

Watch: What Experts Advise for Seniors Living Under the Long Shadow of Covid

Oct. 11, 2022, transcript

Judith Graham: Good afternoon. I'm Judy Graham, and I write the "Navigating Aging" column for Kaiser Health News. Thanks for joining us here today to discuss the long shadow that covid-19 continues to cast over the lives of older adults. A few housekeeping items to start. If you have questions for our panel, please put them in the Q&A box at the bottom of your Zoom screen. I'll lead a discussion among our panelists for the first hour or so of this 90-minute event. Then we'll devote about 20 minutes to questions. For those unable to make it today, the webcast will be housed permanently on Kaiser Health News' website. We'll begin with remarks by Rani Snyder, vice president of Program at The John A. Hartford Foundation, one of the sponsors of this event, and a longtime supporter of Kaiser Health News. Rani, on to you.

Rani Snyder: Thanks so much, Judy. Hi, everyone. And many thanks, Judy. Your reporting is of tremendous value to all of us. What you're doing is helping older people and their family caregivers to navigate aging in this country. And we so appreciate it. As Judy mentioned, I'm Rani Snyder. I'm the vice president for Program at The John A. Hartford Foundation. And we're really proud to support today's event and the Kaiser Health News reporting desk that is covering aging and health issues. We are a nonpartisan philanthropy based in New York City, but we operate nationally, and our mission is to improve the care of older adults. And we do that through three main programmatic areas: creating age-friendly health systems, supporting family caregivers, and improving serious illness and end-of-life care. And I really want to welcome and thank our audience for joining today's discussion about the ongoing impact of covid-19 and the pandemic on older adults and their families. While the pandemic has certainly moved to a new place, thank goodness, the Kaiser Family Foundation just released data last week showing a summer spike in deaths, during which the biggest impact was on older adults, who now represent 88% of deaths. That's the highest share yet. And in addition, long covid is affecting older adults differently or not being recognized at all. We know that older adults are getting boosters at higher rates than others, but there's still a lot of confusion around the differences of perspective on how to be safe. So beyond covid illness and death, the effects of the pandemic live on in our lives and on family caregivers. And those effects are nothing short of profound. Mental health impacts continue. People have delayed care for other conditions. Sometimes there are ongoing economic impacts from the pandemic itself, and the experience across all of those issues can be really different depending on where you live, depending on your income, depending on your race and ethnicity. So, as we move forward, it's really important that we listen to older adults and their family caregivers and the organizations and the people who provide services to them, and then ultimately take action to do what we can to improve the situation. Our foundation, The John A. Hartford Foundation, is doing that in our efforts to promote age-friendly health systems that ultimately deliver evidence-based care focused on what matters to older people and their families across all settings. I want to thank all of our terrific panelists who are going to help us understand the long shadow of covid and its impact on older people in our communities. So many thanks again to the audience for joining in the conversation. And please continue to follow the incredible

aging and health journalism of Kaiser Health News and Judy Graham on these topics and more. And with that, Judy, I'm going to turn it back to you. ... You're muted, Judy.

Graham: Thank you, Rani. Sorry, muted there. The topic we're discussing today couldn't be more timely. On the national stage, President [Joe] Biden's recent statement that the pandemic is over, a remark he later sought to modify, has sparked controversy and confusion. As a country, we remain torn between a desire to move on from the past few years and the need to acknowledge covid's ongoing toll. Rani spoke about the new findings from a Kaiser Family Foundation report last week that 88% of all deaths from covid are among older adults. Millions of older adults aren't sure what to do, how to stay safe, even at this time. Should they stay at home, avoid indoor spaces, wear masks everywhere they go, travel by plane to see family members over Thanksgiving or Christmas? Millions more are coping with ongoing physical and mental health issues related to the pandemic. Many older adults understand their lives will never be the same. Our distinguished panel will address these issues and more from multiple perspectives. I've asked them to introduce themselves before our discussion gets underway. Audience members: Please note you'll be on mute throughout the session. Dr. Brangman, let's begin with you.

Sharon Brangman: Hi. Thank you for inviting me to this excellent discussion today. My name is Dr. Sharon Brangman, and I chair the Department of Geriatrics at Upstate Medical University in Syracuse, New York. And I also direct our Center of Excellence for Alzheimer's Disease there. So thank you for having me.

Graham: Thank you, doctor. Kathryn Haslanger, on to you.

Kathryn Haslanger: Hi. Thanks. I'm very excited to be part of this discussion and really appreciate that you're shining the light on this issue that just has not gotten enough attention. I'm Kathryn Haslanger. I'm the chief executive officer of JASA. We're a human services nonprofit based in New York City. We served 40,000 older New Yorkers last year. And our complete reason for being is to assist older New Yorkers so that they can age in their own homes, engaged in the community, and calling their own shots. Our staff and our clients are as diverse in race, ethnicity, culture, language as the New York that we know and love. And we have a particular focus on low-income New Yorkers, where all of these problems have really been exacerbated.

Graham: Thank you, Kathryn. Richard, can you go next?

Richard Gard: Yes. I'm Richard Gard, and I'm a doctor, but of music. So I'll give a little bit of my history, since I'm not here as a physician. My parents were musicians and I performed with them from a very early age, and I've been a professional musician since then. I had the good fortune to perform all over the United States, the U.K., Australia, and China. My wife, Evie, is a fantastic singer and together we performed, produced, and directed concerts in small theaters, large arenas, and even Carnegie Hall. I was also a teacher at the high school and college levels with my final two decades at the Yale School of Music. I'm a lifelong church musician, and I served for the past 22 years as the director of music at St Thomas More, the Catholic Chapel at Yale. So, Evie and I were always busy. It was always exciting to work with students, faculty, and fellow musicians in this very busy and artistic environment here in New Haven, Connecticut. As musicians say, I had a

dream gig. I got to do music all the time. We also managed to be healthy, very athletic, and we enjoyed sailing, nearshore and we did many long offshore trips. Evie and I have six children and three grandsons. They live on both coasts, so we often travel. We planned to cruise the U.S. on our boat after 2020. But all of this travel and music and teaching and activity came to a sudden halt on March 13, 2020, a day I'll never forget. I was at Yale New Haven Hospital in the emergency department. My doctor sent me, after Evie called her very early in the morning, as they were worried I'd suffered a heart attack overnight. The emergency room didn't diagnose that I'd had a cardiac infarction, but my vitals and my respiration were crazy, while my chest pain and my distress rapidly increased. I told the doctors I felt like I had the flu. Not a heart attack. The flu. A terrible flu. A swab test eventually established I did not have influenza. But then a physician guessed I must have that new virus, the novel coronavirus from China. And I was placed in isolation while they tried to figure it out.

