



UCOA Quarterly Meeting Agenda Thursday – November 12, 2020

12:00 AM - 01:30 PM

Business Meeting

ALL VIRTUAL

Join Zoom Meeting <https://zoom.us/j/640416337>

Or Dial 669 900 6833

Meeting ID: 640 416 337

(Zoom conference information will remain the same for all UCOA quarterly meetings)

UCOA Business Meeting

12:00 Welcome to Commission Members and Community Partners Andrew Jackson
Welcome and Introduction to New First Time Attendees

12:05 Executive Director Report Rob Ence

Public Policy

- Commission Sunset and Statutory Change Recommendations
- Utah Home Health Policy Change Recommendations Melissa Hinton
- Other priorities discussion Jeremy Cunningham

Community Resources

- U4A/UCOA Virtual Center – pilot for volunteer and event management
- Website additions
- Recap of Center on Aging Caregiving Retreat
- Other programs discussion

12:35 Justice in Aging – Outing Ageism in the COVID Era Mark Supiano

- Age as a “tie-breaker” for health care decisions
- Other COVID-related updates

1:05 I-SNPs (Institutional Special Needs Plan) Tracy Altman
Additional comments Gary Kelso

1:25 Partner and community events to share (see handouts)

1:30 Adjourn

Next UCOA Virtual Meeting – Thursday – February 11, 2021

(Public and partner comment and input welcomed throughout. Session will be recorded.)

Purpose of Sunset Reviews

Review statutes that are scheduled to be repealed, in order to:

- eliminate programs that do not serve a clear public purpose; and
- improve existing programs.

Guidelines for Sunset Review

From [Utah Code § 63I-1-103](#)

[...]

(3) The interim committee shall then consider:

- (a) the extent to which the statute or agency has operated in the public interest and any areas in which the statute or agency needs to improve its ability to operate in the public interest;
- (b) the extent to which existing statutes interfere with or assist the legitimate functions of the statute or agency, and any other circumstances including budgetary, resource, and personnel matters that have a bearing on the capacity of the statute or agency to serve the public interest;
- (c) the extent to which the public has been encouraged to participate in the adoption of the rules established in connection with the statute or agency;
- (d) the extent to which the statute's provisions or agency's programs and services are duplicative of those offered by other statutes or state agencies;
- (e) the extent to which the objectives of the statute or agency have been accomplished and their public benefit;
- (f) the adverse effect on the public of termination of the statute or agency; and
- (g) any other matter relevant to the review.

Questions for Sunset Review

1. Is the program necessary?
2. Is the program accomplishing its objective?
3. Are there ways to improve it?

Options for Sunset Review

Allow program
to expire

Recommend legislation	Reauthorize	Specific time (≤ 10 years)
		Make permanent
	Repeal	
	Improve	

63I-1-103 Guidelines for conduct of review.

- (1)
 - (a) Any statute or agency scheduled for termination may be reviewed by an interim committee at the direction of:
 - (i) Legislative Management Committee;
 - (ii) the chairs of an interim committee; or
 - (iii) an interim committee as approved by motion and majority vote of its membership.
 - (b) The review shall begin not later than one year before scheduled termination and end before January 1 of the year in which termination is scheduled.
- (2) In determining whether to reauthorize the statute or agency, the agency overseeing the statute or agency scheduled for termination shall clearly identify for the interim committee the public purpose and interest for which each statute or agency was originally created and clearly identify whether that public purpose and interest is still relevant.
- (3) The interim committee shall then consider:
 - (a) the extent to which the statute or agency has operated in the public interest and any areas in which the statute or agency needs to improve its ability to operate in the public interest;
 - (b) the extent to which existing statutes interfere with or assist the legitimate functions of the statute or agency, and any other circumstances including budgetary, resource, and personnel matters that have a bearing on the capacity of the statute or agency to serve the public interest;
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 - (d) the extent to which the statute's provisions or agency's programs and services are duplicative of those offered by other statutes or state agencies;
 - (e) the extent to which the objectives of the statute or agency have been accomplished and their public benefit;
 - (f) the adverse effect on the public of termination of the statute or agency; and
 - (g) any other matter relevant to the review.
- (4) It is the responsibility of any agency scheduled for termination or any agency which has oversight responsibilities for a statute scheduled for termination to seek its reauthorization with the Legislature.

Renumbered and Amended by Chapter 382, 2008 General Session



Health and Human Services Interim Committee

September 16, 2020

RE: Sunset Review/Request for Reauthorization of the Utah Commission on Aging

Dear Committee Members:

The undersigned parties represent individuals and organizations with a common interest in addressing the current and future needs of our aging population and their impact on our families, communities, and state. We are committed to the collaborative and strategic efforts of the Commission in providing insights, research, solutions, public policy recommendations, and educational efforts that help agencies and individuals navigate the challenges and opportunities of aging. The major issues and concerns that exist today for Utah's older adults are amplified in our COVID-19 environment. The work of the Commission on Aging has never been more relevant and essential.

We are united in *respectfully requesting that you VOTE TO REAUTHORIZE the Utah Commission on Aging.*

For your consideration:

- The Commission continues to meet and exceed its statutory requirements in serving the public interest.
- The purposes for which the Commission was created are still relevant and increasingly vital.
- The ability of the Commission to magnify its reach and impact would be enhanced by permanent reauthorization and additional resources.
- The Commission successfully connects service providers, researchers, educators, and policy makers for effective and efficient community impact.

