

## VIEWPOINT

## Caring for Older Adults With Diabetes During the COVID-19 Pandemic

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**Across the world,** older adults (aged  $\geq 70$  years) with comorbidities such as diabetes are at highest risk of adverse outcomes and mortality caused by coronavirus disease 2019 (COVID-19).<sup>1-3</sup> These unprecedented times pose a great challenge to this heterogeneous population with varying levels of complexity, frailty, and multimorbidity, as their normal routines have been disrupted while respecting social distancing measures. This has greatly affected their ability to access and receive health care, obtain diabetes medications and supplies, and maintain a healthy lifestyle and social connections. Unlike other situations in their lifetime, this pandemic has potential to last for many months. In this Viewpoint, we present the challenges that older adults with diabetes may encounter and offer practical recommendations to care for them during the COVID-19 pandemic (Table).

Telemedicine instead of face-to-face visits has now become the norm. The use of diabetes share apps or platforms such as Glooko, LibreView, or Dexcom Clarity has enabled many patients to upload the data from their glucometers, continuous glucose monitors, and/or insulin pumps so that their clinicians can make informed decisions. However, it needs to be recognized that not all older adults with diabetes are tech savvy or have computer access. Furthermore, up to 44% of older adults with diabetes have some form of cognitive dysfunction.<sup>4</sup> In these situations, a telemedicine visit may lead to frustration and distress for both the clinician and the patient. We recommend that clinicians identify these patients ahead of time and schedule longer phone appointments so that patients can read their glucose values over the phone. If a patient does not show up for their telemedicine visit, this should raise a red flag and prompt further investigation, given that there are stay-at-home advisories in place. Did the patient fall or experience severe hypoglycemia? Have they been hospitalized? Clinicians and health care teams should get in touch with family or visiting nurses to ensure the patient's well-being.

In most older adults, both with type 1 and type 2 diabetes, there are competing comorbidities and geriatric syndromes that can present immediate danger. This problem is further exacerbated when families move their loved ones from nursing homes to live with them during the pandemic. This may actually put them at more risk of harm if families are not well equipped with the skills to address the patient's health care needs. In these cases, it is important to establish communication with the family for support and education on how to care for their loved ones.

Another proactive step is to identify "high-risk" patients (eg, type 1 diabetes, recurrent hypoglycemia), prioritize patient goals, provide repeated education, and

reassess the diabetes treatment plan to lower disease and treatment burden. Clinicians should liberalize glucose targets according to guidelines to minimize the risk of hypoglycemia.<sup>5</sup> Simplifying the diabetes plan will also reduce anxiety and ensure that patients can adhere to the treatment regimen. For instance, basal-bolus insulin regimens and sliding scales can be simplified to once-daily basal insulin with oral agents in most older adults with type 2 diabetes while still maintaining good glycemic control.<sup>6</sup> Patients with type 1 diabetes always require insulin; however, sliding scales can be simplified to a correction scale to minimize errors (eg, if blood glucose  $>250$  mg/dL [13.9 mmol/L], give 1 additional unit of insulin at mealtime; if blood glucose  $>350$  mg/dL [19.4 mmol/L], give 2 additional units). For patients who rely on caregivers, simplification will also minimize the amount of face-to-face interaction, thereby reducing the potential exposure to COVID-19. Consolidating daily medications to once or twice daily dosing and reducing polypharmacy can be another helpful way to decrease treatment burden. Furthermore, ensuring that patients have adequate prescription refills, such as a 90-day supply, for diabetes medications, pump supplies, and/or glucose monitoring supplies will prevent crisis situations.

It is understandable during this pandemic that patients may feel overwhelmed and that they are failing their diabetes management. This provides an opportunity for clinicians to reassure patients and decrease the burden of diabetes self-care. Delaying bloodwork for hemoglobin A<sub>1c</sub> in the next few months and decreasing the frequency of glucose monitoring can be beneficial. Patients with type 2 diabetes can be advised to decrease glucose checks to once per day to guide treatment (eg, check fasting glucose on some days, and before lunch or dinner on other days). If glycemic control is optimal, less frequent testing can be recommended for these patients.

