

Aging in Place Social Justice

RFP for Coronavirus State and Local Fiscal Recovery Funds

The Council on Aging of Buncombe County, Inc.

Dear Heather Bauer Heather N Bauer
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Application Form

Question Group

Buncombe County requests proposals for projects to help the community recover from and respond to COVID-19 and its negative economic impacts.

Buncombe County has been awarded \$50,733,290 in Coronavirus State and Local Fiscal Recovery Funds (Recovery Funding), as part of the American Rescue Plan Act. This infusion of federal resources is intended to help turn the tide on the pandemic, address its economic fallout, and lay the foundation for a strong and equitable recovery.

Buncombe County is committed to investing these funds in projects that:

- Align to county strategic plan and community priorities
- Support equitable outcomes for most impacted populations
- Leverage and align with other governmental funding sources
- Make best use of this one-time infusion of resources
- Have a lasting impact

Proposals shall be submitted in accordance with the terms and conditions of this RFP and any addenda issued hereto.

[Click here for the full terms and conditions of the RFP](#)

Coronavirus State and Local Fiscal Recovery Funds*

Name of Project.

Aging in Place Social Justice

Amount of Funds Requested*

\$242,825.00

Recovery Fund Eligible Category*

Please select one:

Services for disproportionately impacted communities

Brief Project Description*

Provide a short summary of your proposed project.

Council on Aging of Buncombe County (COA) social workers & aging service specialists will provide human service, screening, enrollment & assistance for subsidies, and care coordination for building resilience, well-being & social engagement. Our home-based service model will focus on victims of elder abuse (scams, fraud, abuse, neglect, self neglect & exploitation), people who live alone, the homebound, family caregivers,

low income Medicare beneficiaries (including dual eligibles), rural seniors, the LGBTQ aging adult population and people living with cognitive impairments. We will provide no cost services, work with businesses and organizations for community asset mapping, public education, volunteer engagement, support & skills training for families; we recognize local businesses as vendors who offer equitable fee-based services when free services are unavailable. We can increase service yield, boost pay, create positions, & make sustainable, equitable aging in place improvements.

Project Plan*

Explain how the project will be structured and implemented, including timeframe.

This is a 2-year proposal; we can begin immediately and implementation is ongoing. The project would supplement our core programs - Resource Coordination, Senior Dining, Medicare services, Volunteer Development. Targets/outcomes in results section; data will be tracked in agency database, among partners and through surveys. We will work with clients from a single point of contact (call) through care management (ongoing), distribute monthly food boxes, provide monthly community educational sessions with partners, deliver/distribute food and supplies at least twice per month, perform follow-ups, provide transportation, etc. upon request (based on client need and availability of staff/volunteers). COAbc staff would connect impacted individuals to legal services, digital inclusion devices & training, cleaning services; assist with applications for subsidies & other benefits programs, enrolling in housing repair programs; facilitate volunteer support & address other areas of need (such as moving, filing police reports, providing resources for skills training, employer education) and monthly web maintenance. COAbc will partner with Dementia Friendly WNC (DFWNC) to enhance their community education sessions with increased information about risks for elder abuse, work with Blue Ridge Pride's Generation Plus to engage the LGBTQ population, educate churches and community center staff, and build out our support of aging adults, caregivers and adults with disabilities who may be limited in what services are available to them due to cost, age, waitlists, service gaps or barriers due to traditional eligibility criteria, funding availability and/or proximity to community services (especially in rural areas). We would expand our homebound food delivery program with shelf-stable foods, produce, and supplies as available (for cleaning, incontinence, pet food, cell phones, etc.). Staff and volunteers would travel within Buncombe County to meet with clients in their homes, conduct educational classes & exercise programs, consult with partners, deliver food & other products. Trained volunteers would provide peer support, offer transportation, and companionship. We work with Age Friendly groups, such as DFWNC, Housing Options for Aging in Place, the Elder Justice Coalition and the Experienced Workforce Initiatives on a monthly basis to create public education resources, gather data, and create referral systems that strengthen our ability to identify needs. In addition to building volunteer infrastructure within our organization, we will work with vendors who offer reduced rates when free services are unavailable], through vendor contracts. This is an opportunity for community capacity building to meet increased needs of community members to age in place. Identified vendors will be recognized as Dementia Friendly and will be vetted to provide these services to vulnerable adults as identified by social workers and scheduled for optimal response and results.

Statement of Need*

Describe the need that this project will address. Include data to demonstrate the need, and cite the source of the data.

Due to the public health crisis, there is a sudden demand for resources & security amidst a booming trend, a need to expand traditional funding & eligibility for aging & caregiver services, and severe economic & social tolls on a disproportionately impacted population. Over 23% of survey results show need for aging in place/educated & capable community. The need exists in data from the County 2020-2025 Strategic Plan - rising median age, rising burden of chronic conditions, growing cost of living, growing spending on healthcare, and more. Currently >60% COAbc clients are 100% -150% poverty level or below. In Buncombe County (BC), ppl age 65+, 28.7% (county profile) live alone, 31.8% live with disabilities, and over 10% did not graduate from high school. Poverty rates increase toward older age (American Community Survey).

According to the US Census Bureau, SNAP is responsible for a decline in the US poverty rate and lifted 2.5 million people out of poverty in 2019. Aging is the greatest risk factor for the development of dementia & our county is aging rapidly, with a 31% increase in people 65 -74, 106% increase in ages 75 -84, and a 90% increase in ages 85+ expected by 2036 (County profile). The average caregiver is a woman in her 40s, caring for parents and children while continuing to work (Family Caregiver Association). According to APS, in 2020 they received 2,000 reports and approx 2/3 were screened in. While 2021 data is not yet available, we have been assured by APS they are busier. Of those 2/3 screened, 27% are substantiated by criteria, meaning approximately 16% of reporting individuals are served by APS (if they accept the help). This project is an integrative, cross-sector scope of collaboration to meet a broad range of need. Caregivers (avg being female - caring for children & parents, 40-50yo, working with health concerns) & individuals who don't meet traditional funding criteria away (others <60) may not know where to turn and fall in the cracks.

Link to COVID-19*

Identify a health or economic harm resulting from or exacerbated by the public health emergency, describe the nature and extent of that harm, and explain how the use of this funding would address such harm.

See attached - JMIR Aging 2021. Older adults were hardest hit. COVID has increased, social isolation, economic burdens, respite and living options, civic engagement, and how one accesses service and support - particularly among adults with cognitive impairments, marginalized groups & caregivers. We recognize increased need for support in determining Power of Attorney, advance directives, evictions, & other legal needs during a time where disaster scams, interpersonal violence, economic and social threats are on the rise. Harm would be mitigated by addressing hunger, poverty, caregiver support, social health & home safety with interdisciplinary framework. Common service centers remain limited or closed, we have seen triple the client demand, & need to grow our workforce. The NC Coalition on Aging has listed recommendations to protect the most vulnerable older adults for 2021, of which one is to "address food insecurity for seniors by supporting...innovative programs initiated during COVID-19". Without additional funding, for example, we would reduce the number of seniors we deliver food to by over 33%. The need, availability of essentials, coupled with inflation have created limitations with current funding & capacity. Social security is still the primary source of income for people age 65 and older (American Community Survey) and these fixed incomes create challenges and force individuals to choose between paying for food, medications, transportation, utilities, & other costs - particularly worsened by availability of products & services in tandem with accessibility issues. For adults across the spectrum, the pandemic has made it more difficult to receive paid care or remain/rejoin workforce due to burden & employment crisis. Hardships in home, businesses & nonprofits are worsening delays in receiving service and the ability to navigate resources reliably - reinforcing isolation, inequities, fear, long wait lists, risks for depression, abuse & poor health outcomes.