Graham: Richard, I'm going to interrupt you because these are introductory remarks. I'm going to come back to you for what happened. We're on the ledge. What happened to you? But I'll come back to that. Richard was the first covid patient at Yale New Haven Hospital. And we'll come right back to that point in just a little bit. Dr. Metzger, can you tell us about yourself?

Eran Metzger: Hi. Eran Metzger calling in from Boston, where I am the medical director of psychiatry for Hebrew SeniorLife, which is a nonprofit organization providing housing and health care for 3,000-plus seniors per day in the Boston metropolitan area. And we provide services ranging from home care, hospice palliative care, to supportive senior housing for low-income seniors to assisted living to long-term care. And I so wish we were here to listen to a recital by Richard and Evie and not having to talk about the long shadow of covid. But I really appreciate, Judy, you convening this, and thank you all for attending.

Graham: Don't we all wish that? And Jessica, finally to you.

Jessica Kelley: Hi. Yes. Let me just add my thanks to get to join this illustrious group to talk about such an important topic. I'm Jessica Kelley, and I'm a professor of sociology at Case Western Reserve University, and I currently serve as editor-in-chief of *Journal of Gerontology: Social Sciences*, which is the flagship journal on the social experience of aging. And we have — and you can go to [our website](#) — we have published to date four special issues on research just on the impact of covid on older adults. And they're all free articles to read. So I'm glad to be here today, and feel free to peruse the work.

Graham: So we were hoping that Dr. Céline Gounder would be with us today. I know she's at the White House, and I think there are technical difficulties in joining this panel. If she joins us, we will be delighted. But in the meantime, we're going to proceed without her. Dr. Gounder is an infectious disease specialist and a senior editor at Kaiser Health News. Let's start with you, Dr. Brangman. The question people have been talking about for weeks: Is the pandemic really over? What are you seeing in clinical practice?

Brangman: So in my perspective, the pandemic is not over. We're definitely in a different point in time than we were when the pandemic first started in 2020. We have antiviral treatments, we

have vaccines that are very effective, but the virus is still spreading. And I know we're all sick of it. We are all fed up with the virus, but the virus isn't quite done with us yet. And I am still seeing pretty high infection rates. Of course, it's a little bit more difficult to know specifically what the infection rate is because we don't have formal testing anymore. We're just relying on home testing and people telling us what's going on. But even with that, we know that local infection rates are high, and hospitalizations are creeping up. And in my part of the world, where we don't have a lot of outdoor time this time of year, we are starting to see people getting sicker and going to the hospital. And of course, with the patients that I take care of, which are primarily people 65 and older, but probably my specialty area are people who are 85 and older — those are the majority of the people that we see — we are still seeing people getting sick and we are trying to help them navigate this world that can sometimes be confusing because they hear so many messages. And the caregivers, the adult children, and family members who are taking care of them are just as confused because they hear so many different messages. So the pandemic is not over. And I think those of us in the medical field understand that very well.

Graham: Another question for you before we move on to other panelists, doctor. We've seen that older adults from Black and brown communities have been disproportionately affected during the pandemic. What's going on in these communities and what are the greatest needs that you're aware of?

Brangman: So the pandemic in general has had a disproportionate effect on older adults. And then if you're an older adult from a Black or brown community, you have been feeling it even more. But even younger people who are from Black and brown communities have been getting sick and dying at higher rates. And a lot of that is due to multiple factors. One of them is getting a clear message from a trusted source. The other one is having access to the vaccines when you need it. And the patients that I particularly take care of are not on the internet. They have landlines. Maybe they have a flip phone, but they can't jump online and schedule themselves for a vaccine, and they often can't navigate public transportation. So we have to make these vaccines accessible to them with a clear message from trusted sources. And we have to figure out how to help people who are suffering from this digital divide. In my part of New York state, there are still people who do not have high-speed internet, and there are people who cannot afford a fancy smartphone or even a monthly internet service fee. So we have to think about how to reach people in other ways. And that means you have to have feet on the ground, access to communities, and you have to have a long view, because many of my patients may not say yes on the first try, but if you keep talking with them and you show that you care about them and that you can explain things in easy-to-understand language, most of my patients will end up getting vaccinated. So we have to learn lessons on how to access communities other than through the internet and other ... and not using multi-syllabic words and medical acronyms and other things that are just unreachable to so many people. And that's not just older adults. I think the scientific world knows how to talk to each other very well. I'm not sure we do a very good job talking to the average, everyday person in language that's easily accessible.

Graham: Thank you, Dr. Brangman. A personal note: I was writing about this back when the vaccines first became available. You might think we would have solved some of these problems or

addressed them better by now. Kathryn, I saw you nodding vigorously. I'm interested in your perspective from your seat in New York City.

Haslanger: I just want to underscore the things that Dr. Brangman just said and how much it resonates with our experience. And I'm pleased, really, that in New York there were concerted efforts to try to overcome some of the obstacles and some of the challenges that she was describing. I mean, JASA, as a community-based organization with a presence in the community, people know us and trust us as a human services provider, as a social services provider. And so when it was time to start talking to people about vaccines, we were able to do that as a trusted voice and as a voice that speaks a lot of different languages and is in sync with many different cultural approaches to how you think about medicine in the medical establishment — being separate from the medical establishment. And I think that was the real strength that a community-based organization could bring. We were able, because of some special initiatives that were available during the early part of the availability of the vaccine, to put thousands of shots in arms. We did clinics in our affordable housing sites. There were ... the cities sponsored a whole range of short-term pop-up clinics and vans that would show up outside a building that we knew had a lot of older adults in it. And we could work in partnership with those, with the drugstores, with the medical providers to overcome the barrier of trust and the barrier of access. We also, in terms of that point about not everybody can jump on the Web and schedule their appointment. Absolutely. We actually were able, through philanthropy, to have some special resources to dedicate so that we could make appointments for folks and help get them there and provide the money for the transportation at a time when folks weren't comfortable using public transportation or weren't mobile enough to use transportation. So those were all really important efforts that we could undertake, and that we could particularly focus on the low-income communities, the communities of color that were feeling the early stages of the epidemic in such enormous proportions.

Graham: And what about today, Kathryn?

Haslanger: So we are still educating. We're still getting out the word. And as, again, as Rani mentioned at the outset, as Dr. Brangman also said, the mixed messages are making that really challenging. Because when people are ... the masking requirements are for the most part gone. Although, certainly our staff are all required to be vaccinated, we're still providing PPE [personal protective equipment]. There are clients who are uncomfortable having somebody come into their home because they're not sure what to think. And then the mixed messages around the vaccines are making it much more challenging this time around.

Graham: Also, are you able to get the kind of financial and community support that you were able to get earlier in the pandemic?

