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Short Communication

Psychosocial telemonitoring and teleorientation for older adults in the Social Security (EsSalud) during the first six months of the COVID-19 pandemic in Peru

Telemonitoreo y teleorientación psicosocial para adultos mayores del Seguro Social de Salud (EsSalud) durante los primeros seis meses de la pandemia por COVID-19 en el Perú

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ABSTRACT

Background: The Peruvian Social Security during the COVID-19 pandemic implemented a psychosocial remote care program for older adults in order to improve their quality of life and prevent the development of mental problems. **The study:** Analysis of secondary data from records generated by teams from the Senior Centers at the national level between May and October 2020, with the aim to describe the experience of implementing Psychosocial telemonitoring and teleorientation for elderly patients during COVID-19 pandemic. **Findings:** A total of 154 280 follow-ups and 36 492 remote care services were provided to older adults. The main interventions provided were emotional support (75.5%) and social counseling (53.8%). The most recorded moods were calmness and worry. Feelings of worry, stress, sadness, and fear are higher in the reports with COVID-19 compared to those without COVID-19. **Conclusion:** Psychosocial telemonitoring and teleorientation for older adults can be used as another way to provide comprehensive care in elderly population.

Keywords: Psychosocial Support Systems, Health Services for the Aged, Telemedicine, COVID-19 (Source: DeCS-BIREME).

RESUMEN

Introducción: La Seguridad Social Peruana durante la pandemia por COVID-19 implementó un programa de cuidado psicosocial remoto para personas adultas mayores con el fin de mejorar su calidad de vida y evitar el desarrollo de problemas mentales. **El estudio:** Análisis de datos secundarios de registros generados por equipos de los Centros del Adulto Mayor a nivel nacional entre mayo y octubre de 2020, con objetivo de describir la experiencia de implementación de telemonitoreo y teleorientación psicosocial a distancia para pacientes adultos mayores durante la pandemia por COVID-19. **Hallazgos:** En total se brindaron 154 280 seguimientos y 36 492 atenciones a distancia a personas adultas mayores. Las principales intervenciones brindadas fueron apoyo emocional (75,5%) y consejería social (53,8%). Los estados de ánimo más registrados fueron calma y preocupación. Los sentimientos de preocupación, tales como estrés, tristeza y miedo fueron altos en pacientes con COVID-19 en comparación con los que no tienen COVID-19. Si bien el servicio brindado en los Centros del Adulto Mayor no fue etiquetado como "prescripción social", la mayoría de los componentes abordan beneficios similares a los modelos de prescripción social en otros países. **Conclusión:** El telemonitoreo y la teleorientación psicosocial pueden ser usados como otro medio para proveer cuidado integral a la población adulta mayor

Palabras Clave: Sistema de soporte psicosocial, Servicios de Salud para Ancianos, telemedicina, COVID-19. (Fuente: DeCS-BIREME).

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest regarding the subject of this scientific article.

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INTRODUCTION

The COVID-19 epidemic has led to an increase of remote healthcare services. The delay in development of effective and safe vaccines, social distancing, and quarantine have created an environment in which the search for alternatives to person-to-person care is a priority[1]. Different strategies such as remote consultations, remote monitoring, and home delivery of medications were implemented to supply medical care[2]. In the disruptive scenario caused by COVID-19, along with medical care, the need for social and emotional support, possibly in remote ways, has emerged as a crucial service as well.

The health and needs of the elderly were especially affected by COVID19 since they are at higher risk of progression to severe disease and mortality from it[3]. COVID19 may also exacerbate problems of isolation, loneliness, and anxious and depressive disorders as a consequence of social distance measures[4]. High prevalence of anxiety disorders (up to 49.7%) and depression (up to 47.2%), plus an increase of sleep disturbances and psychological stress have been reported due to COVID19[5]. Being female, having family members with COVID-19, having negative feelings, and lack of resources seem to act as potential risk factors[5].

The need to provide new forms of health care to elderly led to the creation of programs such as CCARRE - Coordinated Care At Risk/Remote Elderly in New York(6), which focused on older adults with cognitive impairment and provided services through videos and calls in which a comprehensive care plan was developed for patients. Spain and Romania assessed the effectiveness of a TV-based platform service for physical and mental health and wellbeing in older people with mild cognitive impairment or mild dementia[7]. These programs address physical and mental health issues of the elderly but they did not address their social issues.

