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)

MARCH 2020: AGE-BASED RATIONING IN ITALY

The Atlantic

IDEAS

The Extraordinary Decisions Facing Italian Doctors

There are now simply too many patients for each one of them to receive adequate care.

MARCH 11, 2020

https://www.theatlantic.com/ideas/archive/2020/03/who-gets-hospital-bed/607807/

MARCH 2020: SIAARTI GUIDELINES

SIAARTI
PRO VITA CONTRA DOLOREM SEMPER

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.

http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid-19%20-%20Clinical%20Ethics%20Reccomendations.pdf

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

MARCH 2020: AGEIST RHETORIC

https://www.nbcnews.com/news/us-news/texas-lt-gov-dan-patrick-suggests-he-other-seniors-willing-n1167341

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

The Salt Lake Tribune

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

DeseretNews.

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/
https://www.deseret.com/indepth/2020/4/7/21206770/coronavirus-corona-covid-19-triage-icu-beds-ventilators-standards-crisis-standards-of-care

MAY 2020

Journal of the American Geriatrics Society

AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

AGS Position Statement: Resource Allocation Strategies and Age-Related Considerations in the COVID-19 Era and Beyond

Timothy W. Farrell, MD, AGSF,[*†‡] Lauren E. Ferrante, MD, MHS,[§] Teneille Brown, JD,[¶‖] Leslie Francis, PhD, JD,[**††] Eric Widera, MD,[‡‡§§] Ramona Rhodes, MD, MPH, MSCS, AGSF,[¶¶‖‖] Tony Rosen, MD, MPH,[***] Ula Hwang, MD, MPH,[†††‡‡‡] Leah J. Witt, MD,[§§§¶¶¶] Niranjan Thothala, MD, MRCP(UK), MBA,[‖‖‖****] Shan W. Liu, MD, SD,[††††] Caroline A. Vitale, MD, AGSF,[‡‡‡‡§§§§] Ursula K. Braun, MD, MPH,[¶¶¶¶‖‖‖‖] Caroline Stephens, PhD, RN, GNP-BC,[*****] and Debra Saliba, MD, MPH, AGSF[†††††‡‡‡‡§§§§§]*

https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16537

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.

AGS POSITION 3

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.

AGS POSITION 4

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.

AGS POSITION 5

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 scare 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.

