MINNESOTA
BOARD ON AGING

Minnesota Board on Aging
Crisis Standards of Care Position Paper

Executive Summary

The 2020 COVID-19 pandemic has disproportionately killed nursing home residents and older adults of color in Minnesota and across the nation. The approaching flu season brings the potential for crisis-driven decisions to determine who receives limited healthcare resources. Given this backdrop, the Minnesota Board on Aging asks the Minnesota Department of Health to provide leadership that:

- Ensures public health, emergency medical services, health care systems and clinicians are familiar with and uniformly implement the guidelines set out in the Minnesota Crisis Standards of Care Framework.
- Provides guidance that warrants objective decision-making for the allocation or reallocation of resources that is based on personalized and evidence-based standards, rather than subjective or generalized ideas of health, quality of life or longevity. Resources must be offered based on objective and transparent criteria. Non-medical factors such as age, race, ethnicity, gender, sexual orientation, disability, immigration status, perceived social or economic worth, ability to pay, first-come, first served must not be used.
- Communicates resource decisions and standards of care, which are consistent, transparent, and accountable.
- Works in collaboration with the Minnesota Board on Aging to ensure that future decisions about health care standards are made without bias against older Minnesotans. Involves the Ombudsman for Long-Term Care in discussions related to health care standards relating to people living in long-term care settings.

Background

As COVID-19 spreads across our state, with nearly 90,000 people testing positive in Minnesota, and nearly 2,000 dead because of this disease, our state's health care system is facing an unprecedented challenge. As the Board tasked by Minnesota's governor to advise on issues affecting the aging and create public awareness of the needs of older persons, the Minnesota Board on Aging (MBA), calls on Minnesota's Department of Health (MDH) and state health care systems to remember their obligations to all residents of this state. In crises, providers must provide non-discriminatory, uniform and consistent medical care to all persons. Subjective

criteria, such as age, race, ethnicity, gender, gender identity or expression, sexual orientation, disability, immigration status, ability to pay or perceived social or economic worth, should not be a factor in determining access to appropriate and sufficient medical treatment and resources.

MDH spearheaded the development of the Crisis Standards of Care Framework (CSC Framework) to create a comprehensive and systematic way of providing medical care in times of emergency or crisis statewide. The goal of the CSC Framework is to create uniform and consistent standards for the provision of ethical and non-discriminatory treatment by medical providers. When health care providers, including facilities, emergency services and other health providing agencies, such as skilled nursing facilities or home and community based services face an overwhelming number of patients, or lack the resources to meet patients' needs, the CSC Framework provides guidance for emergency measures and the allocation or reallocation of resources.

The Issue

Unfortunately, Minnesota' CSC Framework, while excellent in many regards, permits potential discriminatory treatment by providers, based on pre-existing conditions and generalized characteristics such as age or disability. Although the framework documents suggest these conditions not be considered when resources are allocated in times of crisis, it does not prohibit consideration. As evidence of this, the May 2020 document, Allocation of Ventilators & Related Scarce Critical Care Resources During the COVID-19 Pandemic, outlines a series of subjective categories which *should not* be considered when medical providers make decisions regarding priority allocation of scarce resources. These categories include:

- *Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status*
- *Ability to pay*
- *Age as a criterion in and of itself (this* ***does not limit*** *consideration of a patient's age in clinical prognostication of likelihood to survive to hospital discharge)*
- *Disability status or comorbid condition(s) as a criterion in and of itself (this* ***does not limit*** *consideration of a patient's physical condition in clinical prognostication of likelihood to survive to hospital discharge)*
- *Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis), unless the patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice)*
- *First-come, first-served*
- *Judgments that some people have greater "quality of life" than others*

- *Judgments that some people have greater "social value" than others.*

This language, combined with other aspects of the framework, raises concerns that older adults or those with disabilities may face particular difficulties accessing equal care. Although the document explicitly states that rationing decisions should not consider age, disability or comorbidity factors as criterion in and of themselves when resources are scarce - it allows for consideration of a patient's age and/or physical condition in clinical prognostication of likelihood to survive to hospital discharge. Many older adults, especially older adults from minority, immigrant or economically disadvantaged backgrounds, are more likely to have disabilities or increased comorbidity factors. For this reason, allowing the potential for subjective bias or disparate treatment based on the existence of comorbidity factors, even in a multi-faceted approach to decision-making, must not happen..