In the case of our country, the Regulation of Law No. 30421, considers different service modalities for the remote approach of people, such as telemonitoring, teleorientation, teleconsultation, among others; which can be used taking advantage of information technologies[8]. It should be noted that it is necessary to take into consideration the literacy of older adults, internet connectivity, among other aspects, for its deployment in this population[9].

Peruvian Social Security (EsSalud) is responsible for the care of almost 30% of Peruvian Population. It is organized in health networks, which are administrative units distributed at national level. In total there are 29 care networks, three of which are located in Lima (Peru's capital) and the others in the remaining regions[10].

EsSalud delivered social services for elderly nationwide before the COVID-19 pandemic; since the lockdown began, it has implemented a strategy for telemonitoring and teletorientation for older people. Health professionals such as social workers and psychologists, who used to provide preventive and recreational activities for elderly in senior center through the face-to-face modality, began to carry them out remotely, including active listening active listening sessions, social and emotional counseling, social-family support actions, social-health orientation, and follow-up for suspected cases of COVID-19[9]. We describe the experience of implementing psychosocial remote care sessions for elderly patients of the Peruvian Social Security during COVID-19 pandemic.

A previous experience in Lambayeque Region, was developed for emotional support through teleconsultation in order to minimize avoidant symptoms; this study was developed in a population with suspected or confirmed diagnosis of COVID-19[11].

METHODS

Description of Psychosocial telemonitoring and teleorientation for older adults in EsSalud

EsSalud is the second largest public health provider in Peru, insuring all the formal employed population and their families[12]. EsSalud has 126 senior centers nationwide that develop and provide preventive and recreational activities. They have the aim to improve quality of life for older adults through the development of family integrative, intergenerational, sociocultural, recreational, productive, and lifestyle programs for active aging[13]. Due to the measures adopted for the pandemic, the senior centers have started to provide services remotely through telephone calls or video calls for their users. Thus, after the start of the pandemic, they implemented a Psychosocial Telemonitoring and Teleorientation Program with the objective of providing emotional and social support to older adults. In Fig 1, you can see how the intervention was deployed.

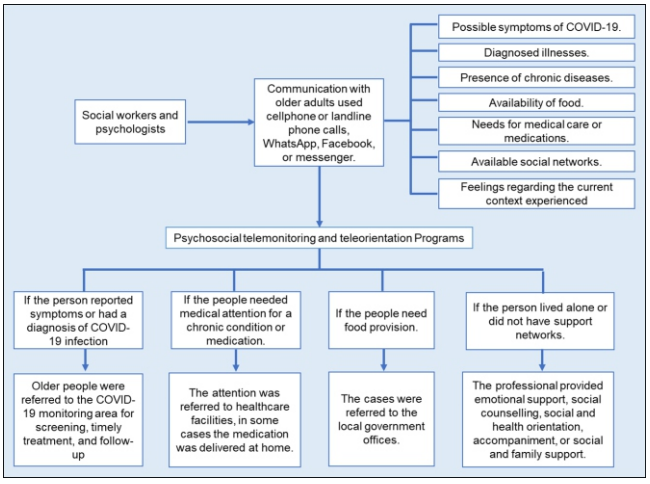

Figure 1.
Outline of the Telemonitoring and Teleorientation Program.

Methods

We performed a secondary data analysis of records generated by the teams of the senior centers at the national level during the first six month of operation, between May to October 2020. The database of Psychosocial telemonitoring and teleorientation program for older adults contains the senior center, the healthcare network to which they belong and the name of the center. It also contains the self-report sociodemographic data of the elderly such as age, number living at home, food availability, presence of violence, the

need for medication, and self-report of COVID-19 infection. We also registered the method of communication and the type of intervention provided. The data are presented descriptively in frequencies and percentages. We analyzed the data using STATA v.16 statistical software (StataCorp, TX, US) and graphics were created using Excel Spreadsheet.

Ethics

The information presented in grouped format to not disclose the identification of any older adult or health professionals. The study protocol was approved by the Institutional Review Board of COVID studies (91-SGRyGISDIS-IETSI-ESSALUD-2020).

RESULTS

Characteristics of psychosocial remote program

Between May 1 and October 31, 2020, 154 280 remote monitoring and care were provided to 36 492 older adults. The number of encounters per month is shown in Fig. 2.