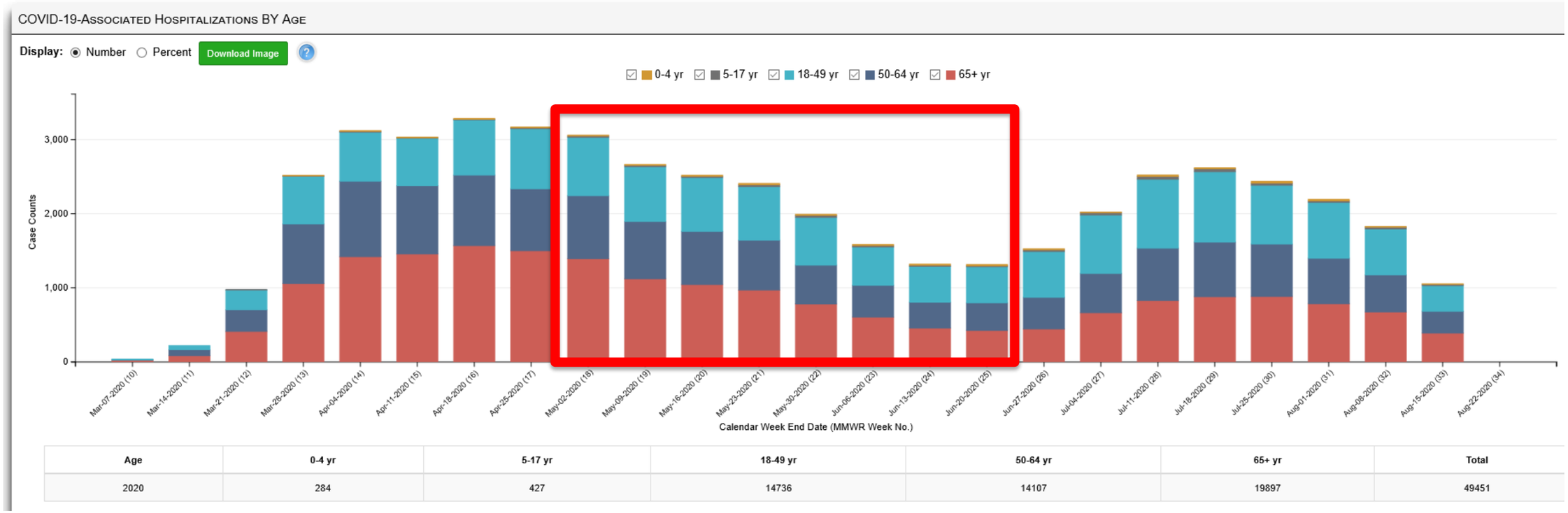
AGS POSITION 7

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



Age	0-4 yr	5-17 yr	18-49 yr	50-64 yr	65+ yr	Total
2020	284	427	14736	14107	19897	49451

https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html

JULY 2020: RATIONING FEARS REEMERGE

NEWS > PHOENIX METRO NEWS > CENTRAL PHOENIX NEWS

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

https://www.abc15.com/news/region-phoenix-metro/central-phoenix/banner-memo-arizona-first-to-activate-crisis-care-plan-in-the-country

JULY 2020: SPOTLIGHT ON INTERGENERATIONAL JUSTICE

THE NEW OLD AGE

Should Youth Come First in Coronavirus Care?

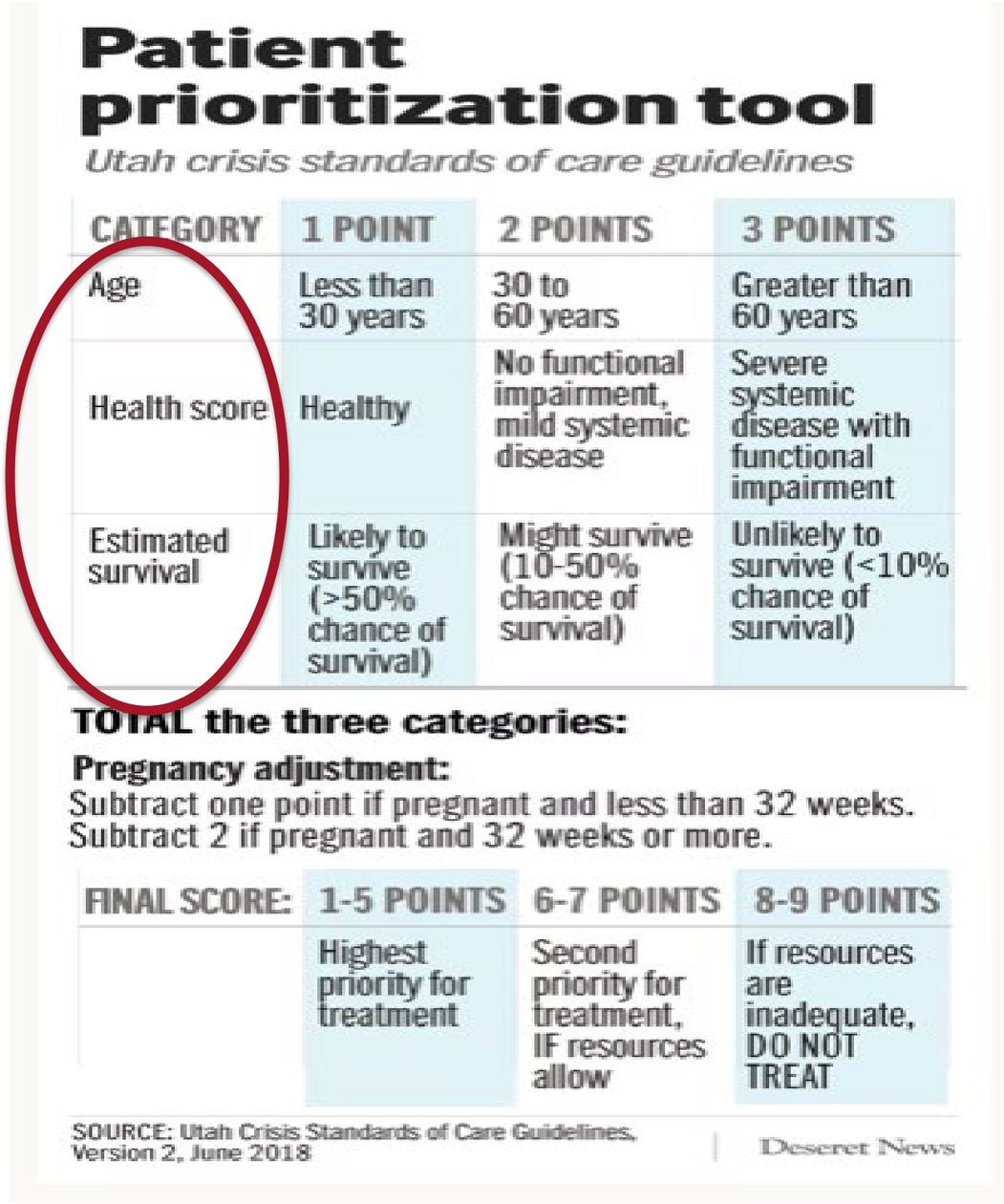
If medical rationing becomes necessary, some older adults are prepared to step aside. But many have the opposite concern: that they will be arbitrarily sent to the rear of the line.