Haslanger: Well, sadly, there's a little bit of an attention-deficit disorder thing that happens with ... you know, there's philanthropy, there are donations that are available early in the crisis, and then their attention kind of moves on. So those resources aren't available in the same way. And the government resources also are just ... all of those funding sources have been spent down and really aren't being renewed at this point. So many folks feel like they've moved on. But as people on this panel have said, covid is very much with us in the communities of older adults.

Graham: Dr. Gounder, thank you for joining us. I really appreciate it. We've been talking about mixed messaging, especially. Let's talk about the boosters and who should be getting them and when, specifically with an eye toward older adults, and how we need to address this population in terms that they better understand.

Céline Gounder: Well, we've definitely seen a shift in the demographics of who is being hospitalized from covid, who is dying from covid. Kaiser Family Foundation, as you know, just released data last week looking at what proportion of deaths are occurring among the elderly. And now 40% of deaths from covid are among people over 85, and almost 90% are occurring among people who are 65 and older. So the vast proportion, vast majority of covid deaths are occurring among the elderly and they are the population we need to be doubling down and protecting better. With respect to the new bivalent boosters, so ... I think, first of all, it's important to emphasize that they are safe. They are effective. They do protect against severe disease, hospitalization, and death. And we certainly see that even older adults who have been fully vaccinated, who have been boosted before, still do benefit from an additional dose of booster and additional vaccination to protect them against severe disease, hospitalization, and death. Based on our polling data, it does seem that most elderly adults do plan to get vaccinated or get their omicron booster. But when I say most, that's over half, but not necessarily all of them. And so there's a lot of work to be done, first of all, to make them aware that these even exist. Many people do not know that they exist. And to help people understand who stands to benefit most. Right now, the push is really to make sure we get those elderly people, immunocompromised people vaccinated with that extra booster, because that really will make a difference here.

Graham: A couple of members of the audience have asked: What do we need to better promote these boosters, the new omicron boosters, and do we need to offer incentives to the older population to get these boosters?

Gounder: I don't think it's a question of incentivizing older adults. I think, one, it's a question of getting the information out there. So some people just simply do not know that these exist. But secondly, many older adults are less able to access vaccination. They might be homebound, disabled, may need help from somebody to get vaccinated. As you'll also remember, when vaccinations were first being rolled out, there was a partnership between the federal government and retail pharmacies to vaccinate people in long-term care facilities, and that was the case in the first year of vaccination. But that has not been the case since then. And look, that costs money. And so that would require funding being allocated by Congress to support such a program. But I think those are the kinds of things ... community health workers would be another solution here who can go out to the community, into the community to find people where they are, where they're living, to provide those vaccinations. And I do think this is one area where there's a little bit of a ray of hope. The CDC [Centers for Disease Control and Prevention] is going to be awarding shortly new public health infrastructure grants, which will include funding for community health worker programs. And this would be an obvious thing for them to be taking on.

Graham: Thank you, doctor. And now on to you, Dr. Metzger. Your expertise is geriatric psychiatry, and your organization serves a wide variety of older adults in different settings. What are you

seeing clinically at this point of the pandemic in terms of mental health concerns among older adults?

Metzger: Thanks, Judy. When I leave this office after this conference, I'm going to be putting on a mask. And I realize in our country the masks have come off for the most part. But I can assure you where I work not only are masks still on, but I will visit long-term care units today and the rest of the week where we are still quarantining, where the staff still have to wear full PPE, including not only masks, but gowns and visors. And as a psychiatrist, I can tell you this is still having a large impact on the emotional health of our older patients. So covid is very much alive where we are. I realize in this country it is sort of gone underground because of some of the comments that our leaders have made. I sort of liken it to that fire that has been burning under the ground of Centralia, Pennsylvania, for 50 years. It's still burning, but most people aren't aware of it. And covid is still burning where our most vulnerable seniors are.

Graham: Tell us more about the emotional side of things that you see, the primary concerns that older adults are bringing to you on that score.

Metzger: Yeah. I see it as involving two aspects. One is the trauma that seniors who were fortunate enough to survive the first wave of covid experienced from the isolation, from having neighbors die, from the uncertainty about whether they were going to live or die. As our researchers have told us, long-term care residents made up a third to a half of the deaths in that first wave of covid. And this has left trauma among the survivors. But because covid is still present, there is still uncertainty about the future. There is still anxiety about decision-making day to day. I was paged Sunday by one of our long-term care residents, who is still able to use my pager, who was scheduled to go to a wedding later that afternoon for her granddaughter. She's 102 years old and she was terrified. She knew that this was perhaps her last opportunity to attend a family milestone event like this. But she also knew how vulnerable she was and that these gatherings still pose a significant risk. And she didn't know what to do.

Graham: Kathryn, you want to speak about social isolation. Please go ahead.

Haslanger: Just in terms of the things that Dr. Metzger was talking about, in addition to the trauma, in addition to the grieving, the losses for so many people who have lost friends and family, what our staff are seeing in the communities where we're working is that folks who had a social circle, a social network, during covid that network just collapsed down into something very tiny. Even a family were still able to be in touch, they weren't doing they weren't able to be in person in the same way. People were told to stay home. They were told not to go out. So they weren't seeing folks that they usually see. And ... that network just didn't survive that extended period of silence and absence. And even now that people are ... and we know social isolation isn't just — *just* — a mental health issue, but it has physical exacerbations. And in terms of the impact on chronic illness is well documented and something that's another significant barrier that has gotten worse during the long shadow of covid. What we're seeing now is we're starting to try to do a few things in person and try to bring folks out a little bit cautiously again, as they're able to. It's really hard. Those networks aren't really growing and rebuilding in the same way. So much has been lost. And it's a real uphill struggle to try to start to recapture it. And we are going to see the

implications of that in people's mobility and their health care, their own health, and their health care utilization as the shadow continues.

Graham: Now Dr. Metzger, I know you told me that Hebrew SeniorLife is trying to move people out of their homes and into activities. Tell us about what you're trying to do and perhaps about some of the non-pharma behavioral interventions that you had before the pandemic and starting those again.

Metzger: Yeah, what was so sad about the pandemic was, among other things, we were making great progress in long-term care in this country in implementing nonpharmacologic measures to improve the quality of life of our long-term care residents with dementia. And almost overnight, we had to stop those expressive arts therapies, life enhancement therapies, other activities around socialization for infection control. And we are getting back to normal levels of those activities, but with those barriers between us and our clients in the form of masks and, in other situations, more extensive PPE. And when you're dealing with a population, a large proportion of whom may have lost language skills, both expressive but also receptive, we depend a lot more on body language, on expression. And when we have to cover those up with these PPE, we really impair our communications and our ability to do, to implement these nonpharmacologic measures to improve quality of life.

Graham: I'm going to go to another question that came in, and this one is going to be for you, Dr. Gounder. It's from Susanna Chan: "How can I better emotionally support my parents who are 80-plus and live independently? They are vaxxed and boosted as much as possible. Just got their flu shot. They haven't had covid yet. However, they have had to significantly curtail their social lives with no indoors events. They remain interested in reading and streamed programs, but winters are very hard. I am concerned that seasonal covid isolation has accelerated their mental and physical aging."