MBA's Proposed Solution

The Minnesota Board on Aging proposes that Minnesota's CSC Framework, including operational documents and medical rationing plans or surge protocols, **prohibit** discrimination and subjective bias against older persons.

All people, regardless of age, race, ethnicity, gender, gender identity, gender expression, sexual orientation, disability, immigration status, ability to pay, or perceived social or economic worth, deserve consistent, compassionate, respectful and fair medical treatment. Crisis does not waive the obligations of health care providers to treat all individuals equitably, fairly and with compassion and respect.

Allocation or reallocation of medical equipment and resources must be done in a manner that is reasonable, equitable and transparent. Medical treatment decisions cannot be based on subjective criteria or generalized understandings, but must be made on personalized and evidence based criteria. The health care system has a duty of care to provide equitable, ethical, compassionate and personalized treatment to those availing themselves of its services. In times of overwhelming crisis and need, making decisions may be challenging, but these decisions must be made objectively and following legal principles. To allow subjective, quality of life or longevity of life criteria into the decision-making process could insert implicit bias, which will lead to inconsistent and subjective decisions and discriminatory allocation of care.

Minnesota's COVID-19 cases and deaths have disproportionately impacted people living in congregate care settings across the state. As of September 15, 2020, 85,351 Minnesotans have tested positive for COVID-19. Of those, 13,762 were age 60 or older and 10,972 were exposed in a congregate care facility. Older persons are more at risk of severe symptoms requiring hospitalization and more at risk of death from the disease. Of the 1,927 Minnesotans who have

died from COVID-19, 1,770, were age 60 or older and more than 1,400 (73%) lived or worked in congregate care sites.

Minnesota's older adults who are people of color are especially impacted. Nearly one third of all Indigenous persons testing positive for COVID-19 are hospitalized, the highest rate of any one group in Minnesota. Black Minnesotans are 7% of the population, but make up 21% of COVID-19 cases, 23% of those hospitalized and 9% of the deaths. Latinx Minnesotans are 6% of the population, 20% of COVID-19 cases, 8% of those requiring hospitalization, and 5% of the deaths. Black Minnesotans test positive for COVID-19 at almost seven times that of white Minnesotans, and Latinx Minnesotans test positive for COVID-19 at more than eight times that of white Minnesotans.

There is no room for discriminatory treatment in health care. Health care systems must ensure that every person seeking treatment receives personalized evaluation and medical treatment, based on clinical considerations of an individual's recovery and health, as determined through the best available evidence.

The Minnesota Board on Aging recognizes that decision making during times of crisis is difficult, but each triage or treatment decision directly impacts the health of an individual, so we ask that the Minnesota Department of Health:

- Ensure public health, emergency medical services, health care systems and clinicians are familiar with and uniformly implement the guidelines set out in the Minnesota Crisis Standards of Care Framework.
- Provide guidance that warrants objective decision-making for the allocation or reallocation of resources that is based on personalized and evidence-based standards, rather than subjective or generalized ideas of health, quality of life or longevity. Resources must be offered based on objective and transparent criteria. Non-medical factors such as age, race, ethnicity, gender, sexual orientation, disability, immigration status, perceived social or economic worth, ability to pay, first-come, first served must not be used.
- Communicate resource decisions and standards of care, which are consistent, transparent, and accountable. Work in collaboration with the Minnesota Board on Aging to ensure that future decisions about health care standards are made without bias against older Minnesotans. Involves the Ombudsman for Long-Term Care in discussions related to health care standards relating to people living in long-term care settings.

As the group tasked with advising the Governor and state policy makers about the concerns of older Minnesotans, we ask that future conversations regarding health care policies that impact older adults always include the Minnesota Board on Aging and the Ombudsman for Long-Term Care.