult for the clinicians and more dangerous for the patients.

An additional finding by Lo and colleagues was that only 12% of the polices identified were posted in more languages than English. This means non-English-speaking populations were even less empowered to advocate for their loved ones, likely enhancing inequity during a pandemic that has unequally affected many racial and ethnic minority populations. The fact that healthcare systems often do not create policies in collaboration with the communities they serve is a missed opportunity to promote cultural awareness and community connections.[4]

The AARP has made advocacy for caregiver access to loved ones inside hospitals and nursing facilities a priority while respecting the need for infection prevention. The Global Council on Brain Health, an independent group of experts convened by the AARP, flagged the remarkably high rates of delirium in hospitalized older adults with COVID-19.[5] This is exacerbated by profound social isolation and vulnerable patients being separated from their caregivers who know and understand them. The AARP has led the charge to rebalance the need to limit the spread of COVID-19 in hospital and long-term-care settings with the need for human connectedness. For example, the AARP chaired the development of the Leadership Council of Aging Organizations' (LCAO) statement before the Special Senate Committee on Aging in 2020. The LCAO asked Congress to ensure the provision of PPE and testing for older people and their caregivers in healthcare settings to stop the separation of caregivers from older people with physical and mental disabilities.[6] Continued advocacy is indicated to ensure hospitals fully consider the needs for vulnerable older adults when creating policies. The AARP's Public Policy Institute Supporting Family Caregivers Providing Complex Care series offers best practices for hospitals working to improve patient and family engagement.[7]

To more equitably balance the risks of infection transmission with the needs of patients dependent on caregivers, we have 3 recommendations.

1. EDs and hospitals need to clearly delineate caregivers from visitors, recognizing the critical role caregivers play in patients' well-being.
2. EDs and hospitals should create visitor policies, and distinct caregiver policies, in partnership with the diverse communities they serve.
3. ED and hospital policies need to be culturally appropriate and accessible, for example, written in multiple languages reflecting the diversity in the communities they serve.

It is in all our interests to advocate for policies that identify caregivers as distinct from visitors and for the resources needed to safely include caregivers in the ED and in all healthcare settings whenever

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possible. Clinicians can look to partner with leading advocates such as the AARP in continuing to advocate for their patients.

CONFLICTS OF INTEREST

Drs. Biese and Agha work with West Health, a philanthropic enitity focused on lowering health care costs to enable seniors to succesfully age in place. Sarah Lenz Lock works with AARP whoose mission is to empower people to choose how they live as they age. There are no other conflicts to disclose.

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