Gounder: Well, I'll share a bit of a personal perspective on that. So my father-in-law had been living in an assisted living facility, actually got moved to memory care early in the pandemic, had Parkinson's disease, and we were not allowed, any of us, into the facility, even if we were masked. And finally, at the very end ... we observed him over remote conversations, which he had a very difficult time engaging with. The staff at the facility was very empathetic, really tried to do their best, would try to have him talk to us over Skype or Zoom, but he really had a hard time engaging with that. And before our very eyes, we really saw him deteriorate over the course of the pandemic. About a year in, he did finally pass away — not from covid; he never got covid — from complications related to Parkinson's disease. And so I do think it is very important to remember the need to have that kind of social contact, the impact that has on cognition, on memory, on orientation. And so I don't think it's an overstatement to say that those kinds of interactions really are important for your parents to be having. And so to the degree that you're able to facilitate more interaction, and safe interactions, but more interactions for them and their friends, depending on where you live, that might be outdoors, that might be setting them up with indoor HEPA filtration units to make the air in the places where they're gathering safer. Maybe it's opening windows, purchasing those at-home rapid antigen tests so that everybody can test before they unmask. If you layer some of those protections — so, for example, the indoor air filtration

units, the HEPA filtration units, as well as testing — you really can make it much safer for people to unmask.

Graham: Thank you. Dr. Brangman, any thoughts that you have on that question?

Brangman: So, yeah, obviously, that's probably one of the main questions I get. And now, especially with the holidays coming, families want to go. I have grandparents who want to go see their grandkids' concerts in school, for example. And schools don't have masking. So I try to explain that we'll never get the risk down to zero. But we have to figure out what is the risk of each event, and which one makes the most sense. And if we're going to talk about family gatherings, if families are going to get together, maybe the week before the event, they start to be very careful about where they go. Don't go to big crowds without a mask and start to prepare for that gathering with vulnerable older people. And then I agree with the concept of everyone testing first. If you can afford to get those air filtration systems, that's great, but they're pretty expensive. A good alternative is to open a window. And again, depending on where you live, that could be a rush of really cold air. But if you have some windows open that keeps the virus moving around, if you can think of the virus like on a roller coaster, it gets harder for it to settle in if it's rolling on all these little airwaves. But we have to figure out how to live with it, this virus, because it's not going away. And as Dr. Metzger noted, being isolated is not good for older people. It's really not good for any of us. We're all social engagers and we need to have that human interaction. I just think we need to figure out the way to make it the safest.

Graham: So, Richard, again, my apologies for cutting you off earlier. You described arriving at the hospital, going into the ICU. Tell us about your experience with having covid and then the sequelae of long covid.

Gard: It bears right now onto ... this idea of the isolation. And particularly surprising to me was not being able to see faces or body language of people for an extended period of time. So I was ... they had no procedures. There was no protocol. There was no test yet. So they put me into a negative airspace room and, again, where they would doff complete suits with breathing apparatus to come in and out of my room, which meant that nobody was coming to bring me, you know, a cookie or a glass of water very quickly, because it was a big production and they didn't have a lot of the PPE yet even. So, they were just figuring it out. And so in that ... I got better after a week and they sent me home, I ended up going back two days later, which is when the fever and so-called cytokine storms started. And that's when I went into ICU and the real adventure started. But during all that time, this was a period of about five weeks, and everybody was more than masked, even having very full clothing that you couldn't really see body movement much, or hands. And I thought — I've never minded being alone, like sailing alone for four days I enjoy. In fact, I enjoy being alone sometimes having, you know, so many people in the family. And so I would have never it would have never occurred to me that I would be affected by not seeing faces or not interacting with people. And pretty quickly, I would learn people just by their voice being a choral conductor. So I could remember somebody by the sound, even though I couldn't see their face at all. But over time ... I couldn't watch TV to see faces because they would just report on how many people died. And it quickly occurred to me, once I was watching that, that I could be just another digit in these numbers that were piling up. As you know, New York City was going into that terrible

time. So I didn't want to watch that. And what happened to me over time that I didn't realize is not seeing faces and such a limited thing even once I got home, I lost the ability to be with people, and it became very threatening for me to be around people that were not masked. And that really is the source of a lot of the trauma that has lived on. And I'm still having therapy and I'm working on being able to be with people just ... it was overwhelming to be with more than two or three or four faces. So it's ... as much as some of the drug therapies I had was the loss of human contact in a way, and asking at times ... I realized I just wanted it. When I was in ICU, I would just ask: Could you please hold my hand? Just touch my hand. Don't poke me with something. Just touch my hand. And they were overwhelmingly busy, so they'd hold my hand, like, 10 seconds then "Sorry, I got to go." And they did. They were very kind. But so ... to people who have a relative or for themselves, if you ... whether or not you were in ICU or you were intubated, whether or not all that, just to realize that getting some ... thinking about that and getting some help to reconnect with faces. Even almost three years later, I'm still gradually going ... just to see you all today was a little bit, brought me some anxiety.

Graham: Wow. Not being able to be with people ... true in the ICU but true in long-term care, true for any older adult who's been profoundly isolated during this period. Richard, a question that I know you'll have lots of thoughts about. Uh-oh. It disappeared. Let me find it. This is from J.D. David: "We're seeing many adults with long covid being told they should be grateful to be alive and there's nothing to be done. Yet we know there are effective therapies, rehab, and palliative care for some of the most frequently seen components of long covid. How can we help providers and older adults recognize that help is available?" So I want you to address this, but please tell us about your journey with long covid and your current recovery.

Gard: Yes. I can see, especially with older adults — my 91-year-old father-in-law lives with us, and when he would go to the doctor by himself, when he didn't live with us, he would go off-topic easily. So it's easy for older adults to be ignored in many ways or, you know, they don't communicate what they need to. But for me, I was extremely fortunate or lucky to have wonderful physicians who I had a relationship with that Yale health plan. And so. I had this very lucky thing, first off, that there were people that knew me and that I guess being a musician and playing in ensembles, I very quickly, instead of being a patient, or something to be acted upon, I endeavor to make myself a team member. And to be part of the team rather than this thing over to the side. And if people can — it also helped me to have something to do — I am just religious in my taking measurements, vitals. I have a lot of prescription drugs and as I've taken them or we've changed them, noting what time all this was and what happened and how I felt after that. So that, for me and for my medical team, that I had an objective record that would help them to help me. And where I got the model from, when I was in the hospital, I realized that the nurses are really the business end of the whole medical world and they're the ones that come in and, you know ... the doctors make the directive, but the nurses are there all the time and they're the ones doing the things to you and with you. And so being my own nurse helped me to get more treatment than I think ... than if I ... if I had just been sick or feeling like, Oh, I can't, you know, I can't walk. I can't. I go 10 steps and I'm exhausted and then I collapse in excruciating chest pain. And my breathing is painful. And then they look and they don't see anything at that time. But having a lot of data allowed them to justify sending me in for, say, a cardiac catheterization, at which time they *did*