https://www.nytimes.com/2020/07/31/health/coronavirus-ethics-rationing-elderly.html

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

2018 UTAH CRISIS STANDARDS OF CARE



Patient prioritization tool

Utah crisis standards of care guidelines

CATEGORY	1 POINT	2 POINTS	3 POINTS
Age	Less than 30 years	30 to 60 years	Greater than 60 years
Health score	Healthy	No functional impairment, mild systemic disease	Severe systemic disease with functional impairment
Estimated survival	Likely to survive (>50% chance of survival)	Might survive (10-50% chance of survival)	Unlikely to survive (<10% chance of survival)

TOTAL the three categories:

Pregnancy adjustment:
Subtract one point if pregnant and less than 32 weeks.
Subtract 2 if pregnant and 32 weeks or more.

FINAL SCORE:	1-5 POINTS	6-7 POINTS	8-9 POINTS
	Highest priority for treatment	Second priority for treatment, IF resources allow	If resources are inadequate, DO NOT TREAT

SOURCE: Utah Crisis Standards of Care Guidelines, Version 2, June 2018

Deseret News

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.*

https://www.deseret.com/indepth/2020/4/7/21206770/coronavirus-corona-covid-19-triage-icu-beds-ventilators-standards-crisis-standards-of-care

https://int.nyt.com/data/documenthelper/6852-utah-triage-guidelines/02cb4c58460e57ea9f05/optimized/full.pdf

AUG. 2020: REVISIONS TO UTAH CSC

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.*

https://www.hhs.gov/about/news/2020/08/20/ocr-resolves-complaint-with-utah-after-revised-crisis-standards-of-care-to-protect-against-age-disability-discrimination.html

AUG. 2020 UTAH CRISIS STANDARDS OF CARE: EXCLUSION CRITERIA

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

https://www.utahhospitals.org/images/pdfs-doc/Utah_Crisis_Standards_of_Care_Guidelines_v7_08182020.pdf

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

https://www.utahhospitals.org/images/pdfs-doc/Utah_Crisis_Standards_of_Care_Guidelines_v7_08182020.pdf

MODIFIED SEQUENTIAL ORGAN FAILURE ASSESSMENT (MSOFA)

Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Row Score
SpO_2/FIO_2 ratio* or nasal cannula or mask 02 required to keep Spo2 >90%	SpO_2/FIO_2 >400 or room air Spo2 >90%	SpO_2/FIO_2 316-400 or Spo2 >90% at 1-3 L/min	SpO_2/FIO_2 231-315 or Spo2 >90% at 4-6 L/min	SpO_2/FIO_2 151-230 or Spo2 >90% at 7-10 L/min	SpO_2/FIO_2 ≤150 or SpO2 >90% at >10 L/min	
Jaundice	no scleral icterus			jaundice/ scleral icterus		
Hypotension†	None	MABP <70	dop <5	dop 5-15 or epi ≤0.1 or norepi ≤0.1	dop >15 or epi >0.1 or norepi >0.1	
Glasgow Coma Score	15	13 -14	10 to 12	6 to 9	<6	
Creatinine level, mg/dl	<1.2	1.2 - 1.9	2.0 - 3.4	3.5-4.9 or urine output <500 mL in 24 hours	>5 or urine Output <200 mL in 24 hours	
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

*Zhou F et al. Lancet 2020; 395 (10229): 1038.

https://www.utahhospitals.org/images/pdfs-doc/Utah_Crisis_Standards_of_Care_Guidelines_v7_08182020.pdf

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

AUG. 2020 UTAH CRISIS STANDARDS OF CARE: TIEBREAKER PROVISION

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.

https://coronavirus-download.utah.gov/Health/Utah-Crisis-Standards-of-Care-Guidelines-v7-08132020.pdf

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 FRAILTY SCALE

1 VERY FIT — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 FIT — 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.

3 MANAGING WELL — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 LIVING WITH VERY MILD FRAILTY — Previously "vulnerable," 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 "slowed up" and/or being tired during the day.

5 LIVING WITH MILD FRAILTY — People who often have **more evident slowing**, and need help with **high 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.

6 LIVING WITH MODERATE FRAILTY — 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, standby) with dressing.

7 LIVING WITH SEVERE FRAILTY — **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).

8 LIVING WITH VERY SEVERE FRAILTY — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 TERMINALLY ILL — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

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.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

COVID-19 IN OLDER PEOPLE (COPE) STUDY

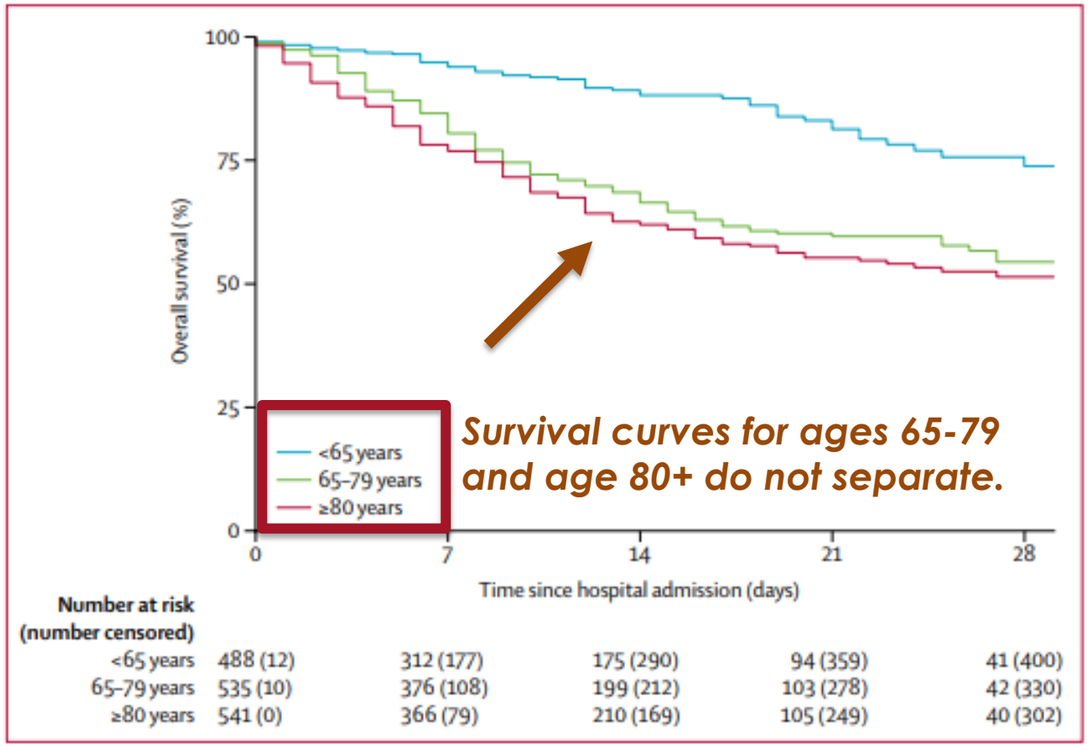
The effect of frailty on survival in patients with COVID-19 (COPE): a multicentre, European, observational cohort study

