

Commentary: Utah health care standards protect the elderly



(Francisco Kjolseth | The Salt Lake Tribune) Intermountain Healthcare medical crews perform COVID-19 testing at their Salt Lake InstaCare location at 389 S 900 East on Wednesday, Nov. 11, 2020.

[By Timothy W. Farrell, Leslie Francis and Mark A. Supiano | Special to The Tribune](#)

When the COVID-19 pandemic history is written, the impact of health care teams on the front lines in preventing the spread of COVID, treating those struggling with its devastating symptoms and comforting families grieving the loss of loved ones will deserve special mention.

This story would not be complete, however, without acknowledging the efforts of other groups that work behind the scenes to support health care professionals, patients and families. The Utah Hospital Association Crisis Standards of Care (CSC) work group is one such example.

This work group, which collaborates with the Utah Department of Health, is charged with providing [crisis standards of care guidelines](#) for the allocation of scarce health care resources during public health emergencies such as the COVID-19 pandemic. These guidelines require intensive review of the medical literature to identify individual characteristics contributing to patients' likelihood of short-term survival, paired with careful deliberation about the ethical and legal implications of any proposed resource allocation guideline.

The work group is comprised of a diverse group, including critical care physicians, hospital medicine physicians, nurses, ethicists and emergency managers, who collectively strive to treat all Utahns equitably under extremely difficult circumstances. While the work group hopes that these guidelines will never need to be used, the present day surge of COVID-19 has placed enormous pressure on Utah hospitals to the extent that the crisis standards of care may soon need to be activated.

The story of the COVID-19 pandemic also includes another unfortunate chapter —namely, disparate impact of the virus on vulnerable groups including, but not limited to, underrepresented patients, those with socioeconomic disadvantages and older adults.

We, representing the disciplines of geriatrics, law and bioethics, have been particularly cognizant of outright discrimination against older adults during the COVID era. At the beginning of the pandemic, older adults were restricted from access to health care resources in Italy. In the United States, ageist sentiment was echoed by some, including politicians who urged older adults to isolate so that the rest of the country could get on with their lives.

Ageist approaches to distributing scarce health care resources were also included within several states' crisis standards of care, sometimes in the form of age-based cutoffs or “tiebreaker” provisions favoring younger patients. Such provisions are not supported by evidence, as a healthy, robust older adult may in fact have better outcomes than someone younger with multiple medical problems.

In addition, using age as a “tiebreaker” unfairly penalizes an older adult twice, as medical conditions that the older adult might have acquired over time will have already been considered in the initial resource allocation assessment.

We would like to publicly acknowledge and congratulate the Utah CSC work group for removing age-based provisions from its crisis standards of care guidelines. In April, this work group removed an age-based cutoff of 90 years or greater, and in November, prior wording that permitted an age-based tiebreaker was removed. The revised version emphasizes an individual assessment of each patient and further that any judgment cannot be “based on any unlawful considerations of race, color, national origin, disability, age, or sex.”

Utah has been a national leader in crisis standards since they were initially established in 2009, and is now a leader in having resource allocation policies free of ageist provisions. We commend the work group for the revised standard that ensures that access to care in a crisis situation will protect and value the health and health care of all people in Utah.

The COVID-19 pandemic story is not yet complete, but should include increased attention to the importance of advance care planning conversations. All Utahns' wishes for their care, particularly for life-sustaining treatments at the end of life, should be made known to their families and health care providers.

These conversations should take place in advance of crisis situations and should never include pressure to avoid health care resources to benefit younger generations. However, such conversations will inevitably identify those who would not wish to receive life-sustaining treatments, such as being placed on a ventilator, for any reason.

If difficult decisions do need to be made about resource allocation now or in the future, older adults in Utah should be able to rest assured that a number that they cannot control — their age — will not count against them.



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The opinions expressed are those of the authors and do not necessarily represent those of the University of Utah.