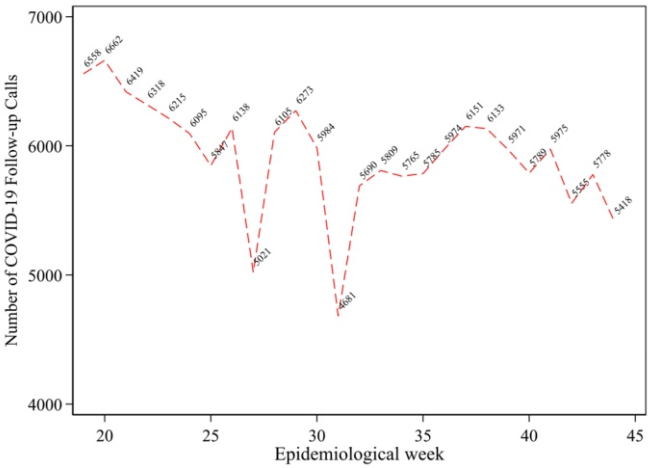

Figure 2.
Number of older adults and number of remote care sessions per month.

The healthcare networks that provided the greatest number of remote care sessions were Lima-Rebagliati (27174), Cusco (13029) and Lima-Sabogal (13029); the number of remote care sessions provided by each healthcare network is shown in fig 3. The healthcare networks with the largest number of older adults who received remote care sessions were those located in Lima.

Characteristics of older adults in the first psychosocial session

At the first remote care sessions, 71.5% of older adults reported living with two or more people at home and only 6.5% reported living alone. The majority of the attendees (90.0%) had no problems with food availability and 0.7 % reported presence of violence at home. Regarding the need of medications, 13.7 % had prescriptions pending and 14.5 % reported lack of prescription and need of medicines (See table 1).

Table 1. Characteristics of elderly in their first remote care sessions.

Characteristics	n = 36492	(%)
Age [mean (Standard deviation)	73.5 (SD: 7.7)	
Number of people living at home		
Alone	2375	-6.50%
With one person	8023	-22.00%
With two or more people	26094	-71.50%
Food availability		
No	3647	-10.00%
Yes	32845	-90.00%
Need of medicine		
Do not need medicine	26192	-71.80%
Prescription pending	5012	-13.70%
Do not have prescription and need medicines	5288	-14.50%
Presence of violence		
Yes	253	-0.70%
No	36239	-99.30%
COVID-19 infection		
Positive	461	-1.30%
Negative/Do not know	36031	-98.70%

Care provided in psychosocial program

Table 2 shows the characteristics of interventions provided in remote care sessions. The main method of communication with patients was through cell phone calls 70.7%, the main intervention provided was emotional support (75.5%), followed by social counseling (53.8%). 41.5% of the remote care sessions were follow-ups and the main reason for follow-up was for emotional aspects (49.3%) and for prescriptions (25.4%). (See table 2).

Table 2. Characteristics of the services provided through telemedicine, May-October 2020.

Characteristics	n	%
Method of communication		
Cell phone calls	109059	70.70%
Landline phone calls	32593	21.10%
WhatsApp	10346	6.70%
Others	2282	1.50%
Type of intervention*		
Emotional support	116503	75.50%
Social counseling	82930	53.80%
Social and health orientation	66307	43.00%
Accompaniment	26536	17.20%
Social and family support	21491	13.90%
Others	18593	12.10%
Reason of follow-up*		
Emotional	75995	49.30%
Prescription	39137	25.40%
Presence of violence	1112	0.70%
Health	1099	0.70%
Food Availability	87	0.10%

** The sum of the values does not add up to 100% because the categories are not mutually exclusive*

The most recorded mood were calmness and worry, although in different proportions between cases with and without COVID-19 infection. In addition, feelings of worry, stress, sadness and fear are higher in those with COVID-19 compared to those without COVID-19 (See table 3).

Table 3. Feelings reported by older adults in remote care sessions, May-October, 2020.