Clinicians should anticipate that patients may not be able to adhere to a diabetes-friendly diet due to changes in financial situation, access to grocery stores and/or meal delivery, and food supply. Ensuring good nutrition with regular meals and avoiding weight loss are more important than diet optimization at this time. Patients can spread out carbohydrates in the diet throughout the day to avoid large spikes in blood glucoses. Similarly, encouraging physical activity at home, by walking inside or in place for 10 minutes 3 times daily, is a safe exercise alternative. Strength training can be incorporated by using resistance bands, or by improvising and using canned goods as weights. If patients have access to the internet, there are online exercise programs that are tailored for older adults. Exercise not only has a positive

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**Table. Challenges for Older Adults With Diabetes During the COVID-19 Pandemic**

Challenges	Strategies to address challenges
Accessibility to health care	<ul style="list-style-type: none"> <li>• Switch to telemedicine.</li> <li>• Use diabetes share apps or platforms to obtain data from the glucometer, continuous blood glucose monitor, and/or insulin pump.</li> <li>• Schedule phone appointments for patients who cannot use technology. Have the patient read glucose values over the phone if unable to upload data.</li> </ul>
Multicomplexity and geriatric syndromes	<ul style="list-style-type: none"> <li>• Identify “high-risk” patients (eg, type 1 diabetes, recurrent hypoglycemia) and prioritize patient goals.</li> <li>• Simplify diabetes treatment plan with repeated education and instructions.</li> <li>• Liberalize glucose goals. During periods of acute illness, instruct the patient to remain hydrated when experiencing hyperglycemia to avoid dehydration and falls.</li> <li>• Reduce polypharmacy and consolidate medication doses.</li> <li>• Avoid hypoglycemia.</li> </ul>
Burden of diabetes self-care	<ul style="list-style-type: none"> <li>• Delay bloodwork for hemoglobin A<sub>1c</sub> for the next few months.</li> <li>• Decrease frequency of glucose checks if glucose is within acceptable range for patients with type 2 diabetes.</li> <li>• Encourage good nutrition with regular meals rather than optimization of diabetic diet; adjust medications to changes in diet.</li> <li>• Advise safer alternatives for physical activity such as walking inside the home or walking in place for 10 min 3 times per day and incorporating strength training (eg, resistance bands), or online exercise programs.</li> </ul>
Psychological stress	<ul style="list-style-type: none"> <li>• Check in during follow-up and empower patients to stay connected using technology (phone, video chat, text message), letters, or cards with family, friends, and/or religious communities.</li> <li>• Screen for depression (Geriatric Depression Scale or Patient Health Questionnaire-2) and refer to mental health colleagues if appropriate.</li> <li>• Communicate via phone or email with caregivers experiencing distress and offer local resources for support.</li> </ul>
Medication and equipment issues	<ul style="list-style-type: none"> <li>• Refill prescriptions and equipment for 90-d supply and request mail or home (contactless) delivery.</li> <li>• Ensure patients have a backup plan in the event of equipment/pump failure (eg, insulin, syringes).</li> </ul>

Abbreviation: COVID-19, coronavirus disease 2019.

association with glucose metabolism, but it may improve mood and prevent sarcopenia, deconditioning, and falls.<sup>7</sup>

During these challenging times, patients are at risk of feeling socially isolated, lonely, or depressed.<sup>8</sup> Patients with diabetes are already at higher risk of depression compared to the general population, and depression is often unrecognized in older adults.<sup>7</sup> Worrying about catching COVID-19 and avoiding hospitalization even when other conditions require it can produce tremendous psychological stress and impact their diabetes control. Checking in during follow-up and empowering patients to stay connected with family using technology, letters, or cards can help them feel less isolated. Many faith communities are also hosting virtual and radio services that patients can attend. Screening for depression using tools such as the Geriatric Depression Scale or Patient Health Question-

naire-2 is important. For those patients with depression, frequent follow-up and a referral to mental health colleagues, if appropriate, can be initiated. Furthermore, for caregivers that are experiencing distress, improving communication by phone or email and giving them local resources for caregiver support should be an integral part of the overall care.

Older adults with diabetes are a highly vulnerable population that may encounter numerous challenges affecting their everyday life; however, clinicians can lessen the load by guiding, reassuring, and supporting them through this pandemic time. Many of the recommendations presented in this article are practical and will continue to be relevant after COVID-19. When this is all over, patients will remember how we made them feel, and how we kept them safe and healthy at home.

#### ARTICLE INFORMATION

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