Respectfully submitted on behalf of the parties listed below,

Rob Ence
Executive Director



Sally	Aerts	Citizen Advocate	Alex	Mack	Jewish Family Services
Tracy	Altman	American Health Plans	Nancy	Madsen	Ut Caregiver Support Program
Troy	Andersen	Assoc Prof Social Work	Gary	Measom	Prof Nursing - Utah Valley U
Amy	Anderson	Sunshine Terrace Fndtn	Lynn	Meinor	Alzheimer's State Specialist
Anne	Asman	Gerontologist, U Psychiatry	Linda	Milne	Citizen Advocate
Paul	Astle	HomespireHealth	Jen	Morgan	ADRC Programs Utah State U
Marc	Babitz	MD, Ut Department of Health	Christie	North	Citizen Advocate
James	Brown	Citizen Advocate	Alan	Ormsby	AARP Utah
Emily	Christensen	Ut Assoc for Music Therapists	Laura	Polacheck	Citizen Advocate
Christine	Clark	Policy Specialist	Alan	Pruhs	Assoc for Ut Comm Health
David	Cook	Comagine Health	Deepthi	Rajeev	Comagine Health Utah
Kristy	Cottrell	Davis Co Aging Services	Emily	Redd	HomespireHealth
Wid	Covey	SeniorLeaf - KSL.com	Andrew	Riggle	Disability Law Center
Ken	Crossley	Engage Arts Utah	Tara	Rollins	Utah Housing Coalition
Jeremy	Cunningham	Alzheimer's Association	Carrie	Schonlaw	Five Co AOG/AAA
Candice	Daniel	St. George VA CBOC	Judy	Shupe	Citizen Advocate
Ronnie	Daniel	Alzheimer's Association	Briana	Sisofo	Gerontologist, Utah DHS
Heidi	DeMarco	Mountainlands AOG - AAA	Allie	Spangler	Utah Health Care Association
Jackie	Eaton	U Gerontology Program	Katherine	Supiano	Assoc Prof, U Coll of Nursing
Linda	Edelman	Assoc Prof U Coll of Nursing	Mark	Supiano	MD, Prof Div of Geriatrics U
Janice	Evans	Citizen Advocate	Cindy	Turnquist	Citizen Advocate
Tim	Farrell	MD, U School of Medicine	Collin	Vesely	Citizen Advocate
Elizabeth	Fauth	Family Studies USU	Clay	Watson	Home Health Provider
Joan	Gallegos	Citizen Advocate	Bob	Wassom	Citizen Advocate
Dave	Gessel	Utah Hospital Association	Troy	Wilson	Elder Law Attorney
Sam	Goodman	Broadcast Prod, Navajo Liaison	Glenn	Wright	Mountainlands AOG
Hailey	Hadean	Citizen Advocate	Jamie	Zwerin	Tooele Co Health & Aging
Deb	Hall	Adult Programs, Utah Pride Ctr			
Matt	Hansen	Homecare & Hospice Assoc Ut			
Mike	Hollingshaus	Data Specialist			
Andrew	Jackson	Mountainlands AOG			
Grant	Johnson	Citizen Advocate			
Gary	Kelso	Mission Health Services			
Paul	Leggett	Aging Services Management			



Health and Human Services Interim Committee

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Respectfully

Kenneth Maryboy
San Juan County Utah Commission Chairman

1 **UTAH COMMISSION ON AGING AMENDMENTS**

2 2021 GENERAL SESSION

3 STATE OF UTAH

4

5 **LONG TITLE**6 **General Description:**

7 This bill modifies provisions relating to the Utah Commission on Aging.

8 **Highlighted Provisions:**

9 This bill:

- 10 ▶ removes the sunset date for the Utah Commission on Aging;
- 11 ▶ modifies the duties and membership of the Utah Commission on Aging; and
- 12 ▶ makes technical and conforming changes.

13 **Money Appropriated in this Bill:**

14 None

15 **Other Special Clauses:**

16 None

17 **Utah Code Sections Affected:**18 **AMENDS:**

19 **63I-1-263**, as last amended by Laws of Utah 2020, Chapters 82, 152, 154, 199, 230,
20 303, 322, 336, 354, 360, 375, 405 and last amended by Coordination Clause, Laws
21 of Utah 2020, Chapter 360

22 **63M-11-201**, as last amended by Laws of Utah 2019, Chapter 24623 **63M-11-203**, as renumbered and amended by Laws of Utah 2008, Chapter 38224

25 *Be it enacted by the Legislature of the state of Utah:*26 Section 1. Section **63I-1-263** is amended to read:27 **63I-1-263. Repeal dates, Titles 63A to 63N.**

28 (1) In relation to the Utah Transparency Advisory Board, on January 1, 2025:

29 (a) Subsection 63A-1-201(1) is repealed;

30 (b) Subsection 63A-1-202(2)(c), the language "using criteria established by the board"
31 is repealed;

32 (c) Section 63A-1-203 is repealed;

95 63M-7-504, is repealed July 1, 2027.

96 (25) Title 63M, Chapter 7, Part 6, Utah Council on Victims of Crime, is repealed July
97 1, 2022.

98 [~~(26)~~] ~~Title 63M, Chapter 11, Utah Commission on Aging, is repealed July 1, 2021.~~

99 [~~(27)~~] (26) Subsection 63N-1-301(4)(c), related to the Talent Ready Utah Board, is
100 repealed January 1, 2023.

101 [~~(28)~~] (27) Title 63N, Chapter 1, Part 5, Governor's Economic Development
102 Coordinating Council, is repealed July 1, 2024.

103 [~~(29)~~] (28) Title 63N, Chapter 2, Part 2, Enterprise Zone Act, is repealed July 1, 2028.