find very fine problems, which I believe has ... forwarded some research and treatments that since I was so early on and I had so many records that it should help other people. But the point being that you don't need to talk to people sometimes you just need to mark down and keep a good diary, like you're a good nurse at the hospital, filling out the history on the computer as they come in every 20 minutes. And that kind of stuff will make you look like you're serious about your health and your future. And it puts your mind into a spot where you're able to do something instead of .. being in a helpless state, I tell you, that leads to suicidal items and ... having some way to move myself, even when physically I couldn't move myself, to do that at least gave me some agency in life instead of ... I went and suddenly ... who knew on that day if I'd known how much everything was just ending. Now I'm much, much better. But this has, like, been in the last three weeks that I'm on a fantastic uprise. But I'll stop talking in case I go too long.

Graham: Oh, congratulations on your recovery. I know you walked a mile the other day, which is a huge accomplishment. Jessica, the problem of having a large panel is it's hard to get to everyone on a timely basis. You edit a major gerontology journal. Tell us about the themes that are emerging from the research world that you're aware of relating to the long shadow of covid and older adults.

Kelley: Yes, sure. And it's been a great privilege to be in this position to see so much of the science that's been submitted and then ultimately published on really the experience of it, the health and the social effects altogether. I would say several, just briefly, a couple of the big themes is very early on the very first studies were really focused on this isolation issue, the sudden cutoff of networks and even sometimes own families who wouldn't go see their grandparents out of fear that they would make them ill. So, sometimes well-intentioned isolation ended up having some negative effects with that as well. So but really it's been in the last, probably, six to nine months that we've been able to think about more of this long shadow effect, what happened *after* that first intensive period and what is downstream. And a lot of the themes have already been mentioned here. One has to do with the consequences of delayed care, that people put off routine screenings, avoided dental procedures, things that they didn't absolutely have to have done during the times they didn't feel safe. And we're actually seeing now that it's costing more, that they're coming in sicker in further stages, later stages of diagnosis, or need more invasive treatments. So that's one thing we're really trying to understand. And we expect that to keep trickling through the system for several years. I'd say another major theme that really came up had to do with, what some of you were talking about, vaccines, and that has to do with sources of trusted information that older adults did. And several studies have found that those older adults who trusted things like the mainstream evening news were much more likely to get vaccinated. But the ones who relied on social media or friends and family for their information actually had much less likely to get vaccinated. So really encouraging or getting a lot of good information out in many ways, in terms of just understanding how to even care for oneself. And the third, probably, big one I think had to do with technology and ... how technology could help people get connected. But it also really underscored this digital divide. You had a lot of older adults who didn't even have smartphones, and suddenly their families want to Zoom holidays. And there was just a lot of concern and the frustration that comes with not being able to use your technology correctly and feeling that no one was there to help you press the right buttons. I mean, I know that I hosted a

Zoom early on for all of my aunts and uncles and my parents so they could practice all their buttons in a safe space before they had to go in to do all their church meetings and the like. So, there's just a lot of those sorts of pieces. I won't go on much more, but I'm happy to talk about any more of those in-depth if there are other questions.

Graham: I know that Dr. Gounder is going to have to leave us early. So I'm going to throw a couple of questions her way that have come through. One is from Michael Gelder, who notes that the virus is mutating and subvariants BA.4.6 and BF.7 grew last week in the six-state region, including Illinois, while BA.5 declined — medicalese here. The question is, with these changes, will the new booster still help older adults?

Gounder: Well, I think the way to think about this is, say, comparing the old boosters to the new boosters. They're actually about equivalent, at least when you give one dose of booster. The big picture answer is: They are protecting you from severe disease, hospitalization, and death, whether it's the old booster, the new booster, the updated booster. And so you should absolutely get one. I do think there's a lot to be done by scientists to better figure out how to be ahead of the variants, because this is what viruses do. They mutate; they evolve. What we really need to be developing is what's called a variant-proof or pan-coronavirus vaccine, which is effective against any variant. And that means trying to identify parts of the virus that don't change as much, what we call in scientific jargon that are “more conserved.” And there are people working on that. But the challenge is that, unlike early in the pandemic, where you had a lot of resources thrown at the problem with Operation Warp Speed, we don't have that kind of funding right now to accelerate vaccine research, and to get a vaccine approved and manufactured cost a lot of money. These large clinical trials cost a lot of money. And they're only going to be more expensive because now you have to compare this new vaccine with the old vaccine. And without getting into all of the statistical details, that actually means enrolling many more people in a study to show an improvement or even equivalence. And so this ... we're in a much more difficult place. We have really good vaccines. But to get to a place where we have even better vaccines is going to take some time and going to take some money.

Graham: So this is another question either for Dr. Brangman or you, Dr. Gounder — just raise your hand if you want to be the one to answer it — from Peter Ellis: “The benefits of Paxlovid seem overblown since it was tested among the unvaccinated. Also, rebound is real. Thoughts.” So this is, you know, you're an older adult, you have been vaccinated, you catch covid. What do you do? Should you get Paxlovid or not? And how do you make that decision?

Brangman: Well, I still encourage my patients to take Paxlovid. It is effective, and a study showed it was especially effective for older adults. Even though all age groups benefited, older adults seem to really benefit. And yes, some people do get rebound, but I still think it's important to take it because it may help your body handle the virus better and keep you from getting very, very sick.

Gounder: I'm going to drop in the chat two Twitter threads, which actually have some of this data. Here's the other one, I was just looking for them. And so now ... so one reason a lot of providers are nervous about prescribing Paxlovid is because, especially as we get older, we're on more and more medications. There are more and more drug interactions. So that first Twitter thread actually

explains and very much simplifies how to manage those drug-drug interactions. There are almost none that cannot be managed. And so it's a lot more straightforward than I think people realize, and that some of the providers realize. The second Twitter thread is actually real-world data. So this was collected through EPIC, which is one of the big health electronic health records companies. And so this is real-world data looking at how Paxlovid is working in real people, not in a clinical trial, but in the real world. And you see that it's quite effective in preventing hospitalization and death among people who are vaccinated, among people who are not vaccinated. But if you're elderly, you really stand to benefit from getting Paxlovid. There's also no evidence that there is harm from a rebound, that you're more likely to get long covid or complications if you get a rebound. It's not pleasant. But the key here is to say, is it keeping you out of the hospital? Is it preventing you from dying? And the resounding answer on this is yes.

