Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Letters to the Editor

Do Long-Term Care Facilities Pursue a Zero COVID-19 Strategy while the Rest of Society Opens Up?

To the Editor:

The world is transitioning toward coronavirus disease 2019 (COVID-19) endemicity. The global peak for incident COVID-19 cases has come and gone in January 2022. Societies and economies are fatigued and worn out from more than 2 years of restrictions and look forward to the resumption of normalcy.[1] Many countries have started to resume quarantine-free international travel.

However, the path ahead for long-term care facilities (LTCFs) is less clear. As compared to the general population, LTCF residents are particularly vulnerable both to contracting COVID-19 and experiencing morbidity and mortality from COVID-19 infection.[2] Outbreaks continue to occur in LTCFs, even though high vaccination rates fortunately attenuate outbreaks and deaths in LTCFs.

Many Asian countries have had moderate success in containing the pandemic and minimizing mortalities in the community and LTCFs.[3] However, this relative success has made the transition to an endemic state harder for the vulnerable LTCF sector. Many LTCFs in Asia maintain stricter visitor protocols than prevailing societal restrictions,[4,5] and the resumption of in-person visits often lags behind societal reopening.[6] Although many societies have transitioned to "living with COVID-19,"[7] LTCFs may find it harder to pivot away from a zero COVID-19 approach.[3,8]

The effects of prolonged visitor restrictions and social isolation on the well-being and mental health of LTCF residents have been widely reported during the pandemic.[8] Although temporary visitor and activity suspensions may have been deemed necessary and worthwhile to attenuate mortality and morbidity, the prolonged pandemic begets the question of whether quantity of lifespan is worth the trade-off in diminished quality of life.[9]

We suggest the following considerations as LTCFs find their own path toward endemicity.

1. Person-centered care approach for residents and staff. In LTCFs, staff, residents, and their loved ones should be involved in discussions about what living with COVID-19 means to them. This includes contingency plans for outbreaks, permitting safe visits for the terminally ill even amid an outbreak, and evaluating the utility of hospital transfers for the critically ill with COVID-19 who do not benefit from intensive care. Society and policy makers should not be reactionary to COVID-19 numbers and mortalities. For example, disallowing resident readmissions when there is a rise in COVID-19 infections detected in the LTCFs can lead to increased bed occupancy in hospitals, without necessarily controlling the spread of COVID-19. Qualitative considerations may not be reflected in case counts alone. Advance care planning remains imperative in the management of LTCF residents with or without a pandemic.
2. Long-term view of resource allocation toward LTCFs. Infection control measures that include the use of personal protective equipment, increased frequency and intensity of disinfection, and medical reviews or hospital transfers consume significant financial and manpower resources. These have been necessary to contain the pandemic in LTCFs. However, the opportunity costs of channeling these resources toward COVID-19 prevention as opposed to engagement programs, care provision, social activities, and infrastructure to enhance quality of life and care in LTCFs must be factored into policy planning for this sector.

The path ahead for LTCFs in an endemic COVID-19 is less straightforward given the vulnerable nature of this setting. Differentiated measures from the rest of society are not unreasonable. However, rapid changes and inconsistencies in visitor policies and approach to COVID-19 can lead to fatigue and disengagement of residents, loved ones, staff, volunteers, and the public. High vaccination rates and herd immunity will help with minimizing mortalities and morbidities, which remain an important goal of care for LTCFs. Nevertheless, the rubrics of LTCF mortalities and case counts alone during a prolonged pandemic need to be reviewed. Important conversations on the quality of life and trade-offs need to take place among various stakeholders including health care management teams, policy makers, staff, residents, and their loved ones to decide on finding the balance amid a prolonged and constantly evolving health care challenge.