Population Served*

Define the population to be served by this project, including volume and demographic characteristics of those served.

In short, we will serve adults age 50+, including low-income Medicare beneficiaries/dual eligibles, people living with dementia, family caregivers, homebound, and those at increased risk for abuse (such as the LGBTQ community as well as those living with cognitive impairments, living alone or those who have had reductions in service and support during the pandemic). Older adults (age 65+) represent over 20% of Buncombe County and aging is the greatest risk factor for developing Dementia. More than 20,000 people in WNC are estimated to be living with dementia, and 56,000 family caregivers (DFWNC research). We know that cognitive impairment (CI) increases risks for neglect, abuse, & exploitation. Pandemic aside, studies show that for 1 report of elder abuse, 13 go unreported. 1 in 3 older adults can't afford to pay for utilities, rent, medication or food; there are budgetary squeezes to meet the current demand among providers, yet the need continues to grow. Adults age 50-59 need more help planning to age in place securely. According to Blue Ridge Pride, LGBT adults from older generations lived under severe stigmatization of their identities. 34%

report concerns that they will need to hide their identify if they need to seek supportive housing. 67% report fear of neglect, and 60% fear verbal and physical harassment. 52% believe they would have been forced to hide their LGBT identity in long-term care settings. According to the latest United States census, the Asheville area has 83% more lesbian, gay bisexual and transgendered (LGBT) identified people than the typical American city or town. Another study, in 2011, also based on the latest official census results, found that Buncombe County (BC) (with 15.5 same sex couples per 1,000) and Asheville (19.7 per 1,000) are the most gay-friendly county and city in the state of North Carolina - "12th gayest city in America." These characteristics speaks volumes to the dangers & challenges ahead if not addressed with urgency.

Results*

Describe the proposed impact of the project. List at least 3 performance measures that will be tracked and reported. If possible, include baselines and goals for each performance measure.

COAbc will strengthen the resilience & capability of the defined population to age in place in a safe, welcoming, knowledgeable community through improved outreach, partnerships, and COAbc services and supports. We will enhance capacity of programs to meet the high level of ongoing need to address elder abuse, hunger, social isolation, safety risks, digital literacy, housing stock, & financial insecurity. We will build volunteer-based infrastructure, educate employers and organizations, and address social justice among this population. COAbc will track reports of abuse as well as household & client outcomes: 1) Increased confidence in accessing service & support 2) Maintain or increase original activity levels 3) Maintain or improve upon original nutritional status 4) Report an improved ability to stay out of institutionalized care 5) Feel successful in navigating resources available 6) Will have cost savings. We will track the types of support provided to effectively target needed services in coming years. Community education programs will build awareness, reduce stigma, teach communication strategies, & provide information on risks for abuse. Over the last 2 years, our Elder Justice Navigator saved clients in excess of \$35,000 in legal services & over \$75,000 in subsidies and assistance programs. COAbc plans to expand access to service & support for 200 new clients across programs. COAbc will assist 1200 callers with information & provide support to a minimum of 40 new caregivers. We will educate a minimum of 20 organizations (with multiple sessions for each organization) to be recognized as a Dementia Friendly business. We will measure comfort levels and knowledge obtained with surveys. We aim to improve web and social media traffic with new and upgraded virtual outreach methods, reaching 200 new site visits per year to Dementia Friendly WNC and Council on Aging of Buncombe County as well as building technology access with tech help for telehealth & connection.

Evaluation*

Describe the data collection, analysis, and quality assurance measures you will use to assure ongoing, effective tracking of contract requirements and outcomes.

We will use the new agency database, client and community surveys, cost savings data, as well as vendor feedback, and collaborative data (ie Adult Protective Services). We will track the number of individuals served, number of participants in education sessions, number of businesses and organizations receiving education, cost savings (particularly to legal help and subsidies) as well as volunteer hours and mileage. We will track demographics and data relevant to our outcomes through initial client assessments, ongoing client visits and upon discharge. We will track referrals (incoming and outgoing), sources, and success stories from clients and their families. We will use the Zarit Caregiver Burden survey with caregivers, as well as self-evaluation tools to identify the client's perceptions of how well we have provided the service. We will compare the number of adults we are able to serve to historical numbers, as well as ensuring that we maintain all accurate financial reports to demonstrate the funding capability and the power of this funding to help us meet our goals. We will use virtual and in-person methods to reach the public as well as clients. We will track advertising results through web impressions and other reporting data. We will complete profiles for clients in direct services. We use initial data from consultations to gauge risk levels for malnutrition, abuse, falls, injuries, likelihood of premature institutionalization or eviction, etc. We will gauge the usage

profile of potential clients of community services and supports, how they were referred to us, and which services they accepted or refused throughout the year to compare to baseline. Our evaluation will connect quantity & quality measures, as well as the impact of our outreach, accuracy of applications, & ability to interpret data to inform future projects. Past success - COA bc clients saved >\$75,000 in benefits through the Elder Justice project in 2yrs and we had over 550 contacts.

Equity Impact*

How will this effort help build toward a just, equitable, and sustainable COVID-19 recovery? How are the root causes and/or disproportionate impacts of inequities addressed?

Our project is a social driver that addresses poverty, hunger, isolation and other social determinants of health. The project team offers a multidisciplinary safety net that brings research, education, information, resources, clinical and non-clinical perspectives that set us up for success. We are keying into a demographic that has also experienced a "perfect storm" in the post acute COVID world, such as difficulty communicating with medical professionals and navigating resources in the wake of fear, isolation, economic burden, decline in health status and reduction in social support. We are advocating for a group that is often overlooked, experiences hidden symptoms of disease, and also are less likely to seek help than those who are functioning at a normal capacity. COA bc & partners bring civic engagement, community education, direct service, non-profit resources, grassroots organizations & vendors together to enhance lives of individuals, families and on the community level. By addressing stigma, increasing volunteer engagement, advocating during care transitions, creating care plans that are designed to empower self-efficacy as well as bringing essential services & resources into the home (that are often otherwise cost-prohibitive or otherwise unattainable), we build long-term solutions for health, safety and well-being (such as lifetime cost savings, preventing falls and premature institutionalization, caregiver skills, improved communication & BC capability). Our unique blend of experiences has brought us focus on diversity, equity and inclusion. We embrace opportunities to integrate service, education and advocacy through collaboration and understanding of the subgroups that are most greatly impacted. Recovery depends on addressing this rapidly aging County, our human rights for social justice, asset mapping, common inequities of this diverse group of people and building resilience to make a generational impact aligned with the County's plan.