Graham: All right. Clear messaging there. We're going to transition now to talking about some of the cognitive deficits in older adults that have arisen during the pandemic, which is part of the so-called long shadow. And Dr. Metzger, I'm going to throw this one your way. It's a question: "Have you seen increased rapidity of older adults who may have had mild cognitive impairment undiagnosed prior to the pandemic, who worsened significantly over the last 2½ years? I have a 90-year-old mother-in-law and a 75-year-old friend who were both undiagnosed with any cognitive impairment prior to covid. Since covid, one has been diagnosed with Alzheimer's disease and the other with Lewy body and seen significant decline. I have to wonder if their decline would have occurred or been as pronounced had it not been for covid."

Metzger: Yes. Anecdotally, we have seen cases, new cases of mild cognitive impairment or major neurocognitive disorder after cases of covid. But we're now getting data that formalizes these anecdotal reports. There was just a report in Nature Medicine last month showing increased rates of mild cognitive impairment and dementia in patients who had an episode of covid. And we also know that covid can cause delirium and delirium can accelerate preexisting cognitive decline or may actually be the precipitant to the development of mild cognitive impairment or a major neurocognitive disorder.

Graham: And can you define delirium for us, doctor?

Metzger: Yes. Sorry about that. Thank you. So delirium is also known as acute confusional state. And it is an episode of impaired attention level of consciousness, thought organization that often happens after a medical stressor such as an infection or even elective surgery. In fact, in seniors, after elective hip surgery, for example, delirium rates can be as high as 1 in every 3 patients who goes for those procedures, depending on their frailty going into the procedure and other medical risk factors. And in most cases, people recover from an episode of delirium and regain their baseline mental health. But in a significant percentage, they don't. They may have persistent impairment in various areas of cognition, and they may have an acceleration of a preexisting cognitive impairment.

Graham: Can the social isolation that older adults are experiencing / have experienced during the pandemic contribute to cognitive decline?

Metzger: We know that loss of stimulation can accelerate cognitive decline or maybe even precipitate it. And loss of stimulation ... stimulation runs the gamut from sensory input, vision, hearing to social interactions and physical activity. So take away any of those and you're increasing the risk for cognitive decline.

Graham: Dr. Brangman, I know you work with people who have dementia. What have you seen during the pandemic and what, if anything, can we be doing now to address some of these issues?

Brangman: So, yes, I have seen, just as Dr. Metzger outlined. So it's a very complex disease. And it can be ... it can manifest in many different ways. When you're stressed, whether it's a physical stress or an external stress, that can increase your risk for developing cognitive impairment or dementia. When you're socially isolated and you're not moving around ... we know that exercise really helps your brain stay sharp, and when you're not moving around, when people were limited to staying in their homes, that with social isolation probably had a compounding effect on speeding up cognitive decline. And then we see people who actually got covid, and in those people who got covid, it causes an inflammation in your brain that can affect the nerves that help us with memory. So we've seen people get what they call "covid brain" who normally didn't have any problems with their brain at all and now they feel like their brain is in a fog and they're not normal. And then we see people who actually had Alzheimer's disease or another dementia get covid, and that made them worse. So there's so many different scenarios out there. And we've had an increase in younger people calling our Center of Excellence with what they think is covid fog or covid brain. And it can be very tricky sorting that out because the early signs of Alzheimer's disease and covid brain have a lot in common. But, in general, if you're younger and you have this, we're hoping that with time it will go away. With older people, it looks like if you have covid, you'll increase your risk of developing Alzheimer's disease down the road or making it worse when you have it. So what we have to do is think about how we help our older adults who are experiencing covid the worst get through this when everyone else has moved on. And so we have to help our older adults navigate the world as safe as possible. We would all like to be in bubble wrap and be as safe as ... when my kids were little, I wanted to put them in bubble wrap, and we know that's not healthy. So for older adults, we have to figure out how to help them navigate the safest way possible. And then we have to ask them what matters to them the most. Do they want to go to that wedding of their granddaughter? Do they want to go to that concert with their grandkids or do they feel more comfortable staying home? A lot of times we try to solve the problem without asking people what they really value. So if they really value going out to a concert to see their grandkids play the flute, we have to help them do that the safest way possible. But we can't presume that we can make that decision for them.

Graham: Kathryn, I see you nodding and I know you have something you want to add.

Haslanger: Well, I just ... responding to this enormous need to try to maintain some kind of social connection and stimulation. During the earlier stages of covid, we really exploded the amount of virtual programming we could be doing, and everything from hangout sessions, concerts, yoga, tai chi, drawing classes. And it's not for everyone. There are real limitations to the virtual world, and we've talked about that. But it's also, you know, aging isn't monolithic, and you can't just know by somebody's age what their interest or aptitude or proclivity is going to be. And there

are ... we've done a lot of work to try to expand, give people devices, provide support and training, make sure that somebody had a reason for wanting as ... what matters to you? Is it staying connected to your grandkids? OK, here's a device that can help you do that and we'll ... provide you some ongoing support so that when you run into your first glitch, you don't just give up and shut it down and put it in the drawer and never take it out again. There's a lot of work that we've been able to do during the early stages of covid. And I think in terms of the long shadow, I think we're all trying to figure out how to build on the strengths and build on what we learned. Because what we've been able to do, as people are gradually coming back together again, is maintain some of this virtual and in-person, so that the folks who lost mobility or have limited ability to get out can still see some of their friends and be part of these communal activities, albeit in a different way. But figuring out this "How do you balance the risks and also how do you take advantage of the benefits?" is something that I think we're all working on going forward.

Graham: Jessica.

Kelley: Yeah. ... We're talking a lot about helping people get to events and manage those sort of risk decisions. And I wanted to underscore two points. One is that we know — one of the studies we published showed that those who took precautions very seriously — shopped the senior hours, double-masked, did every ... were very vigilant about those sorts of things — have actually been slower to return to their normal levels of — or their *pre-pandemic*, I won't say normal — pre-pandemic level of social activity. And I think, often when the rest of the world has moved on, it can often ... that can be another form of isolation when it feels like they're still concerned and no one else is. And so understanding that people aren't all in the same place with that. And the other to keep in mind, that at all these points — one of the things we're all saying is — it's a constant risk-benefit analysis, which we didn't have before the pandemic. You didn't have to think that hard about going to the grocery store. And so, I think, you know, also being patient with that sort of level of cognitive and mental health burden that goes into every decision that we didn't have before. And that's very taxing on all of us, but particularly older adults.

Graham: Richard, what have you found has been most helpful for you in terms of ... let's start with outreach from family and friends. What has made the most difference during this long journey you've had with covid and long covid?