104 [~~(30)~~] (29) Section 63N-2-512 is repealed July 1, 2021.

105 [~~(31)~~] (30) (a) Title 63N, Chapter 2, Part 6, Utah Small Business Jobs Act, is repealed
106 January 1, 2021.

107 (b) Section 59-9-107 regarding tax credits against premium taxes is repealed for
108 calendar years beginning on or after January 1, 2021.

109 (c) Notwithstanding Subsection [~~(31)~~] (30)(b), an entity may carry forward a tax credit
110 in accordance with Section 59-9-107 if:

111 (i) the person is entitled to a tax credit under Section 59-9-107 on or before December
112 31, 2020; and

113 (ii) the qualified equity investment that is the basis of the tax credit is certified under
114 Section 63N-2-603 on or before December 31, 2023.

115 [~~(32)~~] (31) Subsections 63N-3-109(2)(e) and 63N-3-109(2)(f)(i) are repealed July 1,
116 2023.

117 [~~(33)~~] (32) Title 63N, Chapter 4, Part 4, Rural Employment Expansion Program, is
118 repealed July 1, 2023.

119 [~~(34)~~] (33) Title 63N, Chapter 7, Part 1, Board of Tourism Development, is repealed
120 July 1, 2025.

121 [~~(35)~~] (34) Title 63N, Chapter 9, Part 2, Outdoor Recreational Infrastructure Grant
122 Program, is repealed January 1, 2023.

123 [~~(36)~~] (35) Title 63N, Chapter 12, Part 5, Talent Ready Utah Center, is repealed
124 January 1, 2023.

125 Section 2. Section **63M-11-201** is amended to read:

63M-11-201. Composition -- Appointments -- Terms -- Removal.

(1) The commission shall be composed of ~~[20 voting members as follows]~~ the following voting members:

(a) the executive director of the Department of Health or the executive director's designee;

(b) the executive director of the Department of Human Services or the executive director's designee;

(c) the executive director of the Governor's Office of Economic Development or the executive director's designee;

(d) the executive director of the Department of Workforce Services or the executive director's designee; and

(e) ~~[16 voting]~~ 20 members, appointed by the governor~~;~~ representing each of the following in accordance with Subsection (3), including:

~~[(i) the Utah Association of Area Agencies on Aging;]~~

~~[(ii) higher education in Utah;]~~

~~[(iii) the business community;]~~

~~[(iv) the Utah Association of Counties;]~~

~~[(v) the Utah League of Cities and Towns;]~~

~~[(vi) charitable organizations;]~~

~~[(vii) the health care provider industry;]~~

~~[(viii) financial institutions;]~~

~~[(ix) the legal profession;]~~

~~[(x) the public safety sector;]~~

~~[(xi) public transportation;]~~

~~[(xii) ethnic minorities;]~~

~~[(xiii) the industry that provides long-term care for the elderly;]~~

~~[(xiv) organizations or associations that advocate for the aging population;]~~

~~[(xv) the Alzheimer's Association; and]~~

~~[(xvi) the general public.]~~

(i) three members that represent the Utah Association of Areas on Aging, the Alzheimer's Association, or another organization or association that advocates for the aging

157 population;

158 (ii) two members that represent an organization or association that advocates for local
159 government; and

160 (iii) two members that represent the general public.

161 (2) (a) A member appointed under Subsection (1)(e) shall serve a two-year term.

162 (b) Notwithstanding the term requirements [of] described in Subsection (2)(a), the
163 governor may adjust the length of the initial commission members' terms to ensure that the
164 terms are staggered so that approximately [$\frac{1}{2}$] one-half of the members appointed under
165 Subsection (1)(e) are appointed each year.

166 (c) When, for any reason, a vacancy occurs in a position appointed by the governor
167 under Subsection (1)(e), the governor shall appoint a person to fill the vacancy for the
168 unexpired term of the commission member being replaced.

169 (d) [~~Members~~] A member appointed under Subsection (1)(e) may be removed by the
170 governor for cause.

171 (e) A member appointed under Subsection (1)(e) shall be removed from the
172 commission and replaced by the governor if the member is absent for three consecutive
173 meetings of the commission without being excused by the chair of the commission.

174 (3) In appointing the members under Subsection (1)(e), the governor shall:

175 (a) ensure each of the following areas are represented:

176 (i) higher education in Utah;

177 (ii) the business community;

178 (iii) charitable organizations;

179 (iv) the health care provider industry;

180 (v) the industry that provides telehealth services;

181 (vi) the industry that provides data analysis services;

182 (vii) the industry that provides information technology support services;

183 (viii) financial institutions;

184 (ix) the legal profession;

185 (x) the public safety sector;

186 (xi) public transportation;

187 (xii) ethnic minorities; and

(xiii) the industry that provides long-term care for the elderly;

~~[(a)]~~ (b) take into account the geographical makeup of the commission; and

~~[(b)]~~ (c) strive to appoint members who:

(i) are knowledgeable or have an interest in issues relating to the aging population[-];

(ii) provide a balanced representation of urban and rural communities in the state; and

(iii) represent the diversity of the population in the state.

Section 3. Section **63M-11-203** is amended to read:

63M-11-203. Duties and powers of commission.

(1) The commission shall:

(a) fulfill the commission's purposes ~~[as listed]~~ described in Section 63M-11-102;

(b) facilitate the communication and coordination of public and private entities that provide services to the aging population;

(c) study, evaluate, and report on the status and effectiveness of policies, procedures, and programs that provide services to the aging population;

(d) study and evaluate the policies, procedures, and programs implemented by other states that address the needs of the aging population;

(e) facilitate and conduct the research and study of issues related to aging, including emerging public health issues with a significant impact on the aging population;

(f) provide a forum for public comment on issues related to aging;

(g) provide public information on the aging population and the services available to the aging population;

(h) facilitate the provision of services to the aging population from the public and private sectors; and

(i) encourage state and local governments to analyze, plan, and prepare for the impacts of the aging population on services and operations.

