AGEISM AND RESOURCE ALLOCATION IN THE COVID-19 ERA: ETHICAL AND POLICY CONSIDERATIONS

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FEBRUARY 3, 2021
DISCLOSURES

• I have no financial conflicts of interest relevant to this presentation.
OBJECTIVES

• Introduce key events and concepts related to ageism and resource allocation in the COVID era
• Review the American Geriatrics Society position statement on resource allocation strategies
• Discuss the Utah and California Crisis Standards of Care
• Reflect on the role of geriatricians in advocacy work for older adults at the policy level
HYPOTHETICAL CASE SCENARIO

You are the triage officer for a hospital operating under your state’s Crisis Standards of Care enacted by the governor. Your hospital’s ICU COVID unit has been full all week. One ventilator becomes available when a patient is successfully extubated.

Later that day, you receive a call from the ED attending about 2 patients who both need a ventilator. **Patient A** is a 70 year old gentleman with a history of insulin-requiring diabetes mellitus, obesity, HFpEF, stage IV CKD, hypertension, and CVA who used a wheelchair prior to admission. **Patient B** is a 90 year old gentleman independent of all ADL and IADL who takes only a multivitamin and, before the pandemic hit, skied to celebrate becoming a nonagenarian.

In-hospital mortality risks for Patient A and Patient B are identical according to the Modified Sequential Organ Assessment (MSOFA).

You review your state’s Crisis Standards of Care guidelines, which include a “tiebreaker” provision that would give the ventilator to Patient A based on age. Is this age-based “tiebreaker” provision ethical?
WHICH HEALTHCARE RESOURCES ARE SUBJECT TO REALLOCATION UNDER CONDITIONS OF RESOURCE SCARCITY?

• **Space** (e.g. hospital beds, ICU beds)

• **Staff** (e.g. intensivists, respiratory therapists)

• **Stuff** (e.g. ventilators, remdesivir, vaccines)
The Extraordinary Decisions Facing Italian Doctors
There are now simply too many patients for each one of them to receive adequate care.

MARCH 2020: AGE-BASED RATIONING IN ITALY

IDEAS

The Atlantic

MARCH 11, 2020

3. An *age limit* for the admission to the ICU may ultimately need to be set. The underlying principle would be to save limited resources which may become extremely scarce for those who have a much greater *probability of survival* and life expectancy, in order to *maximize the benefits* for the *largest number* of people. In the worst-case *scenario of complete saturation* of ICU resources, keeping a “first come, first served” criterion would ultimately result in withholding ICU care by limiting ICU admission for any subsequently presenting patient.

4. Together with age, the *comorbidities* and *functional status* of any critically ill patient presenting in these exceptional circumstances should carefully be evaluated. A longer and, hence, more “*resource-consuming*” clinical course may be anticipated in *frail elderly* patients with severe comorbidities, as compared to a *relatively shorter*, and potentially more benign course in healthy young subjects.

PRIORITIZATION OF ETHICAL PRINCIPLES

- 4 widely accepted ethical principles in Western societies: autonomy, justice, beneficence, and nonmaleficence

- **Usual care:** Autonomy > justice and beneficence

- **Rationing:** Justice and beneficence > autonomy
Texas Lt. Gov. Dan Patrick suggests he, other seniors willing to die to get economy going again

"Those of us who are 70 plus, we'll take care of ourselves. But don't sacrifice the country," Patrick told Tucker Carlson.

MARCH 2020: SELF-REFLECTION

• Feeling of powerlessness during COVID – what can I contribute?

  Undergraduate exposure to medical ethics
  Tideswell leadership training
  Outstanding interprofessional colleagues
  + Support of AGS staff and CEO

*Motivation to push back on ageist sentiment during COVID*
MARCH/APRIL 2020: LOCAL RESPONSE

Commentary: Family values are needed more than ever in the time of COVID-19

Update: Who decides who lives and dies during a crisis? Utah has new answers

Policymakers, health care providers and others rely on "crisis standards of care" to make those hard decisions fair and formulaic — but some worry that older adults and people with disabilities will bear the brunt.

https://www.sltrib.com/opinion/commentary/2020/03/31/commentary-family-values/
AGS Position Statement: Resource Allocation Strategies and Age-Related Considerations in the COVID-19 Era and Beyond

AGS POSITION 1

Age per se should never be used as a means for a categorical exclusion from therapeutic interventions that represent the standard of care. Likewise, specific age-based cutoffs should not be used in resource allocation strategies.