Gard: Yes. I have a big family. I'm one of seven children, and so I have a lot from my family. And everybody wanted to see me. And, you know, to Zoom ... even though they couldn't visit. But at the same time, that was a double-edged thing because ... especially in the beginning, it was very difficult for me to be in the presence of people and to handle faces and talking again. I also .. I'm a talker, and it was difficult for me to talk more than four or five minutes without having a lot of physical pain and being exhausted for hours after. And in the beginning, when ... I was special, everybody, you know, the first month after I got out of intensive care. Yeah, that was helpful, but not. And pretty soon, one of my doctors and my wife realized they really needed to limit how much talking and meeting with people I did. And certainly not to go out and meet anybody. Not because I was afraid to get sick even, but I would be knocked backwards for days by the encounter and the stress. And it set my trauma ... it set me more and more from a fight-or-flight feeling down into just completely shut down. So I'd say the thing that helped me a lot come out of that is that,

as I improved — and I pushed this — was exercising or being able to walk, at first 10 steps and then stopping. I have a watch, so I could monitor my heart rate, other than just having chest pain and having to stop. So by exercising — somebody else, you know, reminded me of this — and I still ... I've pushed to exercise more and more every day as the one way that has helped me get my ... get out of the brain fog. And not only to get some stamina back, because I'd love to resume my activities. I would love to be able to hike again. I would love to be able to play the piano again. My fingers just don't follow what I'm thinking anymore. And ... but it's better, and I'm better and better by trying to do movement and even do some, for me, strenuous — brief, strenuous activity. And there's lots of stuff before covid. There is research to support this. And so that, and that's something that you can do. And you don't have to go anywhere and you don't need a prescription. So I would say that, and then gradually, and with my wonderful wife and, like I say, I'm so lucky with my medical team, my cardiologist, my primary [care physician], and my pulmonologist to watch me and help me — my psychiatric, I have an APRN [advanced practice registered nurse] now — to kind of titrate the social interaction and, again, and doing these things so that the stress of it all doesn't overwhelm me. So I got ... I'll stop.

Graham: Thank you, Richard. I appreciate that. We know that covid has hit disadvantaged communities very hard and exacerbated issues of poverty and food scarcity. And now we're seeing the families whose resources have been depleted, older adults whose resources have been depleted by covid facing rising rents and evictions. Kathryn, can you tell us what you're seeing in New York City, the intersectionality of covid poverty and insecurity among older adults?

Haslanger: I think what you're saying is really important because we, before covid, we start with the issues in the communities where we work, the issues of poverty. And you've got to put the crisis in affordable housing and food insecurity and then access to quality primary care at the top of that list. And then you layer over that the special issues of aging and *ageism*. And then you add covid on top of that. And that's been the devastating situation that we have really been trying to deal with. And I think one ... our helpline has exploded with an increased volume of calls, our legal services folks are getting inundated with the need for help with evictions and foreclosures. It was great that there was an eviction moratorium that went, you know, that protected people's housing for as long as it did. But it wasn't a rent moratorium. It was just an eviction moratorium. So there are a lot of folks who had increased costs related to getting access to food, getting access to the medical ... when they *did* need medical care, they had to spend their very limited resources in those other ways. It's not like they were able to sock it away for when the rent eventually became due. So we're seeing this real explosion of the housing crisis at this point that we're trying hard to respond to. And I think another wrinkle on that affordable housing crisis is, when so many people's situations were destabilized during covid ... we had situations where there was an older adult and their sibling lost their job or lost their situation, and they had to move in with them. Or an adult child moved in with an aging parent into tight quarters. This is New York City. People live in tiny apartments with a lot of pressure about, you know, they were there together all day. And there was a lot more stress, a lot more tension in the relationship. And then the elder abuse calls that resulted from that, that that's just something that we don't really talk about, that actually is not limited to people in low-income circumstances, you know, that's across communities. But having to really find ways to work, again, when people are reluctant to have somebody else

coming into their home, but you need to actually make sure you're having a candid conversation ... you're really getting the whole picture so that you can figure out how to help and support somebody. As we start thinking about what we do as covid moves from being pandemic to endemic, I guess that's the way we talk about it. We still ... we can think about the covid aspects. We really need to think about the underlying problems of poverty that this is just really highlighted during this period.

Graham: So we have about 15 minutes left. I'm going to transition to another topic that's really important, which is we have a lot of older adult adults with greater needs because of the pandemic — needs for socioeconomic, needs for food assistance, needs for housing assistance, also needs for assistance in the home. And we have a health care workforce crisis both for home care and for long-term care. Can you — I'll start with you, Dr. Metzger, and then maybe you, Dr. Brangman — can you tell me what you're seeing and what impact that's having on older adults now, in terms of the workforce crisis?

Metzger: As you said, we knew there was a workforce crisis long before the pandemic and that it was going to get worse even without a pandemic. But the pandemic has accelerated that. In long-term care, where I spend most of my time, we experience that as having a less stable, less consistent workforce of nurses and nursing assistants, and familiar staff who develop relationships with these patients are really key to the care that we provide. So bring in rotating staff who are masked and you can imagine what happens to the client-caregiver relationship. And financially having to hire agency or travel nursing staff continues to be a severe stressor on organizations such as mine.

Graham: Any thoughts, Dr. Brangman?

Brangman: Oh, yes. I deal with this every day because our goal is to keep people in their own home for as long as possible. And to do that, they need help. And so I have so many adult children calling in, you know, in tears because they can't find anyone. This has been a workforce that has been working for years at low pay. Most of the workers are single mothers, usually Black or brown, immigrant community, the most vulnerable. Many of them died during the pandemic, so there are fewer of them. And ... we've always needed them, but now we really do. And it's also in the nursing homes. And that has a kind of a domino effect, because you have older people in the hospital who could very well be in a nursing home, but they can't be discharged because the nursing homes are full and they don't have all the hands they need. So that backs up the hospital, which then backs up the emergency department. So we are starting to see what those of us in geriatrics have been talking about for years, is that how do we have a health care workforce that responds to the fastest-growing segment of our population, which are people over the age of 85, who are the most vulnerable to any stressors, whether it's a pandemic or the flu or falling. These are older adults who need more hands on deck, and we are a reactionary society. We don't like to plan ahead. We wait for a crisis and then we try to figure it out. And, you know, that's the worst time to figure things out. So that's where we are right now. I have so many patients who could benefit from having someone come into their home, either daily or a few times a week. We just can't find it. So then they end up falling and they go to the hospital and then they get lost in the hospital system, which is a very expensive level of care. And it's not meeting their needs because

the hospital addresses acute immediate problems, not long-term problems. So we really need someone to look at this from a policy standpoint. We have to pay front-line workers, whether the home health aide or a certified nursing assistant. We have to pay them a wage so they can live and people will choose this as a job. It's a really hard job. It would challenge any of us to do this on a regular basis.

Graham: And the pandemic has just made it worse because of all of the issues that have fallen on these workers' shoulders.