(2) To accomplish ~~[its]~~ the commission's duties, the commission may:

(a) request and receive from any state or local governmental agency or institution, summary information relating to the aging population, including:

(i) reports;

(ii) audits;

(iii) projections; and

219 (iv) statistics;

220 (b) apply for and accept grants or donations for uses consistent with the duties of the

221 commission from public or private sources; and

222 (c) appoint special committees to advise and assist the commission.

223 (3) All funds received under Subsection (2)(b) shall be:

224 (a) accounted for and expended in compliance with the requirements of federal and

225 state law; and

226 (b) continuously available to the commission to carry out the commission's duties.

227 (4) (a) [~~Members~~] A member of a special committee described in Subsection (2)(c):

228 (i) shall be appointed by the commission;

229 (ii) may be:

230 (A) [~~members~~] a member of the commission; or

231 (B) [~~individuals~~] an individual from the private or public sector; and

232 (iii) notwithstanding Section 63M-11-206, shall not receive any reimbursement or pay

233 for any work done in relation to the special committee.

234 (b) A special committee described in Subsection (2)(c) shall report to the commission

235 on the progress of the special committee.

236 (5) This chapter does not diminish the planning authority conferred on state, regional,

237 and local governments by existing law.



PO Box 58503, Salt Lake City, Utah 84108 | www.unp.org

October 13, 2020

RE: Federal Changes to Utah's Home Health Policy

Utah Rules Committee and/or To Whom it May Concern,

This letter is written on behalf of Utah's Nurse Practitioners and the American Association of Nurse Practitioners, as well as the Utah Nurses Association and other stakeholders. NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. There are over 290,000 NPs in the United States and more than 3,000 in Utah. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia. NPs complete more than one billion patient visits annually.

Utah Nurse Practitioners is writing to make you aware of recent changes to federal Medicare and Medicaid Home Health ordering laws and regulations. On March 27, 2020 the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. Section 3708 of the CARES Act permanently authorizes nurse practitioners to certify for Medicare and Medicaid home health care services in accordance with state law. Per that legislation, the Centers for Medicare and Medicaid Services (CMS) had six months from the passage of the legislation to implement this section via rulemaking. However, on May 8, 2020, CMS issued an interim final rule which **permanently** implements Section 3708 of the CARES Act, retroactively effective to March 1, 2020. However, these policy changes defer to state law, and we have identified that [Utah Administrative Code Rule R432-700](#) does not reflect the recent changes to federal law.

We respectfully request that the [Utah Administrative Code Rule R432-700](#) be updated to reflect the federal changes to the (Medicare/Medicaid) home health benefits. Without these changes, NPs that provide health care for patients receiving (Medicare/Medicaid) home health care services are not able to initiate or make necessary adjustments to medication or treatment without additionally obtaining a physician signature on documents, even when that physician has no knowledge of the patient/does not see the patient. The current inability to order home health care services causes delays in care for patients and needlessly increases health care costs. It is of the utmost importance that the rule language be changed prior to the expiration of the public health emergency due to the complications that a delay could cause -- potentially putting clinicians, reimbursement and patient episodes of care at risk.

NPs give standardized health care for Utah's Medicare/Medicaid patients in clinic practice which will continue in the home health care setting. The current structure fractures care and puts patients at risk for avoidable complications, adds to health care costs, and interrupts continuity

of care. Delays in care are especially problematic for home health care patients who suffer from more chronic conditions and report more limitations on activities of daily living than the non-home health care Medicare and Medicaid beneficiary population. NPs are qualified to provide this care without physician certification and are already the largest home-based primary care providers for Medicare and Medicaid patients.

In light of Utah's increasing case numbers and deaths during the COVID pandemic, UNP appreciates your efforts to change the current rule of this essential and timely issue. UNP looks forward to working with Utah's legislators, Public Health officials and other stakeholders in building a stronger health care system for the future.

Should you have comments or questions, please contact Melissa J Hinton, DNP at dr.mhinton@gmail.com or (435)680-7063.


Sincerely,

Melissa J Hinton, DNP, ARPN, FNP-BC, CARN-AP
President Utah Nurse Practitioners Association



Melissa J. Hinton DNP, FNP-BC

Sharon Dingman, DNP, MS, RN
President Utah Nurses Association



Sharon K. Dingman, DNP, MS, RN

Matt Hansen, DPT, Executive Director
Home Care and Hospice Association of Utah




Matt Hansen, DPT

Bradley Pace, PA-C, Executive Director
Utah Academy of Physician Assistants



Bradley Pace

Rob Ence, MBA, Executive Director
Utah Commission on Aging



Rob Ence

Teresa Garrett, DNP, APHN-BC, RN
Utah Action Coalition



Teresa Garrett

Proposed language updates to Rule R432-700. Home Health Agency Rule.

R432. Health, Family Health and Preparedness, Licensing.

Rule R432-700. Home Health Agency Rule.

As in effect on January 1, 2020

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R432-700-6. Services Provided by a Home Health Agency.

(1) A home health agency shall provide services to patients in their place of residence, or in special circumstances, the place of employment.

(2) Services shall be directed and supervised by a licensed practitioner. These services may help avoid premature or inappropriate institutionalization.