Project Partners*

Identify any subcontractors you intend to use for the proposed scope of work. For each subcontractor listed, indicate:

- 1.) What products and/or services are to be supplied by that subcontractor and;
- 2.) What percentage of the overall scope of work that subcontractor will perform.

Also, list non-funded key partners critical to project.

Funded partners include a local grassroots group, Dementia Friendly WNC that we serve as fiscal sponsors for as well as vendors/businesses, at approximately 30% of overall grant as follows: Dementia Friendly WNC (DFWNC) will offer community education sessions to businesses, organizations and churches, pay mentors and peer support volunteers stipends for their work, enhance a service directory and resources on their website, as well as garner engagement opportunities, including memory cafes and working with 10 new Dementia Friendly businesses and providing education to all COA bc staff & volunteers, and working with other volunteer groups who provide community health and home visits. Bio One, Wildwood Herbal, Verizon Wireless, SimplyChange, and Watkins Supershine are examples of businesses that have committed to becoming Age Friendly and who will provide vendor services for cleaning, downsizing, decluttering, digital inclusion, food and sanitation at reduced rates. These funded partners will receive payments for programming and services from this budget. AARP and GenerationPlus have agreed to work with us on community education, building a volunteer workforce, and ensuring outreach for LGBTQ community among other adults served by the grant - not funded partners. Among others, MANNA FoodBank, Pisgah Legal,

Habitat for Humanity, MAHEC Home Based Primary Care, Mountain Mobility, AdventHealth and Western Carolina University School of Nursing are examples of existing referral partners to assist with connecting community dwelling adults to services and receiving appropriate referrals into their programs - not funded partners. We continue to work closely with Land of Sky Regional Council, Buncombe County DHHS and other charitable organizations for referrals and through various Age Friendly workgroups for recognition, referrals and streamlined service approach for no wrong door communication and collaboration to connect individuals appropriately-not funded partners.

Capacity*

Describe the background, experience, and capabilities of your organization or department as it relates to capacity for delivering the proposed project and managing federal funds.

We have served Buncombe County seniors since 1964, have earned a Gold Seal of Transparency on GuideStar, and our leadership team is comprised of professionals with appropriate experience, skills, training and certifications respectively. We are the go-to source for information and navigation for resources, serve 7 other counties with several of our programs, and are members of a variety of coalitions at the state and national level for all things aging. We manage a \$1+M budget in a typical year and in 2020-2021 we pivoted to expand suddenly with a budget just over \$2M. COAbc has been managing federal funds for many of its key programs, with over 60% of overall funding coming from the government as providers for Home & Community Block Grant programs (Congregate Nutrition, Information & Assistance, Housing and Home Improvement, Consumer Directed Services, In Home Aide, Institutional Respite), through Older American's Act (including Family Caregiver Support contracts), and a CARES Act, HDC5 & Families First Coronavirus Act funded organization. We provide SHIP services with the NC Department of Insurance Services and Social Security Administration, work as a NCOA benefits enrollment center, and as a certified Affordable Care Act navigator program through the NC Consortium. Our staff includes social workers, trained aging service specialists, and we work closely with Buncombe County Department of Health and Human Services, Land of Sky Regional Council and many other partners, including MANNA FoodBank, PisgahLegal, Asheville Area Habitat for Humanity, MAHEC's Home Based Primary Care, National Church Residences (HUD housing) and others as part of our network. We lead the Buncombe Aging Service Alliance, subcontract with cleaners/farmers/home care agencies and contract caregivers, as well as serve on multiple steering teams for projects such as the Age Friendly Buncombe Advisory, Elder Justice Coalition, Dementia Friendly WNC, and Experienced Workforce Initiative

Budget*

Provide a detailed project budget including all proposed project revenues and expenditures, including explanations and methodology. For all revenue sources, list the funder and denote whether funds are confirmed or pending. For project expenses, denote all capital vs. operating costs, and reflect which specific expenses are proposed to be funded with one-time Buncombe County Recovery Funds.

Download a copy of the budget form [HERE](#). Complete the form, and upload it using the button below.

Council on Aging Recovery Request.xlsx

Special Considerations*

Provide any other information that might assist the County in its selection.

COVID19 on Older Adults.pdf

This project is meant to become a self-sustaining community-based effort through an appropriate education, training, service and workforce development model for collective impact. It touches on the

following: Educated & Capable Community, Environmental Stewardship (support of local farms, food systems and education) Resident Well-Being and Vibrant Economy. We have made conscious decisions as to how the program may be sustained beyond this short term opportunity, including the ongoing impact of education, skill building, expanding individual, organizational & community resilience. COAbc also continues to seek ongoing funding support outside of block grant & aging services, through foundations, sponsors and donors. We are committed to furthering collaboration, making the best use of available funding. We continue to grow leadership, staff & volunteers as we expand on programs & services that meet these needs and build infrastructure. DFWNC has sustained a model for providing community education since its inception in 2015. They have educated over 400 individuals face-to-face, & 100 this past year virtually. DFWNC is an adaptable organization and will be more so with an upgraded website & enhanced educational materials. We currently have effective processes in place such as an application & dementia friendly business evaluation. Together we will achieve results that last into the future, including the continued dementia friendly practices integrated into businesses & organizations, the capability of caregivers & volunteers, as well as impact on the care economy. The specific sustainability of this project will include continuing these services beyond this period, utilizing lessons learned as a springboard for broadening our reach, & furthering our impact in the "ripple" effect of having businesses, organizations & community members living Dementia friendly principles in the years to come. With increased awareness & reduced stigma, our community evolves. Thank you.

File Attachment Summary

Applicant File Uploads

- Council on Aging Recovery Request.xlsx
- COVID19 on Older Adults.pdf

**Coronavirus State and Local Fiscal Recovery Funds
Proposed Project Budget**

Organization Name:	Council on Aging of Buncombe County, Inc.
Project Name:	Aging in Place Social Justice
Amount Requested:	\$242,825

Proposed Project Revenue Funder	Amount	Confirmed or Pending?	Notes
Proposed Buncombe COVID Recovery Funds	\$ 242,825.00	Pending - 2 yr	This funding would enhance the infrastructure of our proposed activities to supplement vendor/professional services, personnel, increase budget for equipment, supplies, outreach and advertising, stipends for volunteers and other costs
WNC Bridge Foundation	\$ 66,650.00	Pending - 1 yr	These funds would be for the partnership with COA and Dementia Friendly WNC (DFWNC) for partial funding toward salary, payroll of Elder Justice Navigator, vendors, supplies, advertising for Elder Justice Navigator and services for people living with
National Council on Aging	\$ 120,000.00	Pending - 2 yr	App submitted for a sustainability grant for Benefits Enrollment Center; we have been funded since 2017 consistently at this level or above for the Benefits Enrollment portion of this work - the grant budget is tight for activities outside of personnel (100%
Local Churches	\$ 9,000.00	Confirmed - 1 yr	Churches provide funding toward homebound food delivery and pantry services in the community and at HUD housing
Private Sources	\$ 20,000.00	Confirmed - 2 yr	Unrestricted donor support toward food and other supplies to be provided through homebound food delivery and as needed assistance to low-income at-risk adults through our Resource Coordination program
MANNA FoodBank (National Council on Aging)	\$ 25,000.00	Confirmed -19 mos	MANNA FoodBank SNAP Senior Enrollment passthrough from NCOA
Foundations	\$ 170,480.00	Pending - 2 yr	Potential applications to cover additional costs for care management and supplies
List other sources here			
List other sources here			
List other sources here			
List other sources here			
List other sources here			
Total	\$ 653,955.00		