Rationale:
• Section 1557 of the ACA prohibits age discrimination in health care programs receiving federal funding
• Age cutoffs ignore the heterogeneity of older adults
• Age is a poor proxy for projected outcomes
AGS POSITION 2

When assessing comorbidities, the disparate impact of social determinants of health including culture, ethnicity, socioeconomic status and other factors should be considered.

**Rationale:**
- Inadequate access to primary care – and resulting chronic diseases – may lead to worse scores upon assessment of chronic comorbidities.
Multi-factor resource allocation strategies that equally weigh in-hospital survival and severe comorbidities contributing to short-term (<6 month) mortality should be the primary allocation method in emergency circumstances that require rationing due to a lack of resources.

Rationale:

• Age is less predictive of mortality than functional trajectory, multimorbidity, and frailty.
• Including chronic comorbidities that are unlikely to affect short-term mortality is ethically problematic.
In order to avoid biased resource allocation strategies, criteria such as “life-years saved” and “long-term predicted life expectancy” should not be used, as they disadvantage older adults.

**Rationale:**
- Concern for implicit bias - these criteria may ignore the social determinants of health that have systematically disadvantaged underrepresented groups.
- Long-term predictions of life expectancy are notoriously unreliable.
Triage committees and triage officers who have no direct clinical role in the care of the patients being considered for allocation of limited resources should be familiar with resources available at their institution and also should be available to clinicians when decisions about allocating scarce resources must be made.

Rationale:
• Concern for ad hoc approach
• Concern for moral distress among front-line clinicians
• Front-line clinicians should be applying – not selecting – emergency rationing criteria when resources are limited
AGS POSITION 6

Institutions should develop resource allocation strategies that are transparent, applied uniformly, and developed with forethought and input from multiple disciplines including ethics, medicine, law, and nursing. These strategies should be used consistently when making emergency decisions. Such strategies should be reviewed frequently to ensure inclusion of the latest science and to identify any evidence of disparate impact or bias.

Rationale:

• Accountability and transparent communication help build public trust in resource allocation frameworks.
• It is inadequate to develop a resource allocation framework that lacks regular and rigorous review.
AGS POSITION 7

Widespread and carefully considered advance care planning discussions are of paramount importance in achieving ethical care decisions based on the individual’s values, preferences and goals. These decisions should not be viewed as a form of rationing, and advance care planning should preferably be done well before a time of crisis. Efforts should be intensified to increase meaningful advance care planning across health systems.

Rationale:

• Advance care planning respects individual autonomy.
• While not a form of rationing, advance care planning will identify older adults who do not wish to receive intensive care.
• Patients should not be pressured, even subtly, to engage in advance care planning to conserve health care resources.
MAY - JUNE 2020: RATIONING FEARS SUBSIDE

https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html
JULY 2020: RATIONING FEARS REEMERGE

Banner memo: Arizona first to activate crisis care plan in the country

THE NEW OLD AGE

Should Youth Come First in Coronavirus Care?

If medical rationing becomes necessary, some older adults are prepared to step aside. But many have the opposite concern: that they will be arbitrarily sent to the rear of the line.

CRISIS STANDARDS OF CARE (CSC)

- Resource allocation guidelines enacted by states for conditions of resource scarcity
- Many such crisis guidelines anticipated a pandemic influenza scenario
- Some crisis guidelines categorically exclude older adults from critical care resources
Patients ≥ 90 years old were excluded from this resource allocation strategy, meaning that they had no claim on critical care under conditions of resource scarcity.
FOR IMMEDIATE RELEASE
August 20, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

OCR Resolves Complaint with Utah After It Revised Crisis Standards of Care to Protect Against Age and Disability Discrimination
AUG. 2020: REVISED UTAH CRISIS STANDARDS

- Utah revised its standards in response to a complaint filed by Utah’s Disability Law Center with the Office for Civil Rights at HHS.*
- Revised UT standards removed age as a categorical exclusion.
- Revised UT standards added age as a “tiebreaker.”