(3) Professional and supportive personnel shall be responsible to the agency for any of the following services which they may perform:

(a) Provision of skilled services authorized by a ~~physician~~ **licensed practitioner**;

(b) Nursing services assessed, provided, or supervised by registered nurses;

(c) Other related health services approved by a licensed practitioner.

R432-700-9. Administrator.

(1) The administrator designated by the governing body shall be responsible for the overall management of the agency.

(2) The administrator shall have at least one year of managerial or supervisory experience.

(3) The administrator shall designate in writing a qualified person who shall act in his absence. The designated person shall have sufficient power, authority, and freedom to act in the best interests of patient safety and well-being.

(4) The administrator or designee shall be available during the agency's hours of operation.

(5) Responsibilities.

The administrator shall have the responsibility to:

(a) Complete, submit, and file all records and reports required by the Department;

(b) Review agency policies and procedures at least annually and revise as necessary and document the date of review;

(c) Implement agency policies and procedures;

(d) Organize and coordinate functions of the agency by delegating duties and establishing a formal means of staff accountability;

(e) Appoint a ~~physician~~ **licensed practitioner** or registered nurse, or health care professional to provide general supervision, coordination, and direction for professional services of the agency;

(f) Appoint a registered nurse to be the director of nursing services;

(g) Appoint the members and their terms of membership in the interdisciplinary quality assurance committee;

(h) Appoint other committees as deemed necessary, describe committee functions and duties, and make provision for selection, term of office, and responsibilities of committee members;

(i) Designate a person responsible for maintaining a clinical record system on all patients;

(j) Maintain current written designations or letters of appointment in the agency;

(k) Employ or contract with competent personnel whose qualifications are commensurate with job responsibilities and authority, and who have the appropriate license or certificate of completion;

(l) Develop job descriptions that delineate functional responsibilities and authority;

(m) Develop a staff communication system that coordinates implementation of plans of treatment, utilizes services or resources to meet patient needs, and promotes an orderly flow of information within the organization;

(n) Provide staff orientation as well as continuing education (staff development) in applicable policies, rules, regulations, and resource materials;

(o) Secure contracts for services not directly provided by the home health agency;

(p) Implement a program of budgeting and accounting;

(q) Establish a billing system which itemizes services provided and charges submitted to the payment source.

R432-700-15. Termination of Services Policies.

(1) The agency may discharge a patient under any of the following circumstances:

(a) A licensed practitioner signs a discharge statement for termination of services;

(b) Treatment objectives are met;

(c) The patient's status changes, which makes treatment objectives unattainable, and new treatment objectives are not an alternative;

(d) The family situation changes and affects the delivery of services;

(e) The patient or family is uncooperative in efforts to attain treatment objectives;

(f) The patient moves from the geographic area served by the agency;

(g) The ~~physician~~ **licensed practitioner** fails to renew orders as required by the rules for skilled nursing or therapy services, or, the patient changes ~~physician's~~ **licensed practitioners** and the agency cannot obtain orders for continuation of services from the new ~~physician~~ **licensed practitioner**;

(h) The patient's payment sources are exhausted and the agency is fiscally unable to provide free or part-cost care;

(i) The agency discontinues a particular service or terminates all services;

(j) The agency can no longer provide quality care in the place for residence;

(k) The patient or family requests agency services to be discontinued;

(l) The patient dies;

(m) the patient or family is unable or unwilling to provide an environment that ensures safety for the both the patient and provider of service; or

(n) The patient's payor excludes the agency from participating as a covered provider or refuses to authorize services the agency determines are medically necessary.

(2) The person who is assigned to supervise and coordinate care for a particular patient must complete a discharge summary when services to the patient are terminated.

R432-700-17. ~~Physician's~~ Licensed Practitioner Orders.

(1) ~~Physician's~~ Licensed Practitioner orders shall be incorporated into the plan of care when skilled care is being provided.

(2) ~~Physician's~~ Licensed Practitioner orders may include:

(a) Diet and nutritional requirements;

(b) Medications;

(c) Frequency and type of service;

(d) Treatments;

(e) Medical equipment and supplies;

(f) Prognosis.

R432-700-18. Patient Records.

(1) The agency shall develop and implement record keeping policies and procedures that address use of patient records by authorized staff, content, confidentiality, retention, and storage.

(2) Records shall be maintained in an organized format.

(3) The agency shall maintain an identification system to facilitate location of each patient's current or closed record.

(4) An accurate, up-to-date record must be maintained for every patient receiving service through the home health agency.

(5) Each person who has patient contact or provides a service in the patient's place of residence must enter a clinical note of that contact or service in the patient's record.

(6) All entries shall be dated and authenticated with the signature, or identifiable initials of the person making the entry.

(7) Services provided by the agency and outcomes of these services must be documented in the individual patient record.

(8) Each patient's record shall contain at least the following information:

(a) Identification data including patient's name, address, age, date of birth, name and address of nearest relative or responsible person, name and telephone number of physician **the licensed practitioner** with primary responsibility for patient care, and if applicable, the name and telephone number of the person or family member who, in addition to agency staff, provides care in the place of residence;

(b) A written plan of care;

(c) A signed and dated patient assessment which identifies pertinent information required to carry out the plan of care;

(d) Reasons for referral to home health agency;

(e) Statement of the suitability of the patient's place of residence for the provision of health care services;

(f) Documentation of telephone consultation or case conferences with other individuals providing services;

(j) Signed and dated clinical notes for each patient contact or home visit including services provided

(h) A written Termination of Services summary which describes:

(i) The care or services provided;

(ii) The course of care and services;

(iii) The reason for discharge;

(iv) The status of the patient at time of discharge;

(v) The name of the agency or facility if the patient was referred or transferred.