Proposed Project Expenses	Proposed	Other Funds	Total	Capital or Operating	Notes
Elder Justice Navigator - Salary & Fringe	\$ 44,000.00	\$ 30,000.00	\$ 74,000.00	Operating	
Volunteer Services Specialist - Salary & Fringe	\$ 21,461.00	\$ 71,134.00	\$ 92,595.00	Operating	Front line COA/abc Personnel (Salary and Fringe) Volunteer Services Specialist to recruit, onboard, train and develop community volunteers and offer COA and community volunteer placements for an age diverse workforce
Vendor (Professional Fees)	\$ 40,000.00	\$ 32,500.00	\$ 72,500.00	Operating	Cost of fresh local produce, delivery services, environmental services, moving services and other identifiable fee-based services with reduced vendor rates (payable to professional service providers)
Printing & Copying	\$ 4,000.00	\$ 1,500.00	\$ 5,500.00	Operating	Printing of educational materials and duplication of resources for education and outreach, client files, etc.
Supplementals	\$ 20,000.00	\$ 20,000.00	\$ 40,000.00	Operating	Purchasing shelf stable goods and liquid nutrition for homebound and at risk deliveries, fans, grab bars, ACs and heaters for at risk clients, pet food, and paper goods (toilet paper, paper towels)
Advertising/Media	\$ 7,000.00	\$ 3,500.00	\$ 10,500.00	Operating	Costs of Newspaper, Broadcast and Digital advertising of project
Direct Programming: Dementia Friendly WNC	\$ 3,000.00	\$ 4,985.00	\$ 7,985.00	Operating	DFWNC payables for programming and website development (COA/abc serves as Fiscal Sponsor and would pay invoices upon receipt)
Volunteer Stipends	\$ 10,000.00	\$ 10,000.00	\$ 20,000.00	Operating	Maximum \$500 per volunteer per year at \$3.50/hour of in-home and community volunteer support (companionship, transportation, peer support, food packing, supply delivery, educational mentors, etc.)
Personal Protective Equipment	\$ 2,000.00	\$ 3,000.00	\$ 5,000.00	Operating	Masks, gloves, face shields
Volunteer Mileage	\$ 2,000.00	\$ 4,000.00	\$ 6,000.00	Operating	Mileage: Delivering food, supplies, to/from community education sites, to/from client homes and on errands
Staff Mileage	\$ 2,000.00	\$ 5,000.00	\$ 7,000.00	Operating	Mileage: Client visits, delivering food and supplies, to/from community education sites, partner and constituent meetings
Telephone/Internet	\$ 4,000.00	\$ 3,000.00	\$ 7,000.00	Operating	Monthly WiFi, Cellular and VOIP services as applicable for staff and volunteers
Equipment & Supplies	\$ 10,000.00	\$ 17,000.00	\$ 27,000.00	Operating	supplies (disinfectant, etc., bed bug solutions, incontinence supplies)
IT Support/Website	\$ 1,200.00	\$ 400.00	\$ 1,600.00	Operating	COA/abc website work (\$80/hr) and IT consulting for network, user support and database at \$50-\$75/hr
Rentals	\$ 4,800.00	\$ 10,000.00	\$ 14,800.00	Operating	Hourly or daily rental of trucks, equipment, monthly storage space for food distribution, handling and delivery
Telephone/Internet Subsidies	\$ 20,000.00	\$ 13,111.00	\$ 33,111.00	Operating	Costs of devices and security for Digital Inclusion Subsidies for clients (Verizon Digital Inclusion Package)
Benefits Enrollment Initiatives	\$ 23,081.50	\$ 145,000.00	\$ 168,081.50	Operating	Premium wages and programming support for public information, panels, volunteer training, community education (COA/abc programming)
10% De Minimis (Indirect)	\$ 24,282.50	\$ 37,000.00	\$ 61,282.50	Operating	Administration of existing and projected funding where applicable (10% de minimis)
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
List expenses here			\$ -		
Total			\$ 653,955.00		

Review

Impact of the COVID-19 Pandemic on Older Adults: Rapid Review

Audrey Lebrasseur^{1,2}, MOT; Noémie Fortin-Bédard^{1,3}; Josiane Lettre¹, MSc, MOT; Emilie Raymond^{1,3}, PhD; Eve-Line Bussièrès^{1,4}, PhD; Nolwenn Lapierre^{1,2}, PhD; Julie Faieta^{1,2}, PhD; Claude Vincent^{1,2}, PhD; Louise Duchesne^{1,5}, PhD; Marie-Christine Ouellet^{1,6}, PhD; Eric Gagnon^{7,8}, PhD; André Tourigny^{7,9}, MD; Marie-Ève Lamontagne^{1,2}, PhD; François Routhier^{1,2}, PhD

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Abstract

Background: The COVID-19 pandemic has drastically changed the lives of countless members of the general population. Older adults are known to experience loneliness, age discrimination, and excessive worry. It is therefore reasonable to anticipate that they would experience greater negative outcomes related to the COVID-19 pandemic given their increased isolation and risk for complications than younger adults.

Objective: This study aims to synthesize the existing research on the impact of the COVID-19 pandemic, and associated isolation and protective measures, on older adults. The secondary objective is to investigate the impact of the COVID-19 pandemic, and associated isolation and protective measures, on older adults with Alzheimer disease and related dementias.

Methods: A rapid review of the published literature was conducted on October 6, 2020, through a search of 6 online databases to synthesize results from published original studies regarding the impact of the COVID-19 pandemic on older adults. The Human Development Model conceptual framework–Disability Creation Process was used to describe and understand interactions between personal factors, environmental factors, and life habits. Methods and results are reported following the Preferred Reporting Items for Systematic Reviews and Meta-analyses Statement.

Results: A total of 135 records were included from the initial search strategy of 13,452 individual studies. Of these, 113 (83.7%) studies were determined to be of level 4 according to the levels of evidence classification by the Centre for Evidence-Based Medicine. The presence of psychological symptoms, exacerbation of ageism, and physical deterioration of aged populations were reported in the included studies. Decreased social life and fewer in-person social interactions reported during the COVID-19 pandemic were occasionally associated with reduced quality of life and increased depression. Difficulties accessing services, sleep disturbances, and a reduction of physical activity were also noted.