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Spiritual Health Predicts Improved PHQ-9 During COVID Isolation in Extended Care Facility Patients

To the Editor:

The COVID-19 pandemic is exacting a toll in terms of illness, death, and disruption, especially for residents of extended care facilities (ECFs), who are at very high risk of morbidity and mortality from the virus. For their own safety, when community transmission is high or when outbreaks occur in their facility, ECF residents are severely restricted from contact with the community, their families and friends, and from each other and staff.[1]

In the ECF environment, COVID-19–related restrictions have the potential to cause even more isolation.[2] Well-being declines when basic social needs are not met.[3] Older people are particularly prone to social isolation, increasing their risk for decline in mental well-being.[2]

People turn to spirituality in times of crisis and uncertainty as a coping mechanism.[4] Compared with religious belief and practice, spirituality is a connection with the sacred, enhancing hope, peace, meaning, and purpose.[5] It can provide a positive, hopeful worldview, offering indirect control over circumstances, thus reducing depression and anxiety.[4]

Our preliminary study looked at whether spirituality offered protection from the psychological strains resulting from increased social isolation of ECF residents occasioned by COVID-19–related restrictions.

Methods

This project was approved by the Reid Health Institutional Review Board. The 124 residents of 2 extended care facilities were screened for eligibility to participate in the study by reviewing their latest documented Brief Interview for Mental Status (BIMS). Residents with BIMS scores greater than 12, indicating adequate cognitive capacity to consent, were invited to participate.[6,7] Two patients declined, and 1 was unable to participate, yielding n = 24 participants (13 female and 11 male; mean age = 74.9 years; 96% White). Each was met individually to explain the project and obtain consent.

For a pre-isolation assessment of emotional well-being, we used participants' Patient Health Questionnaire-9 (PHQ-9) scores obtained nearest in date prior to the initiation of the protective quarantine in March 2020. If admitted after that date, we used their admitting PHQ-9 score as the initial score. We used a second PHQ-9 score obtained within 30 days before commencement of the study (December 2020). We subtracted participants' second PHQ-9 (quarantine) score from their first PHQ-9 (prior to quarantine) score to obtain a measure of change in functioning (see Figure 1).

To measure spirituality, we met with participants to complete the Functional Assessment of Chronic Illness Therapy–Spiritual Wellbeing–Non-Illness (FACIT-SP-NI).[5] The FACIT-SP-NI Total score indicates overall spiritual well-being, with subscales for Meaning (eg, having a life purpose) and for Faith (eg, finding comfort in one's own faith).[5]

We used Microsoft Excel (2016) to run descriptive statistics and simple linear regressions, with $P < .05$ significance.

Results

Change in PHQ-9 scores ranged from 7 points improved emotional well-being to 9 points worsened well-being during the quarantine isolation. Initial PHQ-9 predicted the subsequent PHQ-9 ($R^2 = 0.60$, $P < .01$).

Stronger spiritual well-being (Total FACIT-SP-NI score, $R^2 = 0.18$, $P < .05$), as well as stronger overall sense of meaning (Meaning subscale, $R^2 = 0.16$, $P = .05$), predicted improved PHQ-9 scores from prior to the quarantine isolation. Stronger faith was not statistically significant in predicting changes in PHQ-9.

Discussion

This preliminary study with residents of 2 extended care facilities found that stronger spirituality predicted improved PHQ-9 from March 2020 to December 2020, during quarantine precautions. Considering other research conducted during COVID-19, a Brazilian study found that adults who relied on their religion and spirituality experienced better mental health.[8] A French study found lower scores on the 2-item French version of the PHQ-9 (HQP-2) for those with stronger spirituality, though this study did not look at changes in spirituality from before the pandemic.[9] Taken together, these results point toward a more general finding well established before the conditions of the pandemic—spirituality is associated with better health outcomes. Our preliminary study suggests spirituality may help preserve residents of extended care facilities from the challenges of isolation during the COVID-19 pandemic.

Key limitations include the small sample size who met the criteria to participate and limitations to geographic, demographic, and racial diversity. Additionally, some of the participants were admitted to the facilities during the COVID-19 pandemic, so their initial PHQ-9 may have reflected their home circumstances during the quarantine. Therefore, our results should be validated by further study in a larger cohort of facilities with greater geographic and ethnic diversity, and in subjects with lower cognitive scores.

Even with these limitations, our results extend research supporting the positive impact of spirituality on health and resilience to health events before the end-of-life process.[10]

The authors declare no conflicts of interest.