(9) For those patients who receive skilled services the following items shall be included in the patient record in addition to R432-700-18(8):

(a) Diagnosis;

- (b) Pertinent medical and surgical history;
- (c) A list of medications and treatments;
- (d) Allergies or reactions to drugs or other substances;
- (e) Clinical notes to include a description of the patient condition and significant changes such as:
 - (i) Objective signs of illness, disorders, body malfunction;
 - (ii) Subjective information from the patient and family;
 - (iii) General physical condition;
 - (iv) General emotional condition;
 - (v) Positive or negative physical and emotional responses to treatments and services;
 - (vi) General behavior; and
 - (vii) General appearance.
- (f) Clinical summaries or other documents obtained when necessary for promoting continuity of care, especially when a patient receives care elsewhere, such as a hospital, ambulatory surgical center, nursing home, ~~physician~~ **practitioner** or consultant's office or other home health agency.

R432-700-21. Nursing Services.

- (1) Nursing services provided through a home health agency shall be under the supervision of a director of nursing services.
- (2) Nursing services shall be provided by or under the supervision of a registered nurse and according to the plan of care.
- (3) When an agency provides or contracts for services, the service shall be provided according to the plan of care and supervised by designated, qualified personnel.
- (4) Nursing staff shall observe, report, and record written clinical notes.
- (5) Nursing services should recognize and use opportunities to teach health concepts to the patient and family.
- (6) All registered nurses or licensed practical nurses employed by, or on contract with, the agency shall have a valid license from the Utah Department of Commerce, Title 58, Chapter 31b.
- (7) Licensed nurses shall have the following responsibilities:

(a) Administer prescribed medications and treatments according to law and as permitted within the scope of the individual's license;

(b) Perform nursing care according to the needs of the patient and as indicated in the written plan of care;

(c) Inform the ~~physician~~ **practitioner** and other personnel of changes in the patient's condition and needs;

(d) Write clinical notes in the individual patient record for each visit or contact;

(e) Teach self-care techniques to the patient or family, or both;

(f) Develop plans of care;

(g) Participate in in-service programs.

(8) The director of nursing services shall be responsible for and shall be accountable for the following functions:

(a) Designate a registered nurse to act as director of nursing services during his absence;

(b) Assume responsibility for the quality of nursing services provided by the agency;

(c) Develop nursing service policies and procedures that must be reviewed annually and revised as necessary;

(d) Establish work schedules for nursing personnel according to patient needs;

(e) Assist in development of job descriptions for nursing personnel;

(f) Complete performance evaluations for nursing personnel according to agency policy;

(g) Direct in-service programs for all nursing personnel.

(9) In addition to the general responsibilities, a registered nurse shall have the following responsibilities:

(a) Make the initial nursing evaluation visit;

(b) Re-evaluate nursing needs based on the patient's status and condition;

(c) Initiate the plan of care and make necessary revisions;

(d) Provide services which require specialized nursing skill;

(e) Initiate appropriate preventive and rehabilitative nursing procedures;

(f) Supervise staff assignments based on specific patient needs, family capabilities, staff training and experience, and degree of supervision needed;

(g) Assist in coordinating all services provided;

- (h) Prepare termination of services statements;
- (i) Supervise and consult with licensed practical nurses as necessary;
- (j) Provide written instructions for certified nursing aide to ensure provision of required services written in the plan of care;
- (k) Supervise certified nursing aide in the patient's home as necessary, and be readily available for consultation by telephone;
- (l) Make supervisory visits with or without the certified nursing aide's presence as follows:
 - (i) Initial assessment;
 - (ii) Every two weeks to patients who receive skilled services;
 - (iii) Every three months to patients who require long-term maintenance services;
 - (iv) Any time there is a question of change in the patient's condition.
- (10) The licensed practical nurse shall have the following responsibilities:
 - (a) Work under the supervision of a registered nurse;
 - (b) Observe, record, and report to the immediate supervisor the general physical or mental condition of the patient;
 - (c) Assist the registered nurse in performing specialized procedures;
 - (d) Assist in development of the plan of care.

R432-700-24. Plan of Care.

- (1) A plan of care shall be established and documented in the patient's record to describe any direct or contract services, care, or treatment provided by the home health agency.
- (2) A plan of care shall be developed and signed by a licensed health care professional.
- (3) The plan of care shall be developed with consultation, as needed, from other agency staff or contract personnel.
- (4) Modifications or additions to the initial plan of care shall be made as necessary.
- (5) Each plan of care shall be reviewed and approved by the licensed health care professional as the patient's condition warrants, at intervals not to exceed 63 days.
- (6) For patients receiving skilled services, the written plan of care shall be approved by a ~~physician~~ **licensed practitioner** at intervals not to exceed 63 days.

(7) The person who is assigned to supervise and coordinate care for a patient shall have the primary responsibility to notify the attending ~~physician~~ **practitioner** and other agency staff of any significant changes in the patient's status.

(8) All care plans and notifications shall be made part of the patient's record.

(9) The plan of care, usually developed in accordance with the referring ~~physician's~~ **licensed practitioner's** orders, shall include:

- (a) Name of the patient;
- (b) Diagnoses (required for patients receiving skilled services);
- (c) Treatment goals stated in measurable terms;
- (d) Services to be provided, at what intervals, and by whom;
- (e) Needed medical equipment and supplies;
- (f) Medications to be administered by designated, licensed agency personnel;
- (g) Supervision of self-administered medication;
- (h) Diet or nutritional requirements;
- (i) Necessary safety measures;
- (j) Instructions, if any, to patient and/or family;
- (k) Date plan was initiated and dates of subsequent review.