*Jonathan Hewitt, Ben Carter, Arturo Vilches-Moraga, Terence J Quinn, Philip Braude, Alessia Verduri, Lyndsay Pearce, Michael Stechman, Roxanna Short, Angeline Price, Jemima T Collins, Eilidh Bruce, Alice Einarsson, Frances Rickard, Emma Mitchell, Mark Holloway, James Hesford, Fenella Barlow-Pay, Enrico Clini, Phyo K Myint, Susan J Moug, Kathryn McCarthy, on behalf of the COPE Study Collaborators**

- 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

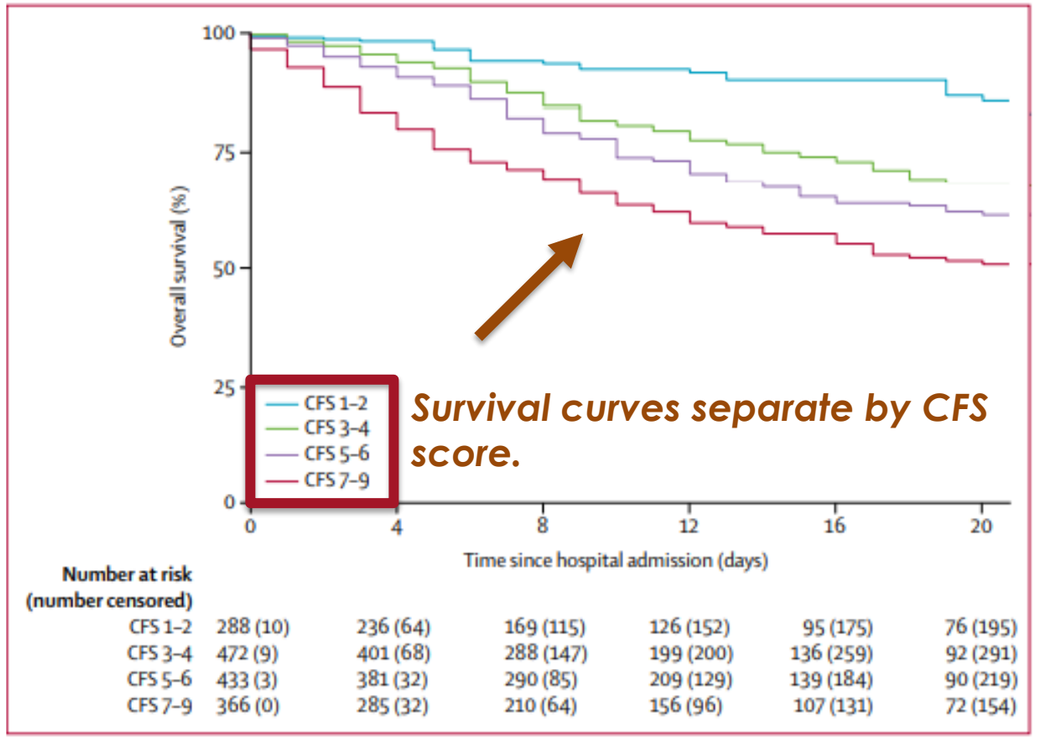
Hewitt et al. The effect of frailty on survival in patients with COVID-19 (COPE): a multicenter, European, observational cohort study. Lancet Public Health 2020; 5: e444-451.