Conclusions: Our results highlight the need for adequate isolation and protective measures. Older adults represent a heterogeneous group, which could explain the contradictory results found in the literature. Individual, organizational, and institutional strategies

should be established to ensure that older adults are able to maintain social contacts, preserve family ties, and maintain the ability to give or receive help during the current pandemic. Future studies should focus on specific consequences and needs of more at-risk older adults to ensure their inclusion, both in public health recommendations and considerations made by policy makers.

(*JMIR Aging* 2021;4(2):e26474) doi: [10.2196/26474](https://doi.org/10.2196/26474)

KEYWORDS

COVID-19; impact; rapid review; older adults; aged individuals; review

Introduction

Background

Since the end of 2019, the SARS-CoV-2 outbreak has resulted in more than 71 million cases worldwide, as of December 16, 2020 [1]. Isolation and protective measures have been established by governments to varying extents around the world in order to mitigate the spread of the virus. These measures include physical distancing, use of face masks, handwashing, stay-at-home policies, and restrictions on social gatherings [2,3]. As a result, the general population has experienced drastic changes in day-to-day life [4]; high COVID-19-related fear [5]; and numerous psychological outcomes such as depression [6], increased sleep problems [7], and financial worries [8].

However, the extent to which the effects of COVID-19 reported by the general population are experienced by the aging population is not well documented. Isolation and protective measures are crucial for the aging population, who are at greater risk of COVID-19-related death [9]. However, isolation and protective measures may also amplify issues that are already present in older adults, such as loneliness, age discrimination, and excessive worrying [10-12]. Considering that physical distancing inevitably leads to some degree of social isolation, speculation towards the pernicious impact of physical distancing on the mental health, daily activities [12], and cognitive decline of older adults [11] is warranted. The COVID-19 pandemic may also amplify age discrimination by negatively impacting access to information, health care services, and support to informal caregivers and familial advocates [13,14].

According to the existing literature, although many older adults are now online [15,16], the majority still need assistance when using digital technologies and to access and assess information [17]. Furthermore, most vulnerable older adults do not have access to web resources or the required digital skills and knowledge for its use to be satisfying and efficient [15,18]. Digital technology is thus insufficient to reach vulnerable populations such as older adults [19].

The fear of contracting the virus could be an additional source of concern for this population, thus contributing to the overall anxiety—a mental health outcome already known to negatively affect the quality of life in older adults [10]. Thus, it is possible that the immediate and long-term effects of the COVID-19 pandemic are heightened for older adults as compared to other age demographics.

Since the beginning of the pandemic, there has been substantial concern surrounding older adults living in nursing home [20]. The percentage of nursing home residents with Alzheimer disease or other types of dementia is significant, reported to

range between 45% and 75% [21-23]. It is possible that people with Alzheimer disease or other dementias are experiencing greater negative outcomes related to the COVID-19 pandemic.

A better understanding of the unique experiences of older adults during the pandemic is needed in order for governing bodies and health care providers to design adequate policies [13] and services as we advance. Therefore, data specific to the needs of older adults within the context of the present COVID-19 pandemic are urgently needed.

Objectives

The aim of this study is to synthesize the existing research on the impact of the COVID-19 pandemic, and associated isolation and protective measures, on older adults. Furthermore, we aim to investigate the impact of the COVID-19 pandemic, and associated isolation and protective measures, on older adults with Alzheimer disease and related dementias.

Methods

Protocol

Given the urgent need for adequate information, a rapid review protocol was chosen. This type of review is conducted using an accelerated systematic review method, which limits certain aspects of the methodology in order to provide evidence within a policy maker's timeframe [24,25]. This approach aligns with the available guidance for Cochrane Rapid Review Methods Group [25] and with the Practical Guide for Rapid Reviews to Strengthen Health Policy and Systems [26]. Methods and results are reported following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) Statement [27]. The protocol for the present review was registered within the PROSPERO database (ID: CRD42020201814).

Conceptual Framework

The Human Development Model–Disability Creation Process (HDM-DCP) conceptual framework was used to describe and understand interactions between personal factors, environmental factors, and life habits [28]. The HDM-DCP model acknowledges the impact of the environment and the person on the execution of life habits. Personal factors include identity (facilitator or obstacle), organic systems (integrity or impairment), and capabilities (ability or disability). Environmental factors are stratified into societal (facilitator or obstacle), community (facilitator or obstacle), and personal (facilitator or obstacle) levels. Life habits consist of daily activities (social participation situation or disabling situation) and social roles (social participation situation or disabling situation). Each of these elements can be seen as a protective factor or as a risk factor for the individual. The HDM-DCP

framework allows observation of changes in these domains over a period of time (eg, the span of the COVID-19 pandemic). The framework puts into evidence social participation and social contacts, both of which may be greatly affected by pandemic-related isolation and protective measures.

Literature Search

Search strategies were developed by two authors (AL and NFB) and reviewed by two other authors (FR and ML). These strategies centered around three concepts: “COVID-19,” “older adults,” and “impact.” The concept “COVID-19” was used to restrict the obtained results to those related to the present pandemic. According to the World Health Organization [29], older adults include people of 60 years of age and older. Therefore, in this study, the concept “older adults” included people aged 60 years and older, without excluding any diagnoses or conditions. The concept “impact” encompasses all three domains of the HDM-DCP model (ie, personal factors, environmental factors, and life habits) [28]. “Impact” variables can be reported by an individual, caregivers, family members, or health care workers, and may vary in the way that they are experienced or perceived. The following databases were used: MEDLINE via PUBMED; Embase, PsycINFO, and PsycARTICLES via Psycnet; and CINAHL and Ageline via

EBSCOhost. The searches were conducted on October 6, 2020. See [Multimedia Appendix 1](#) for detailed search strategies used for each database.

Eligibility Criteria

The Population, Exposure, Comparator, and Outcomes (PECO) framework was used to develop the eligibility criteria used for the purposes of this review (see [Table 1](#)) [30]. Eligibility criteria were defined as follows: (1) peer-reviewed original papers with data related to our research question (opinion papers, reviews, methodological articles, preprints, and unpublished documents were excluded); (2) publication dates limited to 2019 and 2020, as the COVID-19 outbreak was first reported in 2019; (3) papers available in English or French; and (4) participants 60 years of age and older with any diagnosis except for COVID-19 survivors. The fourth criterion was applied in order to differentiate the effect of the pandemic from the physiological and health-related outcomes associated with a COVID-19 diagnosis. Furthermore, only papers that specified in the abstract the inclusion of older adults in the study were included. Outcomes that did not fit into the domains of the HDM-DCP framework (eg, knowledge about the spread of the disease) were excluded.

Table 1. Population, Exposure, Comparator, and Outcomes inclusion criteria.