R432-700-25. Medication and Treatment.

(1) Skilled treatments shall be administered only by licensed personnel to comply with signed orders from a person lawfully authorized to give the order. This order may be remotely given but shall be subsequently signed by the person giving the order within 31 days.

(2) Medications shall be administered according to signed orders from a person lawfully authorized to give the order. This order may be remotely given but shall be subsequently signed by the person giving the order within 31 days.

(3) All orders remotely given shall be received and verified only by licensed personnel lawfully authorized to accept the order. Remotely given orders shall be recorded in the patient's record.

(4) If medications are administered by agency personnel, the orders and subsequent changes in orders, shall be signed by the ~~physician~~ **licensed practitioner** and included in the patient's record.

(5) Unlicensed staff may administer medications only after delegation by a licensed health care professional under the professional scope of practice.

(i) If a licensed health care professional delegates the task of medication administration to unlicensed assistive personnel, the delegation shall be in accordance with the Nurse Practice Act and R156-31B-701;

(ii) The medications must be administered according to the prescribing order;

(iii) The delegating authority must provide and document supervision, evaluation, and training of unlicensed assistive personnel assisting with medication administration;

(iv) The delegating authority or another registered nurse shall be readily available either in person or by telecommunication; and

(v) Delegation to unlicensed staff shall not include delegating medication set up for subsequent medication administration.

(6) Orders for therapy services shall include the procedures to be used, the frequency of therapy, and the duration of therapy.

(7) Orders for skilled services shall be reviewed or renewed by the attending ~~physician~~ **licensed practitioner** at intervals not to exceed 63 days. ~~Physician's~~ **The practitioner's** signature and date shall be evidence of this review or renewal.

(8) ~~Physician~~ **Licensed practitioner's** orders may be transmitted by facsimile machine. The agency must be able to obtain the original signature, upon request, if verification of the signature is requested.

R432-700-26. Therapy Services.

(1) Physical, occupational, speech, and nutrition therapy services offered by the agency, as either direct or contract services, shall be provided by, or under the supervision of, a licensed or certified therapist in accordance with the plan of care under Title 58.

(2) The qualified therapist shall have the following general responsibilities:

(a) Provide treatment as ordered and approved by the attending ~~physician~~ **licensed practitioner**;

(b) Evaluate the home environment and make recommendations;

(c) Develop the plan of care for therapy;

(d) Observe and report findings about the patient's condition to the attending ~~physician~~ **licensed practitioner** and other agency staff, and document information in the patient's record;

(e) Advise, consult, and instruct when necessary, other agency personnel and family about the patient's therapy program;

(f) Provide written instructions for the certified nursing aide to promote extension of therapy services;

(g) Supervise other agency personnel when appropriate;

(h) Participate in in-service programs.

(3) In addition to the general responsibilities, a physical, speech or occupational therapist may perform the following:

(a) Provide written instructions for personal care aides and certified nursing aides to ensure provision of required services written in the plan of care;

(b) Supervise aides in the patient's home as necessary, and be readily available for consultation by phone;

(c) Make supervisory visits with or without the aide's presence, as required.

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

As COVID-19 cases surge in Utah and hospitals and ICUs become overwhelmed, the state is expected to start implementing its Crisis Standards of Care policy that uses age as a tie breaker, in the event health care providers need to choose who has access to life-saving medical care. Justice in Aging strongly objects to any policy that would deny lifesaving care to older adults based solely on age.

Last month, Justice in Aging [opposed the U.S. Department of Health and Human Services Office of Civil Rights](#) endorsement of Utah's health care rationing policy as biased against older adults. Denying care to older adults based solely on age is both unconscionable and discriminatory. Across the country, older adults have borne the brunt of this terrible disease. They have died at astronomical rates, with people aged 65-74 years old dying at 90 times the rate of people 18-29. [In Utah, people over the age of 65 account for 74.5% of deaths](#), a number that will likely increase when the state turns to the rationing of care and systematically denies care based on age.

The often articulated idea that older people have "had their turn" devalues the contributions that older adults continue to make to our families and communities, discounts a person's potential to recover and rebound, and codifies reliance on age-based bias into one of the most delicate decisions healthcare providers must make during this pandemic. When a tie breaker becomes necessary, the Utah policy places a thumb on the scale against older adults, by virtue of their age alone.

Age discrimination hurts people of all ages. This policy could deprive grandchildren of their grandparents, young workers of mentors and leaders, and undermine the community's faith in the fairness of health care in the state. [Justice in Aging has worked to exclude age-based bias from standards](#) in Arizona, California, Florida, Maryland, Massachusetts, Oregon, and Texas, and helped California rewrite its standards so they don't illegally discriminate against older adults and people with disabilities.

Utah should follow the lead of these states and remove this illegal age bias from their standards, before health care providers are faced with having to make these critical decisions based on age alone.

The Later Innings of Life: Implications of COVID-19 Resource Allocation Strategies for Older Adults

Older adults bear a disproportionate burden of hospitalization and mortality due to COVID-19. They are also at risk for unjust treatment by healthcare resource allocation frameworks under conditions of resource scarcity. Early in the pandemic, age-based cutoffs for resource allocation were proposed and reportedly implemented in Italy.¹ In the United States, the Office for Civil Rights of the Department of Health and Human Services reached resolutions with several states to revise crisis standards of care that had included age-based cutoffs.² These cutoffs have largely been eliminated from state crisis standards of care; however, they may be reappearing in decisions about allocation of other potentially scarce medical resources, such as vaccines.