*OCR resolved similar complaints with Tennessee, Pennsylvania, and Alabama.

Non-ICU Care Criteria: Patients with the following conditions should be offered non-ICU care:

- a) DNR or similar POLST or advance directive.
- b) Cardiac arrest without easily identifiable AND reversible cause.

The following must be evaluated using reasonable modifications for individuals with underlying disabilities, where appropriate:

- c) Severe acute trauma with a REVISED TRAUMA SCORE <2.
- d) Acute MSOFA greater than 11, as initial cutoff.
- e) Acute MSOFA greater than the Crisis MSOFA Cutoff determined in Step 3.

(c), (d), and (e) incorporate the Glasgow Coma Scale

AUG. 2020 UTAH CSC: ADDITIONAL FEATURES

• Emphasis on shared-decision making, including review of patient preferences on POLST form

• Individualized patient assessment

• Crisis MSOFA cutoff score reassessed daily by the Crisis Triage Officer based on available resources
  – Promotes resource sharing and “load leveling” across Utah hospitals

MODIFIED SEQUENTIAL ORGAN FAILURE ASSESSMENT (MSOFA)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>SpO₂/FiO₂ ratio* or nas</td>
<td></td>
<td>SpO₂/FiO₂ ≥400</td>
<td>SpO₂/FiO₂ ≥316</td>
<td>SpO₂/FiO₂ ≥231</td>
<td>SpO₂/FiO₂ ≥151</td>
</tr>
<tr>
<td>cannula or mask O₂</td>
<td></td>
<td>or room air SpO₂ &gt;90%</td>
<td>or room air SpO₂ &gt;90%</td>
<td>or room air SpO₂ &gt;90%</td>
<td>or room air SpO₂ &gt;90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-3 L/min</td>
<td>1-3 L/min</td>
<td>1-3 L/min</td>
<td>1-3 L/min</td>
</tr>
<tr>
<td>Jaundice</td>
<td>no scleral icterus</td>
<td>jaundice/ scleral icterus</td>
<td>jaundice/ scleral icterus</td>
<td>jaundice/ scleral icterus</td>
<td>jaundice/ scleral icterus</td>
</tr>
<tr>
<td>Hypotension†</td>
<td>None</td>
<td>MABP &lt;70</td>
<td>dop &lt;5</td>
<td>dop &gt;15 or epi ≥0.1 or noepi ≥0.1</td>
<td>dop &gt;15 or epi &gt;0.1 or noepi &gt;0.1</td>
</tr>
<tr>
<td>Glasgow Coma Score</td>
<td>15</td>
<td>13 - 14</td>
<td>10 to 12</td>
<td>6 to 9</td>
<td>&lt;6</td>
</tr>
<tr>
<td>Creatinine level, mg/dL</td>
<td>&lt;1.2</td>
<td>1.2 - 1.9</td>
<td>2.0 - 3.4</td>
<td>3.5-4.9 or urine output &lt;500 mL in 24 hours</td>
<td>&gt;5 or urine output &lt;200 mL in 24 hours</td>
</tr>
</tbody>
</table>

MSOFA score is the total score from all rows = 19 (maximum score)

- 3-day mortality ~ 50% for MSOFA >11†
- MSOFA scores are associated with in-hospital mortality among patients with COVID*
- MSOFA does not include age, unlike other illness severity scoring systems (e.g. APACHE)

†Grissom CK et al., Disaster Med Public Health Prep 2013
THE REST OF THE STORY…
OCT. 2020: REQUEST FOR 2ND REVISION TO UTAH CRISIS OF CARE STANDARDS

• Aug. 2020 revision removed the age cutoff, but the “age as a tiebreaker” provision remained

• 2 geriatricians and a bioethicist/legal scholar argued against “age as a tiebreaker” before the Utah Hospital Association CSC Workgroup

• AGS position statement was essential in this effort
Tiebreakers: Because younger persons generally have better short-term mortality outcomes than older persons with the same clinical condition, when after individualized assessments of short-term mortality risk, not all patients with similar MSOFAs can be given ICU/ventilator care, relative youth may be used as a tiebreaker.