Characteristics	without Covid-19		with Covid-19	
	n (%) = 151101 (97.9%)		n (%) = 3179 (2.1%)	
Feelings*				
Calm	75490	50.00%	1063	33.40%
Worry	49112	32.50%	1606	50.50%
Stressed	20070	13.30%	585	18.40%
Optimistic	16302	10.80%	184	5.80%
Sad	14690	9.70%	562	18.70%
Fear	12.146	8.00%	592	18.60%

** The sum of the values does not add up to 100% because the categories are not mutually exclusive*

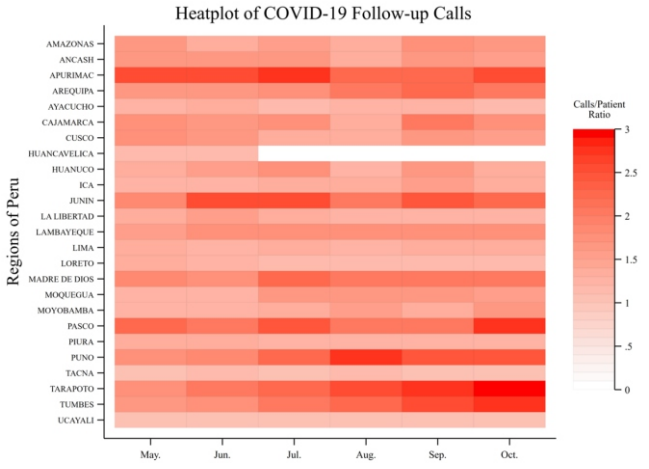

Figure 3.
Heatplt of COVID-19 follow up-calls.

DISCUSSION

Although the service provided in the care centers was not labeled "social prescribing", most of the components address similar benefits as social prescribing models in other countries. Initiatives on social prescribing have been introduced in Netherlands, Canada, Australia and the United States, but is a common practice in the United Kingdom[14]. Social prescription is the process by which a person is referred to community resources, can be done by any primary care professional, and will address emotional or practical needs, for example, housing or employment advice, bereavement support, health behavior counselling, spaces for arts, sport or creative activities[9, 15]. Some case-studies suggest that social prescribing in older adults experiencing social isolation and mild-to-moderate mental health problems cause positive effects on self-esteem, mental wellbeing, reduce loneliness and reduce health service use[9, 16]. In addition, in other studies, it has been shown that the social prescription service allows people to participate in the community, generating more optimistic feelings about life[17].

The COVID-19 pandemic have increased existing emotional, social, and economic challenges in population health that social prescribing may address. A social prescribing model that involves workers from the primary care and include principles of universality, comprehensiveness, and integration presents an opportunity to improve people wellbeing in the COVID-19 era[18].

Regarding the provision of care through remote services, implementation of remote services is challenging not only for users, but also for healthcare providers. In Brazil, it is reported that the implementation of a remote care sessions program, the difficulties of health personnel in the early stages, was reflected in low adherence to services, as professionals gained more experience, adherence and fidelity to the service improved[19]. We cannot affirm this with our data because we worked with secondary data and did not collect healthcare professional perceptions.

In spite of the benefits offered by technology and remote care, it is necessary to reflect on some of its limitations, such as lack of access, distrust and technological literacy[6] which are higher among older adults; this is consistent with a study where it was found that a third of older adults did not adapt to the use of telemedicine, plus the use of the telephone was an important option, especially for people with disabilities[20]. That is not just a problem for users, also for providers, since health professionals also experienced problems adapting to the use of technology, which was overcome over time[21].

Despite the resistance and lack of thrust regarding the use of technology, healthcare workers and older adults gradually adapted to the use of new means of care delivery; this is an indicator about the necessity to focus public health policies on capability approach as an ultimate goal[22], recognize the digital gap, and contextualize strategies to the reality of people[20].

The impossibility of some older adults to have a telephone at home, cell phone or internet, or to have them but not know how to use them, indicates that those who have had access to remote services are probably a privileged group. According to our study, the least amount of telemonitoring was carried out in Huancavelica, which is the region with a 60.5% rural population, 80% speaks Quechua, 17.7% of its population is illiterate and very few have access to higher education[23].

The information from this study is descriptive and it has not been possible to measure the effect of remote care on the quality of life of older adults. However, in the experience of CARE, one benefit could be that caregivers and patients improve their mood and decrease their symptoms of depression and anxiety[6]. We hope that to some extent this has happened with older adults in Social Security.

Senior Centers through their Psychosocial telemonitoring and teleorientation have been carrying out an important task of health, emotional and social assistance to the elderly. During the first 6 months of this remote assistance, more than 150 thousand remote care sessions were carried out for the benefit of around 36 thousand elderly people. The main services offered have been emotional support, social counseling and social and health orientation.

This experience shows the need to articulate health and social services in favor of the well-being of older adults, through strategies such as social prescription.

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