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Older Adults with COVID-19: Special Considerations for Refusal of Admission and Alternate Care Plans

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Balancing a patient's wishes with the provision of excellent clinical care can be challenging when a patient wants to leave the emergency department (ED) against medical advice (AMA). This situation is more complex when it involves Coronavirus Disease 2019 (COVID-19), which is associated with rapid decompensation and the need for community containment. It is worth noting that when patients present to the ED, they are not encountering the same hospital experience they may have had in the past due to COVID-19. Most notably, restricted visitations from family caregivers and change in encounters with providers (masks, gowns, telephone or video assessments) can create an unsettling situation for patients. Strategies for creating a patient-centered disposition plan and mitigating the negative consequences of leaving AMA are discussed below, including safe care delivery models that avoid hospital admission.

UNIQUE CARE CONSIDERATIONS IN THE COVID ERA

- Older patients with underlying health conditions may feel fine yet experience a rapid clinical decline.[1]
- Community exposure risk to others may not be well-understood by patients, minimizing their compliance with quarantine and social isolation procedures in the community.
- Inaccurate perceptions related to COVID-19 are commonplace and may negatively impact patient and caregiver engagement in the healthcare plan.

STRATEGIES FOR CREATING A PATIENT-CENTERED DISPOSITION PLAN

- Discuss goals of care and priorities for all patients, not just those who are unwell, to guide individual care planning. The discussion should expand beyond end-of-life care and should include what matters most to the patient. Specific elements to address include:
  - Social and cultural considerations, such as the involvement of caregivers, presence of dependents (whether people or pets), living arrangements, and ability to access care.
  - Financial considerations and work-related concerns.
- Evaluate health literacy which significantly impacts the patient's understanding of the disease process, specifically the risk of rapid deterioration and the importance of quarantine.
- Involve caregivers in the care plan as much as possible after obtaining patient consent. This should be encouraged but cannot be enforced in an independent older adult who has capacity.
- Apply the considerations above to caregivers of older adults who lack capacity to make their own medical decisions. Surrogates should use substituted judgement rather than best interest. They should think of what the patient would have wanted rather than what the surrogate wants for the patient.[2]
  - Consideration of abuse or neglect by the caregiver is prudent as it is frequently missed by healthcare providers.[3] Suspicion of abuse should prompt the involvement of social work and adult protective services.

MITIGATING THE NEGATIVE CONSEQUENCES OF LEAVING AMA

Leaving the hospital AMA does not negate the involvement of the healthcare team in providing the best possible alternative. There are ethical and legal responsibilities to support the patient's decision, even if clinicians disagree with it, and to minimize the negative effects as much as possible. The clinician should engage in a compassionate and transparent conversation on implications of refusing care and present a clear alternative transition plan to the community.

- Specifically inquire about the reasons for refusing hospital admission as they may be unfounded, or can be addressed by interdisciplinary healthcare team members, social work, or patient's caregivers.
- Determine and document the patient's medical decision-making capacity specifically related to their comprehension of information and implication of actions.
    - Lack of decision-making capacity is missed in up to 42% of older adults in the ED.[4]
    - Assessing medical decision-making capacity includes formalized capacity tests (such as the Aid to Capacity Evaluation),[5] surrogate tests (such as the Mini-Mental Status Exam), or consultation with the psychiatry team in complex cases.
    - Delirium can temporarily affect decision-making capacity and is frequently missed in older adults.[6] Screen for delirium using a validated tool, such as the Delirium Triage screen, preferably in all older adults in the ED, or at least prior to discharge.
    - Patients who lack capacity to make medical decisions should not be allowed to leave AMA. Rare exceptions are with the ascent of the surrogate and involvement of the hospital's ethics/risk management teams.
- Provide clear instructions on post-acute service referrals such as home health and primary care providers. Further, involve the patient/caregivers in developing that plan to promote effective use of resources and increase chances of adherence.
- Ensure all patient instructions are written clearly in a language that the patient understands. Be sure to utilize interpreter services (if needed) so that adequate teach-back of discharge instructions and the follow-up plan can be implemented.
- Provide clear parameters on when to use over-the-counter medications for symptom management as needed and when to contact the provider.

ALTERNATIVE CARE DELIVERY MODELS WHEN NEITHER DISCHARGE NOR ADMISSION ARE THE "RIGHT" ANSWER

- Home healthcare: prompt and frequent home visits (preferably within 24 hours) in addition to ensuring availability of needed medications.
- Virtual technology: telehealth visits for follow-up and use of wearable technology.

CONCLUSION

Older patients with COVID-19 can leave AMA even if that decision is high-risk. Clinicians should assess patients' capacity, address their needs, involve their family caregivers (if possible), and explore alternate care delivery models.

KEY WORDS

COVID-19; Against medical advice; capacity

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