Component	Description
Population (P)	People aged 60 years and older, excluding COVID-19 survivors
Exposure (E)	COVID-19 and its associated isolation and protective measures
Comparator (C)	Other age groups, before the pandemic, or none
Outcomes (O)	<ul style="list-style-type: none"> Personal factors such as identity factors (facilitator or obstacle), organic systems (integrity or impairment), and capabilities (ability or disability) Environmental factors such as societal (facilitator or obstacle), community (facilitator or obstacle), and personal (facilitator or obstacle) levels Life habits such as daily activities (social participation situation or disabling situation) and social roles (social participation situation or disabling situation)

Study Selection and Data Extraction

Data retrieved from the databases were exported to Covidence [31]. Two reviewers independently screened the titles and abstracts of the obtained records. These reviewers then read the full text of the selected papers and determined whether they should be included. Any disagreement was resolved via consensus. Next, a single reviewer completed data extraction, which was then verified by another reviewer. The following variables were extracted: title, year of publication, country, study design, objectives, participant characteristics (eg, diagnosis and age), and outcomes. The references of the included papers were screened by the reviewers (one reviewer per study), and the titles and abstracts of additional papers were screened if relevant.

Level of Evidence Appraisal and Data Synthesis

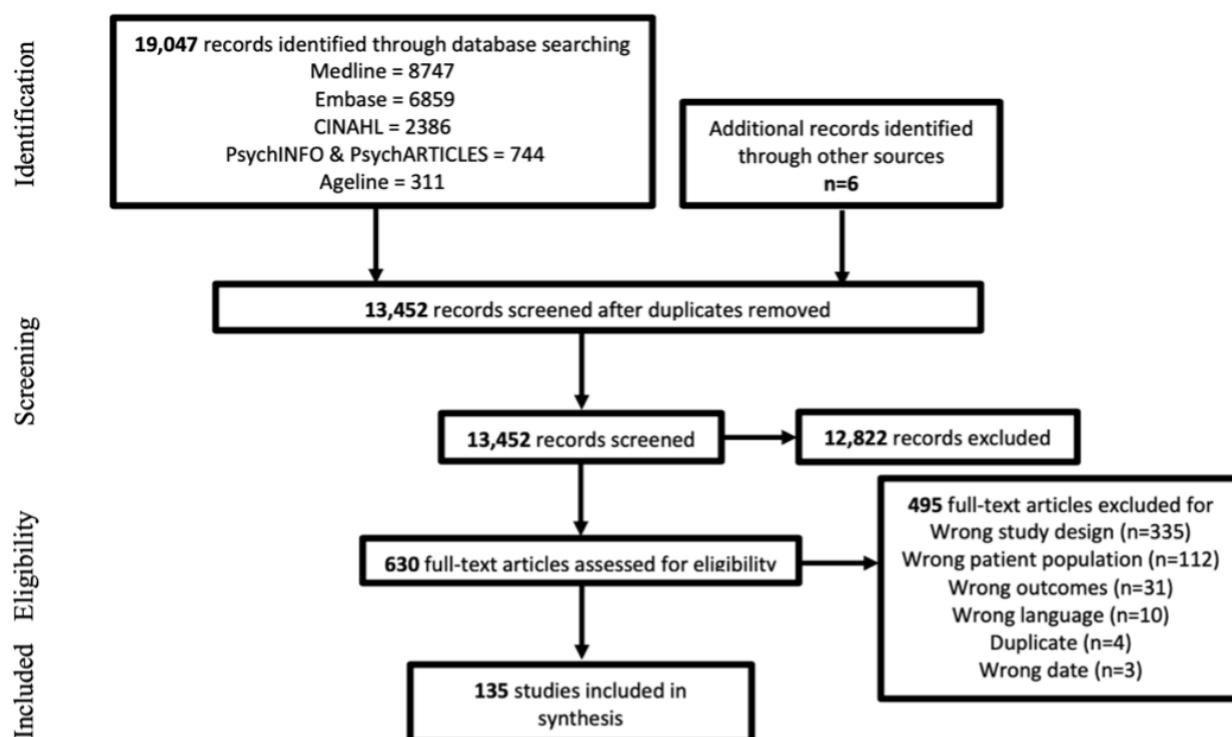
Two reviewers established the level of evidence for each selected study, based on the levels of evidence classification of the Centre for Evidence-Based Medicine [32]. Due to the limited turnaround time, no risk of bias assessment was performed. A narrative approach consistent with the data synthesis of a rapid review [24] was used.

Results

Literature Search

The search strategy identified 19,053 records. A total of 13,452 records remained after duplicates (n=5601) were removed. Upon title and abstract screening, the number of papers reduced to 630, after the exclusion of 12,822 records. Thereafter, full-text screening resulted in a final inclusion of 135 records ([Figure 1](#)), following the exclusion of 495 others for various reasons.

Figure 1. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) flow diagram.



Characteristics of Included Studies

The selected records and their corresponding levels of evidence are shown in Table S1 of [Multimedia Appendix 2](#). In all, 113 of 135 (83.7%) studies were determined to be of level 4 according to the Centre for Evidence-Based Medicine—Levels of Evidence [32] (transversal data collection), 20 (14.8%) studies were determined to be of level 2b (longitudinal studies), and 2 (1.5%) studies were of level 2b and level 4 (mixed study designs).

Of the 135 studies included, 40 (29.7%) studies included only older adults (≥ 60 years old) whereas 95 (70.3%) compared various age groups. Moreover, 15 (11.1%) studies included persons with specific conditions such as Alzheimer disease [33-35], Parkinson disease [36], frontotemporal lobar degeneration [37], severe cognitive impairments [38], ovarian cancer [39], gynecological cancer [40], patients with cancer actively treated with systemic therapy [41], pre-existing depression [42], chronic conditions [43], long-term respiratory conditions [44], migraine [45], epilepsy [46], and visual impairments [47]. A total of 29 (21.5%) studies were conducted in North America [40,42,43,48-73], 14 (10.3%) in China [46,74-86], 61 (45.1%) in Europe [33-38,41,44,87-139], 3 (2.2%) in Japan [140-142], 4 (3.0%) in Israel [143-146], 4 (3.0%) in Brazil [147-150], 4 (3.0%) in Australia [151-154], 2 (1.5%) in India [155,156], 1 (0.7%) in Malaysia [157], 2 (1.5%) in Kuwait [45,158], 1 (0.7%) in Saudi Arabia [159], 3 (2.2%) in Argentina [160-162], 1 (0.7%) in Cameroon [163], 1 (0.7%) in Russia [164], 1 (0.7%) in Ghana [47], 1 (0.7%) in Cyprus [165], and 3 (2.2%) in multiple countries [39,166,167].

Outcomes of Included Studies

Personal Factors

Older adults reported a presence or worsening of psychological symptoms, and greater loneliness because of pandemic-related social isolation [33,38,47,49,51,52,56,57,62,63,77,78,84,89,90,99,105,114,117,128,135,139,140,148,156,160]. Compared to younger age, older age (ie, ≥ 60 years) was, however, associated with fewer psychological symptoms [39,44,50,54,57,59,64-67,74,77,89,95,97,98,101,107,109,111,114,116,120,121,124,125,127,136,138,147,151,153,157,158,161,162,165], lower loneliness [92,95,104,130,140,159], and better mental health and well-being [95,106,126,157,161,162]. Older adults were also shown to be better at regulating their emotions and coping with stressful events [44,61,68]. In contrast, 6 (4.4%) studies reported that older adults had more severe psychological symptoms than participants of other age groups [83,85,86,96,118,156], and some studies noted no psychological symptoms for most participants [42,79,119,165].