Brangman: Exactly. And they are often the ones who can least control their environment. As Kathryn said, they often live in multigenerational housing. They often have more than one job. So we get calls that *they* are sick. And then when they're sick, then I have to work with my older adult to see if they got it. And it just adds to everyone's workload and stress level.

Haslanger: There's no substitute for fair pay, and people need fair pay and they need health insurance and they need to be able to have planned paid time off to deal with the other aspects of their life. In addition to that, the direct care workers are the eyes and ears in the home. They are a critical source of information that can be the early-warning system. When they have the training and the knowledge to identify what a small change might mean and to communicate that in an actionable way to somebody else on the clinical care team. That's how you can get upstream of the problems. That's how you can get ahead of it. And it gives the direct care worker more respect and an opportunity to see their impacts in a broader way than they are able to often on a day-to-day basis. Those are essential ingredients. We've known about it a long time. We just need to do it.

Graham: So here's the final ...

Brangman: I can give you an example really quickly. I had a patient I was trying to connect through telehealth, and she did not have a computer; she had a landline. But her home health aide had a smartphone. But her home health aide didn't have a good data plan. So my telehealth visit would have used up this home health aide's entire budget for her data plan, and I could not do that in good conscience. So we had to try to figure out another way to get my patient evaluated who was homebound. So how do we have a home health aide who has a cellphone with limited data, who is taking care of someone that she needs that phone as a critical link to provide the care? We should be able to help that patient connect with their doctor, not at the expense of the home health aide.

Graham: And by the way, another long trend related to covid, the expansion of older adults who are homebound. There's been a significant increase in that population. Let's ... I'm going to flip this and address a question from Bridget Deets, and I'm going to throw this to you, Dr. Metzger: "What advice or thoughts would you have for older adults who need to enter a long-term care setting but are nervous or scared of nursing home environments because of how violently covid ran through long-term care facilities?" For instance, an older adult that needs rehab after some kind of procedure but is terrified about going into long-term care. What thoughts do you have about that?

Metzger: Yeah, and those fears are reasonable, given our experience with that first wave of covid and the terrible mortality. I will say that our understanding of how to protect seniors in skilled

nursing facilities has really changed since that first wave. We're much better at rapid identification, at short periods of quarantine, which are focused on people who are at risk, and of using agents like Paxlovid when necessary to decrease the likelihood of serious or fatal outcomes. So in these settings, really, the numbers look much, much better. We also know from some research, though, that location matters and that all skilled nursing facilities are not created equal, so that those facilities that had higher Medicare ratings tended to have better outcomes in terms of protecting their residents and that those facilities who have a higher staff-to-resident ratio did a better job of keeping people safe.

Graham: So what would you recommend when people are looking at the potential for rehab? What kinds of information should they check? What kinds of questions should they ask?

Metzger: Right. I think it's fair to ask how that facility does respond now to identifying a case within their population, but also how they screen new admissions. And I would check on the publicly available Medicare rating website to see what, if any, deficiencies have been identified in that facility and how they compare to other sites in their area.

Graham: So we have about 5 minutes left. I'll take a few more questions and then maybe ask the panelists to go around and, you know, if there's a point you want to bring forward at the end of this conversation and underline it, to think of what that might be. Dr. Brangman, people want to know: When should I get my booster? Is it three months? Is it two months? Is it four months? How do I make that decision? What do I need? What are the things that I need to think about in figuring out when to get it?

Brangman: So you should get your booster ... it could be in that two- to three-month window ... of your last booster. Or if you had an actual covid infection, you should probably wait about three months to get the new booster. And I know calling it bivalent makes it confusing to a lot of people, so I just call it the new booster. And in fact, they're not even giving the old one anymore. So you should just get the booster within about two to three months of your previous booster or about three months after you've had the covid infection itself.

Graham: And another medical question. People have so many questions for doctors! So you, Dr. Brangman: Do monoclonal antibodies have the same risk of rebound covid that Paxlovid does? Should they be the preferred treatment now if they don't have that risk?

Brangman: So they don't have that risk, but they're not as easy and convenient to get. So you need an appointment and you need to have an IV. And hospitals are pretty short-staffed right now. So Paxlovid is a tablet, it's a pill. You can get it with a prescription pretty quickly. So I don't think you should necessarily pick one or the other. It depends on which one you can get the easiest. And I would not worry about rebound that much. I think it's been a little bit overstated. Paxlovid is very effective, especially if you're an older adult, in keeping you from getting really, really sick.

Graham: So let's do a round-robin here and start with you, Jessica. If you had to highlight a few issues that you've heard come out of this session today that you really want to underscore, what would those be?

Kelley: Well, thank you for this opportunity to be here and to learn from my colleagues. This has been really fun. I do have to say that I wanted to emphasize a couple of things. One, I want to go back to this idea of the insecurity and the ... that the covid just showed us the vulnerabilities that were already there. And they've just gotten worse. And that we need to be aware that aging isn't a universal thing. And we have a lot of folks who are aging in very vulnerable situations made worse in this. So just keeping in mind that this is an uneven recovery from the transition from the pandemic to the endemic. And keeping our eyes on those who are most vulnerable.

Graham: Richard, what are your thoughts as we bring this to a close?

Gard: Hang in there. And yeah, covid is still going. But being as active and, for your older adult relatives, be gentle, but be persistent about going in and connecting with them. It does far more than you'll know. You know. Well, yeah. That's it. That's it.

Graham: OK. Thank you. Kathryn, how about you?

Haslanger: So I guess my remark would be that there's a lot that we know about vaccines and treatments and how to keep ourselves healthy and being safe. And it's really hard to think about any of that if you don't have a safe and affordable place to live, a roof over your head, and if you're not completely sure where your next meal's coming from. So that dealing with those underlying issues is really essential if we're going to make progress on anything else.

Graham: Dr. Metzger.

Metzger: I think among our younger population, there's a race back towards normalcy. And for many younger people, they *can* go back to fairly normal lives. But, I think as we've highlighted today, our older citizens are being left behind in this race toward normalcy. I think we could achieve a *new* normal for them with certain precautions. And we've talked about some of those today.

Graham: And Dr. Brangman.

Brangman: So as someone who takes care of older adults all the time, I think it's important that we remember them. I mean, we all want to be there one day, right? And as we all try to get past this and think it's over, we have to realize it really isn't. And there are still members of our community, our grandparents, mothers, and fathers, who are still really impacted by covid. And what we have to do is help them figure out how to navigate the safest way possible. And I really don't see a problem with wearing masks indoors. There's no shame in wearing a mask indoors. It's probably the most effective thing that you can do. So, get a good N95 mask, and if you're going to be indoors, wear it.

Graham: Thank you all. We've reached our time limit. Thank you, panelists. Thank you, audience, for attending. It's been a wonderful conversation.