COPE STUDY: FRAILTY PREDICTS COVID OUTCOMES BETTER THAN AGE



Number at risk (number censored)					
<65 years	488 (12)	312 (177)	175 (290)	94 (359)	41 (400)
65–79 years	535 (10)	376 (108)	199 (212)	103 (278)	42 (330)
≥80 years	541 (0)	366 (79)	210 (169)	105 (249)	40 (302)

Figure 2: **Overall survival by age**



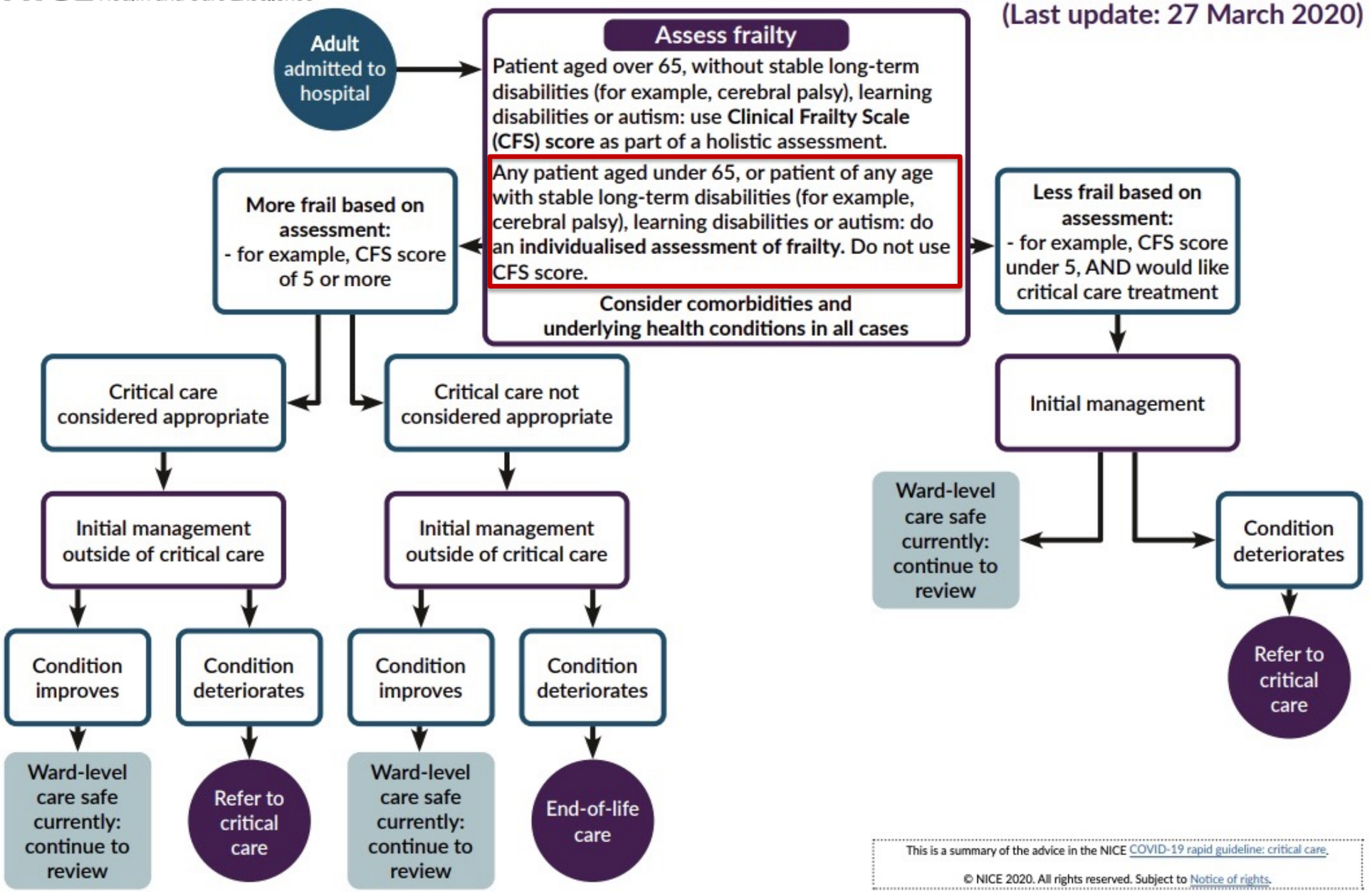
Number at risk (number censored)						
CFS 1–2	288 (10)	236 (64)	169 (115)	126 (152)	95 (175)	76 (195)
CFS 3–4	472 (9)	401 (68)	288 (147)	199 (200)	136 (259)	92 (291)
CFS 5–6	433 (3)	381 (32)	290 (85)	209 (129)	139 (184)	90 (219)
CFS 7–9	366 (0)	285 (32)	210 (64)	156 (96)	107 (131)	72 (154)