DECOUPLING FRAILTY AND AGING

“Frail older adult”

“Older adult who may or may not be frail.”

Consider including frailty assessment within crisis standards of care
# CLINICAL FRAILITY SCALE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>VERY FIT</strong> People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.</td>
</tr>
<tr>
<td>2</td>
<td><strong>FIT</strong> People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.</td>
</tr>
<tr>
<td>3</td>
<td><strong>MANAGING WELL</strong> People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.</td>
</tr>
<tr>
<td>4</td>
<td><strong>LIVING WITH VERY MILD FRAILTY</strong> Previously &quot;vulnerable,&quot; this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being &quot;slowed up&quot; and/or being tired during the day.</td>
</tr>
<tr>
<td>5</td>
<td><strong>LIVING WITH MILD FRAILTY</strong> People who often have more evident slowing, and need help with higher order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.</td>
</tr>
<tr>
<td>6</td>
<td><strong>LIVING WITH MODERATE FRAILTY</strong> People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standing) with dressing.</td>
</tr>
<tr>
<td>7</td>
<td><strong>LIVING WITH SEVERE FRAILTY</strong> Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ≈ 6 months).</td>
</tr>
<tr>
<td>8</td>
<td><strong>LIVING WITH VERY SEVERE FRAILTY</strong> Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.</td>
</tr>
<tr>
<td>9</td>
<td><strong>TERMINALLY ILL</strong> Approaching the end of life. This category applies to people with a life expectancy &lt; 6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death.)</td>
</tr>
</tbody>
</table>

## SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help. In very severe dementia they are often bedfast. Many are virtually mute.

Clinical Frailty Scale ©2005–2010 Rockwood. Version 7.0 (EN). All rights reserved. For permission: www.geriatricmedicine.rockwood.ca

COVID-19 IN OLDER PEOPLE (COPE) STUDY

The effect of frailty on survival in patients with COVID-19 (COPE): a multicentre, European, observational cohort study


- Observational study of 1564 patients hospitalized with COVID-19 (10 out of 11 hospitals from the UK, 1 in Italy) between 2/27/20 – 4/28/20
- CFS was assessed in all patients
- Primary outcome was 7-day in-hospital mortality

COPE STUDY: FRAILTY PREDICTS COVID OUTCOMES BETTER THAN AGE

Survival curves for ages 65-79 and age 80+ do not separate.

Survival curves separate by CFS score.

COVID-19 rapid guideline: critical care in adults
(Last update: 27 March 2020)

Assess frailty
Patient aged over 65, without stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism: use Clinical Frailty Scale (CFS) score as part of a holistic assessment.

Any patient aged under 65, or patient of any age with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism: do an individualised assessment of frailty. Do not use CFS score.

Consider comorbidities and underlying health conditions in all cases

Adult admitted to hospital

More frail based on assessment:
- for example, CFS score of 5 or more

Critical care considered appropriate

Initial management outside of critical care

Condition improves

Ward-level care safe currently: continue to review

Condition deteriorates

Refer to critical care

Critical care not considered appropriate

Initial management outside of critical care

Condition improves

Ward-level care safe currently: continue to review

Condition deteriorates

End-of-life care

Less frail based on assessment:
- for example, CFS score under 5, AND would like critical care treatment

Initial management

Ward-level care safe currently: continue to review

Condition deteriorates

Refer to critical care

End of life

This is a summary of the advice in the NICE COVID-19 rapid guideline: critical care.
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NOV. 2020: 3RD REVISION TO UTAH CRISIS STANDARDS OF CARE

• Removed “age as a tiebreaker”

• Added a 3-part tiebreaker based on:
  (1) Clinical trajectory
  (2) Reassessment of prospect of short-term survival based on relevant tools such as CFS or the 4C mortality score
  (3) Randomization to lottery (using a random number generator and not a game of chance)
Commentary: Utah health care standards protect the elderly

By Timothy W. Farrell, Leslie Francis and Mark A. Supiano | Special to The Tribune | Nov. 27, 2020, 12:19 p.m. | Updated: 5:28 p.m.
HYPOTHETICAL CASE SCENARIO REVISITED

You are the triage officer for a hospital operating under your state’s Crisis Standards of Care enacted by the governor. Your hospital’s ICU COVID unit has been full all week. One ventilator becomes available when a patient is successfully extubated.

