



## **Key Points on COVID-19 and Older Adults** **American Psychological Association Committee on Aging (CONA)**

Older adults vary in their needs, their risks, and their ability to engage in active coping during the crisis. As such, responses to the COVID-19 outbreak should not *solely* depend on chronological age as criterion in policies, medical decisions, or allocation of resources. Treating age 60 or 65 and above as a cutoff for discussions of risk for hospitalization or mortality related to COVID-19 obscures tremendous differences across subgroups of older adults. And efforts to assist in coping with the disease need to account for these varying circumstances.

### **Heterogeneity of the population**

Adults over age 65 are not a single “group” - treating them as such may generate problems for two distinct populations. The oldest adults over age 85, and older adults suffering from comorbid health conditions are at particularly high risk for mortality and require considerable protection to prevent infection. By contrast, healthy older adults, particularly those in the 65 to 74 year old age range, have much lower mortality rates. In other words, older adults vary in their needs, their risks, and their ability to engage in active coping during the crisis.

More specifically, this population includes:

- Individuals who are healthy and contributing to society through paid or volunteer work (24% of older adults engage in regular volunteering (as well retirees who can be called to back to work).
- 18% of adults aged 65+ who are actively involved in caregiving for a spouse, aging parents, or other relatives.
- Almost two million older people who live in households with a grandchild, and half a million grandparents who have custody of their grandchildren. These rates are higher among Hispanic, African American, and low income older adults.
- 35% of older adults who report at least one disability, e.g. in self-care, walking, or hearing, though this rate is highest among adults over age 80. These individuals may be at risk of further decline due to non-COVID related health issues in the absence or regular services, therapies, and healthcare.
- 2.6% of older Americans who are residents of skilled nursing homes and are at greatest risk of contracting COVID-19, and of mortality when they contract COVID-19. This increased mortality may reflect a combination of factors that contribute to risk: advanced age of nursing home residents (majority aged 85+), close living quarters, illnesses, disabilities, and risk factors that precipitate their move to their nursing facility. Furthermore, limiting exposure to family is necessary to avoid infection. But social isolation increases risk of depression and suppresses the immune system.
- Persons reaching age 65 have an average life expectancy of an additional 19.5 years (20.6 years for females and 18.1 years for males). As such, these individuals have nearly two decades of life remaining if they recover from COVID-19.

## **Recognition of ageism**

Current framing of the COVID-19 outbreak tends to dichotomize the spread and severity of the disease with regard to 2 groups – young and old. We need to extend the lens of the spread and consequences of the disease in messaging and policy decisions. Spread of the disease may occur at any age. Messaging needs to be framed with regard to this issue.

## **Empowering older adults while they remain at home**

- Social distancing is recommended for all ages to slow the spread of the virus, protect the health care system, and help protect vulnerable older adults. Many cities and states have already instituted “shelter in place” and “stay at home” orders that formalize this practice.
- Loneliness is a problem at all ages. Indeed, many young adults report feeling lonely. Again, reflecting heterogeneity of the aging population, loneliness typically *decreases* into the early 70s, but then increases for adults over age 75.
- Social isolation may be particularly prevalent with advancing age, nearly half of women over the age of 75 live alone. Social isolation is a risk factor for depression, physical illness and mortality. Efforts must be made to assist older adults during a stay-at-home order.
- Many older adults are technologically savvy using smart phones, tablets, videoconferencing and the internet for communication. However, older adults who have not adopted newer technologies still rely primarily on telephone. Younger family members and social agencies need to embrace this older form of technology when engaging in outreach to these populations, including technological adaptations for telehealth.

## **Key facts (from Centers for Disease Control)**

The risk for serious disease and death in COVID-19 cases among persons in the United States increases with age, and this is true across each decade of adulthood.

### Hospitalization

Rates of hospitalization show an increasing pattern across adulthood, with:

14.3-20.8% of cases in 20-44 years old

21.2-28.3% of cases 45-54 years old

28.6-43.5% of cases 65-74 years old

31.3-70.3% of cases 85 years old and over

### Mortality

In the US, 80% of deaths from COVID-19 have occurred in adults age 65 and above, but the case-fatality rate varies greatly among subgroups of people 65 and over. Estimates from the CDC are:

2.7-4.9% among those 65-74

10.4-27.3% among those 85 and older

The discrepancy in the comparatively low mortality rate among adults aged 65 to 74, but the relatively high hospitalization rate suggests that a majority of individuals in this age range benefit from life-saving medical intervention at the hospital.

## References and Resources

- Bureau of Labor Statistics (2016). *Volunteering in the United States- 2015*. Washington DC: US Department of Labor. <https://www.bls.gov/news.release/volun.nr0.htm>
- American Psychological Association (2017). *Older adults' health and age-related changes: Reality vs. myth*. Retrieved from <https://www.apa.org/pi/aging/resources/myth-reality.pdf>
- Bureau of Labor Statistics (2016). *Unpaid Eldercare in the United States- 2017-2018 Summary*. Washington DC: US Department of Labor. <https://www.bls.gov/news.release/elcare.nr0.htm>
- Center for Disease Control (March, 2020). Severe outcomes among patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020. *MMWR Morb Mortal Wkly Rep.* ePub: 18 March 2020. DOI: <http://dx.doi.org/10.15585/mmwr.mm6912e2>
- Center for Disease Control (July 31, 2015). Prevalence of disability and disability type among adults — United States. *MMWR Morb Mortal Wkly Rep.* ePub: 18 March 2020. DOI: <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6429a2.htm>
- Centers for Medicare and Medicaid Services. (2015). *Nursing home data compendium. Baltimore, MD: CMS.*
- GeroCentral COVID webpage for Clinicians and Consumers: <https://gerocentral.org/clinical-toolbox/covid-19-resources/>
- Hawkey, L. C., Wroblewski, K., Kaiser, T., Luhmann, M., & Schumm, L. P. (2019). Are US older adults getting lonelier? Age, period, and cohort differences. *Psychology and Aging*, 34, 1144-1157.
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*. <https://doi.org/10.1371/journal.pmed.1000316>
- US Department of Health and Human Services. Administration for Community Living, Administration on Aging.(2018). 2018 Profile of older Americans.