Figure 1: **Overall survival by CFS category**
CFS=clinical frailty score.

Hewitt et al. The effect of frailty on survival in patients with COVID-19 (COPE): a multicenter, European, observational cohort study. Lancet Public Health 2020; 5: e444-451.

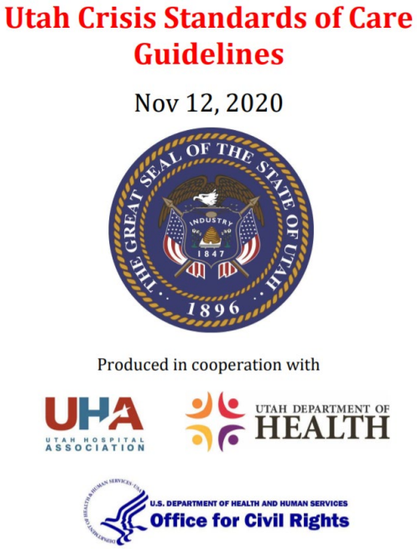
NICE National Institute for Health and Care Excellence

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



This is a summary of the advice in the NICE COVID-19 rapid guideline: critical care.

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)

NOV. 2020: ACKNOWLEDGEMENT OF UTAH HOSPITAL ASSOCIATION CSC WORKGROUP

SEARCH

The Salt Lake Tribune

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.

https://www.sltrib.com/opinion/commentary/2020/11/27/commentary-utah-health/

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.

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?**

CALIFORNIA CRISIS STANDARDS OF CARE

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 $\geq$20
- Metastatic Cancer with expected survival $\leq$ 6 months despite treatment
- Refractory hematologic malignancy (resistant or progressive despite conventional initial therapy)

California SARS CoV-2 Crisis Care Guidelines

DEC. 2020/JAN. 2021: RESTRICTIONS ON EMS SERVICES AND OXYGEN USE IN LOS ANGELES

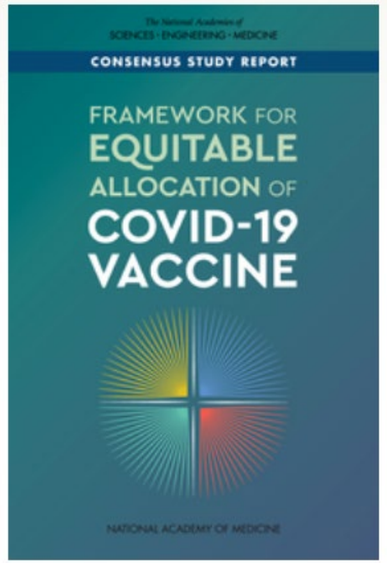
- Restrictions on EMS services reflect resource allocation occurring in the field
  - CSC guidelines generally focus on hospital care

- 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

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

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

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THANK YOU!

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