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You review your state’s Crisis Standards of Care guidelines, which include a “tiebreaker” provision that would give the ventilator to Patient A based on age. Is this age-based “tiebreaker” provision ethical?
California SARS-CoV-2 Pandemic Crisis Care Guidelines

CONCEPT OF OPERATIONS
HEALTH CARE FACILITY SURGE OPERATIONS AND CRISIS CARE
06/2020
CALIFORNIA CRISIS STANDARDS OF CARE

- Assigns priority groups based on mSOFA score
- Does not allow categorical exclusions based on age
- Resolves ties according to “severe medical comorbidities and advanced chronic conditions that limit near-term duration of benefit and survival.”
- Uses randomization to lottery as a last resort to break ties
EXAMPLES OF LIFE-LIMITING COMORBIDITIES IN THE CALIFORNIA CRISIS STANDARDS OF CARE

- Minimally conscious or unresponsive wakeful state from prior neurologic injury
- American College of Cardiology/American Heart Association Stage D heart failure
- World Health Organization Class 4 pulmonary hypertension
- Severe chronic lung disease with FEV1<20% predicted, FVC<35% predicted
- Cirrhosis with a model for end-stage liver disease score >20
- Metastatic Cancer with expected survival ≤ 6 months despite treatment
- Refractory hematologic malignancy (resistant or progressive despite conventional initial therapy)
Restrictions on EMS services reflect resource allocation occurring in the field
- CSC guidelines generally focus on hospital care

Introduces potential for ad hoc approaches and “soft rationing” involving older adults
RECENT EXAMPLES OF AGS ADVOCACY REGARDING RESOURCE ALLOCATION
SEPT. 2020: NATIONAL ACADEMIES DRAFT FRAMEWORK FOR VACCINE ALLOCATION

• AGS provided oral and written testimony opposing NASEM’s “life-years saved” argument
• NASEM softened “life-years saved” language in their final vaccine allocation framework
DEC. 2020: ACIP TIERED ALLOCATION SYSTEM FOR COVID VACCINES

• ACIP* considered multiple ethical factors in generating a tiered system including maximizing benefits/minimizing harms, promoting justice, and mitigating health inequities

• AGS was represented in ACIP deliberations about this tiered approach

*ACIP: Advisory Committee for Immunization Practices
JAN. 2021: CDC LISTENING SESSION ON COVID VACCINE AND COGNITIVELY IMPAIRED OLDER ADULTS

• AGS recommended that the CDC consider:
  – Homebound older adults
  – Role of family caregivers in vaccination
  – “Unbefriended” or “unrepresented” older adults who lack decision-making capacity and also lack surrogate decision makers
AGS POSITION STATEMENT: POST-PANDEMIC RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Review outcomes of resource allocation strategies that were actually implemented.</td>
<td>Unjust resource allocation strategies could persist beyond COVID.</td>
</tr>
<tr>
<td>2 Review resource allocation strategies for discriminatory provisions.</td>
<td>Age-based cutoffs could exacerbate extant ageism.</td>
</tr>
<tr>
<td>3 Implement ethical resource allocation strategies in health care facilities and systems where none exist.</td>
<td>Ad hoc approaches will be unjust, and will burden front-line clinicians.</td>
</tr>
</tbody>
</table>
LESSONS LEARNED

“The only thing worse than having a resource allocation framework is not having one.”

-Doug White, MD, MAS
LESSONS LEARNED

• Ageism is pervasive but can be opposed
• The AGS is highly respected by local and national policymakers
• Geriatricians – even those without prior policy experience - are well positioned to advocate for older adults outside the walls of the health system
ACKNOWLEDGEMENTS

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THANK YOU!

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