Several variables were associated with poor psychological health and well-being, including living alone [117], decreased social interactions [88], feeling close to death, high levels of COVID-19-related health worries [145], stress [70], health concerns and ageism [143], not having cognitive impairments [38], and male status [78]. In contrast, religious faith, exercise, self-care, and time spent in nature were associated with positive psychological well-being [70].

Various worries surrounding the current pandemic were reported in these studies [36,49,105,107,110,155]. For instance, older adults were more worried about COVID-19 [68,75,96,118,167], whereas younger individuals were more concerned about the

risks related to social isolation [164]. Older adults were less concerned for their emotional well-being, work goals, and finances [65], and they perceived they had lower chances of “running out of money” [53]. However, more worries about financial difficulties were reported in another study [164]. Older adults perceived the risks of COVID-19 (in comparison to that of the flu) to be higher [48,138], but aged men were less worried about COVID-19 (eg, contracting the virus, dying due to COVID-19, or disruptions to lifestyle) than their younger counterparts [48]. Their concerns were focused on others rather than themselves [144]. Anxiety associated with cancer was lower in older adults than in younger adults [41]. Expectations (eg, income decline, duration and long-term impact of COVID-19) were associated with an experience of stress, which was further associated with other negative effects [69]. Finally, the passage of time during the pandemic was found to be slower for older adults [115].

Regarding the impairment of organic systems, higher age was associated with poorer health status [80] and in some cases, a decline of functional status [163]. Decreases in mobility, functionality, vitality, and physical conditions were also noted [36,148]. An aggravation in neuropsychiatric and physical symptoms was reported in individuals with Alzheimer disease, dementia, and frontotemporal lobar degeneration, as well as in nursing home residents [34,35,37,93,139]. An exacerbation of migraine days and severity was observed among individuals with a migraine diagnosis [45]. One out of six older patients with epilepsy experienced increased seizures, but this frequency increased considerably among younger people with epilepsy [46].

Environmental Factors

Decreased social life and fewer in-person social interactions observed during the pandemic were occasionally associated with reduced quality of life and increased depression [42,63,128,139]. Some individuals continued to meet their relatives almost daily [36]. Furthermore, some studies reported on the negative impacts of the pandemic for caregivers [34,35].

Older adults reported unmet personal, domestic, or social needs [128]; difficulty finding help with functional needs such as bathing [62]; insufficient personal care [139]; decreased care rendered by caregivers [47]; and reductions in social support services hours [99]. Multiple barriers to care delivery were noted during this time [166]. For instance, one study reported that older adults were more likely to miss or cancel medical appointments [129], whereas another reported the opposite [60]. One study reported that treatment delays and postponed appointments were more common among older adults [130], whereas another reported this was more commonly observed among younger people [40]. More patients missed medical appointments during the pandemic as compared to the pre-pandemic timepoints [84,163], and rehabilitation services were discontinued for the majority due to the quarantine [160]. Finally, as compared to the previous years, psychiatry consultations for older individuals had reduced in one study [113] but reported to have increased in another [76].

Life Habits

Changes in sleep habits and sleep disturbances were reported to be affected by COVID-19 [37,56,84,87,105,134,160]. Of note, some studies indicated that sleep issues were lower in older adults than in younger adults [122,134,147].

Older adults reported a lower increase in unhealthy food intake, screen use, tobacco use [149], alcohol use [149,154], and cannabis use than did younger adults [123,152], in addition to a lower rise in unhealthy lifestyle changes or drinking [131]. One study indicated that the majority of older individuals consumed a balanced diet, limited their alcohol intake, and had adequate sleep patterns [82], whereas another study reported no change in alcohol use patterns [71]. This finding was contrasted by other studies that found that older adults increased binge drinking, alcohol frequency, alcohol consumption, and cigarette smoking [56,114,132]; changed their eating habits [132,148]; ate more [56,87]; and ate more often [87]. One study reported a higher consumption of unhealthy foods among older adults, as compared with participants of other age groups [149]. Food insufficiency increased in older adults during the pandemic, but to a lesser extent than that among younger adults [73], and decreased care resulted in hunger [47].

Changes in daily routine and plans were reported in a few studies [43,52,58]; however, one study noted no changes in the performance of daily habits among older adults [102]. Behavioral changes, such as buying more food and water than usual, going out less frequently, reducing social contacts, and staying away from public places were noted in several studies [36,47,58,146]. Unemployment increased in older adults, but at a lower rate than that in other age groups [72]. Higher age was associated with fewer sexual activities [108]. Some studies reported a decrease in physical activity [56,132,141,142,149] and a decline in attendance at physical activity workshops [133]. However, studies reported contradictory results regarding physical activity among older adults during the pandemic. Indeed, it was noted that older adults had the lowest levels of physical activity among all age groups [55,100]; however, they had the smallest decrease in physical activity [100], the lowest prevalence of insufficient physical activity [81] and were less likely to have changed their physical activity levels during the pandemic [137]. Moreover, physical activity was associated with higher resilience, positive affect, and lower depressive symptoms [94,141]. Older adults were also reported to have a lesser change in unhealthy movement behaviors [150].

A study indicated that a lot of time was spent learning about COVID-19 [87], and more time was spent using social media [56], internet [144], and electronic products [150]. One study reported a higher usage of electronic products by older people [149], whereas others reported contrasting findings [74,81]. Participants felt *blessed*, *lucky*, and *fortunate* to be able to stay in contact with others through social media [91]. Variation in game use by older adults did not differ from that observed in younger populations [167]. Older adults had fewer positive work events but more remote social interactions, social networks, and outdoor activities [65]. Finally, older adults engaged in more solitary activities and in fewer in-person activities [56].

One study reported that the majority of older adult travelers were planning to travel by air in the next year [103], whereas another found that older adults were canceling out-of-town trips [58]. The COVID-19 pandemic has presented significant challenges to most older adults [58], and compliance to hygiene recommendations was seen as a psychological burden by this population [148].

Discussion

Principal Results

Older adults are known to experience loneliness, age discrimination, and excessive worrying [10-12]. Therefore, we initially anticipated that they would experience greater negative outcomes related to the COVID-19 pandemic. However, this hypothesis was not uniformly supported by the available literature. The findings summarized within this review suggest that older adults experienced negative outcomes related to the pandemic, but to a lesser extent than their younger counterparts. Younger adults experienced greater psychological repercussions from isolation and feeling of loneliness [168]. There was indeed a correlation between young age and poor mental health [126], higher anxiety, depression, and stress [153]. This result may be explained by the daily experience of loneliness and social isolation among older adults prior to the pandemic [12], which in turn meant that COVID-19 led to fewer changes in their daily routine as compared to employed, younger adults. Another potential explanation is the influence of certain personal factors among older adults, for example, greater resilience that is associated with more purpose in life [112], better regulation of emotions, and better coping strategies in the case of stressful events [44,61,68]. These personal factors could explain the generally better psychological response by older adults throughout the COVID-19 pandemic. Additionally, these findings may be explained by sampling methods used in the available research. In other words, the isolation measures implemented in long-term care facilities may have caused additional barriers to conducting studies with residents. In our study sample, 16 (11.8%) studies were conducted among community dwelling older adults, 3 (2.2%) included older adults living in residential care facilities, 3 (2.2%) included older adults living in one of these two locations, and 113 (83.7%) studies did not detail this sampling information. Without uniform sampling methods, it is more difficult to draw strong conclusions. Older adults may have little to no access to technology [169], such as a computer or a smartphone, which are often required to participate in web-based surveys. The most isolated individuals may be the most difficult to reach, particularly if they lack access to social media or maintain minimal presence in public and community organizations—platforms often used by researchers to contact participants. Fewer opportunities to participate in surveys may explain the relative scarcity of research on vulnerable older adult populations, such as those with dementia or Alzheimer disease, during the present pandemic. In studies that compared different age groups, the proportion of aged individuals was often very small compared to other age groups. It is possible that the older adults who participated in surveys were healthy and had access to technology and, therefore, were not the most

vulnerable. This could explain why certain studies suggested that younger people were more impacted than older adults.

One study reported that anxiety symptoms in older adults were associated with ageism [143], something that the current pandemic seems to have exacerbated [170]. The COVID-19 pandemic has been characterized as an older adult problem, and social media, among other platforms, have been used by people to share ageist attitudes (eg, posts published with the hashtag “BoomerRemover”) [171-173]. Greater awareness of age discrimination is needed to reduce these behaviors. There are other potential sources of anxiety among older adults, such as being unable to access support services since the onset of the COVID-19 pandemic [99]. More research is needed to understand the impact of ageism on older adults’ well-being, as compared with other risk factors.

The impact of the pandemic on older adults can also influence their caregivers [34,35]. Indeed, family caregivers reported living with anxiety and fear [174] and having difficulty balancing caregiving challenges with their own needs [175] during this crisis. It is therefore important to consider the needs of the caregivers in future policies and in the implementation of isolation and protective measures.

The available literature offered different strategies for maintaining the well-being of older adults; these included using technology to ensure social connections, pursuing outdoor activities, and incorporating daily structure [176]. Different programs were also deployed during the pandemic with the aim of reducing social isolation through contact with a student volunteer who engaged in weekly phone calls with participants living in nursing homes [177] and a single call with participants living in long-term care facilities and in the community [178]. The use of technology to protect and improve mental health [179] and to maintain the health and independence [180] of older adults during this crisis was also discussed. The transformation of an on-site program into an online program for older populations [181] was found to be effective. Innovative programs should therefore be created with the goal of supporting vulnerable older adults and minimizing the long-term consequences and feelings of loneliness.

Physical activity should be promoted during the pandemic, especially for more at-risk individuals such as those living with chronic diseases [182]. Older adults should be guided to safe and accessible physical activity programs, selected according to the individual’s level of autonomy, mobility, frailty, and health status, to avoid deconditioning during confinement. Physical activity is associated with a better quality of life [183] and decreased symptoms of depression in older adults [50], whereas increased inactivity could accelerate their physical decline [184]. Personalized physical activity programs with monitoring should therefore be made more accessible to this population to minimize deconditioning and help older adults maintain their physical and mental health, while ensuring their safety.

The secondary impacts of COVID-19 should be considered by governing bodies and institutions when taking action and making decisions about health care access and public health measures, both during the current pandemic and for future health crisis.

Mental health concerns have been reported among older adults [185], but few concrete actions have been taken to mitigate them.

Strengths and Limitations

Some studies classified older adults as including people below 60 years of age (eg, ≥ 50 years) [186-188]. Those results were excluded, along with potentially important data, to respect our eligibility criteria and to clearly differentiate the outcomes relative to older versus younger populations. Moreover, some studies focused on older adults with specific conditions, for example, Parkinson disease [36], cancer [39,40] or Alzheimer disease [33], which makes it difficult to differentiate the effects associated with their age from those associated with their condition. These studies were still analyzed, keeping in mind that individuals living with a variety of diagnoses are potentially more vulnerable to encounter negative outcomes related to the secondary effects of COVID-19. Some diagnostic keywords were selected because of the relationship between specific neurological conditions and higher age (eg, dementia and Alzheimer disease). This selection may have resulted in the omission of eligible studies that include older adults with other conditions such as cancer or cardiovascular diseases. However, a limitation in the selected keywords was needed to screen studies within a reasonable timeframe. In addition, the decision was made to exclude studies about COVID-19 survivors, because of the various physical and psychological changes that may be associated with the incidence of this condition. Contradictory results could also be attributable to the variance in health care systems and differences in isolation and protective measures implemented in various countries. Because of constant changing measures across countries, it would have been difficult, if not impossible, to analyze data in such a way. This aspect was, therefore, not considered in our data analysis in order to provide results in a reasonable timeframe. Future studies should take into consideration the country-specific variation in COVID-19 responses. Moreover, it is also possible that the sample age was not mentioned in the abstract or the title of the published papers, which would have resulted in the exclusion of the study during the first stage of screening.

Implication for Practice and Policy

Results obtained through this rapid review have highlighted the presence of psychological symptoms, decrease in social interactions, exacerbation of ageism, and the deterioration of physical conditions among older adult populations during the COVID-19 pandemic. It is essential that governing bodies and decision makers understand the needs of older adults when making choices regarding the implementation of social distancing measures. They should carefully choose their words when describing this pandemic, to avoid any form of age discrimination in the media.

Older adults represent a heterogeneous group, which could explain the contradictory results found in the sampled literature. Sample demographics should be considered in future studies to identify variables within older adult populations that could be associated with a poorer overall experience with the pandemic, and stronger conclusions could then be made. Indeed, studies that specifically target vulnerable age groups, such as adults living in rural areas [189] and deaf individuals [190], should be conducted to minimize the effects and long-term consequences in such populations. The impact of COVID-19 should be assessed separately according to various living environments in order to identify more at-risk individuals (eg, older adults in the community setting versus long-term care facilities). Future studies should also analyze different protective and risk factors among older adults. For example, it would be interesting to compare the effect of living alone versus living with others, of being in the younger range of the older adult demographic (eg, 60 years old) versus being in the latter range (eg, 85 years old), or of living independently at home versus living in a nursing home. Moreover, the general population could learn from older adults, regarding their resilience, regulation of emotions, and coping strategies, to improve their psychological response during this pandemic. Individual, organizational, and institutional strategies should be established to ensure that older adults are able to maintain social contacts, preserve family ties, and maintain the ability to give or receive help during this pandemic. The effectiveness of various strategies, such as making communication technologies more accessible, providing technology use training, and promoting technological innovations, should also be assessed to enable social interactions despite isolation and protective measures.

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Conflicts of Interest

None declared.

Multimedia Appendix 1

Search strategies.

[\[DOCX File, 23 KB-Multimedia Appendix 1\]](#)

Multimedia Appendix 2

Table S1. Synthesis of the 135 selected studies and their level of evidence.

[\[DOCX File , 113 KB-Multimedia Appendix 2\]](#)

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Abbreviations

HDM-DCP: Human Development Model–Disability Creation Process

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-analyses

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