In September 2020, the National Academy of Sciences, Engineering, and Medicine (NASEM) released its Discussion Draft of the Preliminary Framework for Equitable Allocation of a COVID-19 Vaccine.³ The draft framework appropriately relies on six basic principles: maximizing reductions in mortality and morbidity, mitigating health inequities, giving equal regard to each individual, setting allocation criteria fairly, ensuring that criteria are evidence based, and communicating with the public about the criteria in a transparent manner.³ It also appropriately recognizes that decisions about vaccine allocation must be responsive to circumstances.³ Under present circumstances, the draft framework recommends prioritizing those at highest risk of becoming infected and experiencing serious outcomes, those in essential social roles, and those at greatest risk of transmitting the virus to others.³

At the same time, the draft framework reintroduces reasoning about age that is ethically problematic. When both younger and older persons are equally at risk, the draft framework recommends prioritizing the younger person for vaccination.^{3(p40)} Underlying this type of age-based tiebreaker are frameworks referred to in ethics as “life-years saved” and “fair innings.”

Even when used as a tiebreaker, moving from rationing based on immediate reductions in mortality and morbidity to rationing based on a life-years saved framework raises ethical concerns. The Office for Civil Rights judged as discriminatory any reliance on “years of life saved” to decide how resources are allocated to population groups.² It observed that such rationing treats individuals based solely

on the category within which they fall, rather than on individualized assessments of their likelihood of survival, and it also reasoned that age cutoffs should never be used to exclude people from life-saving treatments, such as ventilators.² In acute care settings, multiprinciple allocation frameworks that equally weigh in-hospital survival (using tools such as the Sequential Organ Failure Assessment) and severe comorbidities contributing to short-term mortality should be the primary allocation method when resources are limited.⁴

Moreover, age is not a particularly good proxy for life-years saved. The life-years saved concept assumes the ability to accurately prognosticate long-term life expectancy; however, long-term predictions of life expectancy are notoriously unreliable. The life-years saved approach, in short, obscures the heterogeneity of older adults with respect to their health status and other individual characteristics.⁴

The so-called “fair innings” argument, which favors younger age groups because they have lived fewer life-years, has also been used to justify resource allocation based on age.⁵ The fair innings argument is intuitively appealing because it seems unfair that younger people should die without having the opportunity to live through various stages of life. However, this argument also rests on ethically problematic assumptions, two of which we describe here.

First, the fair innings argument assigns greater value to earlier rather than to later stages of life. If the short-term (i.e., <6 month) prognoses of a younger adult and an older adult are identical, the fair innings argument would still favor allocating a limited healthcare resource to the younger adult based on his/her being at an earlier stage in life. This assumption—that earlier stages of life are more valuable—may reflect ageism.

Second, the fair innings argument does not account for factors, such as racism, disparate access to health care, and economic inequality, that are associated with decreased life spans and thus fewer “innings.” These factors call attention to many complex reasons why innings may be judged unfair that do not rest simply on whether some persons have had fewer innings than others.

A final version of the NASEM report, “Framework for Equitable Allocation of COVID-19 vaccine,”⁶ was released in October 2020. This document incorporated feedback from the public, including oral and written testimony from the American Geriatrics Society (AGS). Importantly, NASEM distanced the guidelines from the previous focus on life-years

saved and instead focused on avoidance of death,^{6(pp3–11)} citing concerns about ageism that had been raised in the AGS testimony. However, NASEM did not exclude the possibility of reverting to the life-years saved argument in situations where younger adults have disproportionately high mortality from a pandemic.⁶ We commend NASEM for deemphasizing the life-years saved approach in its final COVID-19 vaccine allocation framework. We also urge NASEM and other groups, including Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices, to avoid reverting to the life-years saved argument in the future given its inherent ageism.

Some resource allocation strategies cite the instrumental value of certain groups, such as essential workers, including hospital and nursing home staff, firefighters, and the police, as priorities for scarce resources. One approach argues against prioritizing older adults with fewer remaining life-years to receive a COVID-19 vaccine because “advanced age reduces likelihood of working in high-transmission settings or being an essential caregiver.”⁷ As with other efforts to insert valuation-based metrics, this approach has significant limitations. As the pandemic continues, we are increasingly aware that the definition of who is “essential” inappropriately excludes many others, such as caregivers, teachers, scientists, delivery drivers, journalists, and grocery store and plant workers. Likewise, society often underestimates the essential contributions of older adults in discussions of instrumental value within resource allocation strategies. For example, grandparents often care for grandchildren and hold together family units. Adults older than 65 years comprised 19% of the caregivers for adults aged 18 years or older.⁸ Grandparents may also take on full-time parenting responsibilities for children whose parents have died or are otherwise unavailable. Given advances in longevity, older adults serve in critical leadership roles throughout government, public health, and business; provide philanthropic support; and serve as mentors to younger adults.

When faced with potential and painful shortages of healthcare resources, allocation decisions should be based on the most direct and immediate goal of minimizing immediate and short-term mortality and morbidity. Resource allocation strategies must be developed with multidisciplinary input, applied uniformly and transparently, and subjected to regular and rigorous review to ensure equitable and unbiased implementation and to remove any ageist provisions. Furthermore, a postpandemic review of resource allocation strategies that were actually implemented—including strategies to allocate a COVID-19 vaccine—should be conducted to ensure that unjust resource allocation strategies do not persist.⁴ By adopting these approaches, it will be possible to ensure that no group is unjustly disadvantaged by resource allocation strategies under conditions of resource scarcity.

Some fans, assuming the game result, do not watch the later innings; however, just as many believe the later innings can be equally important.

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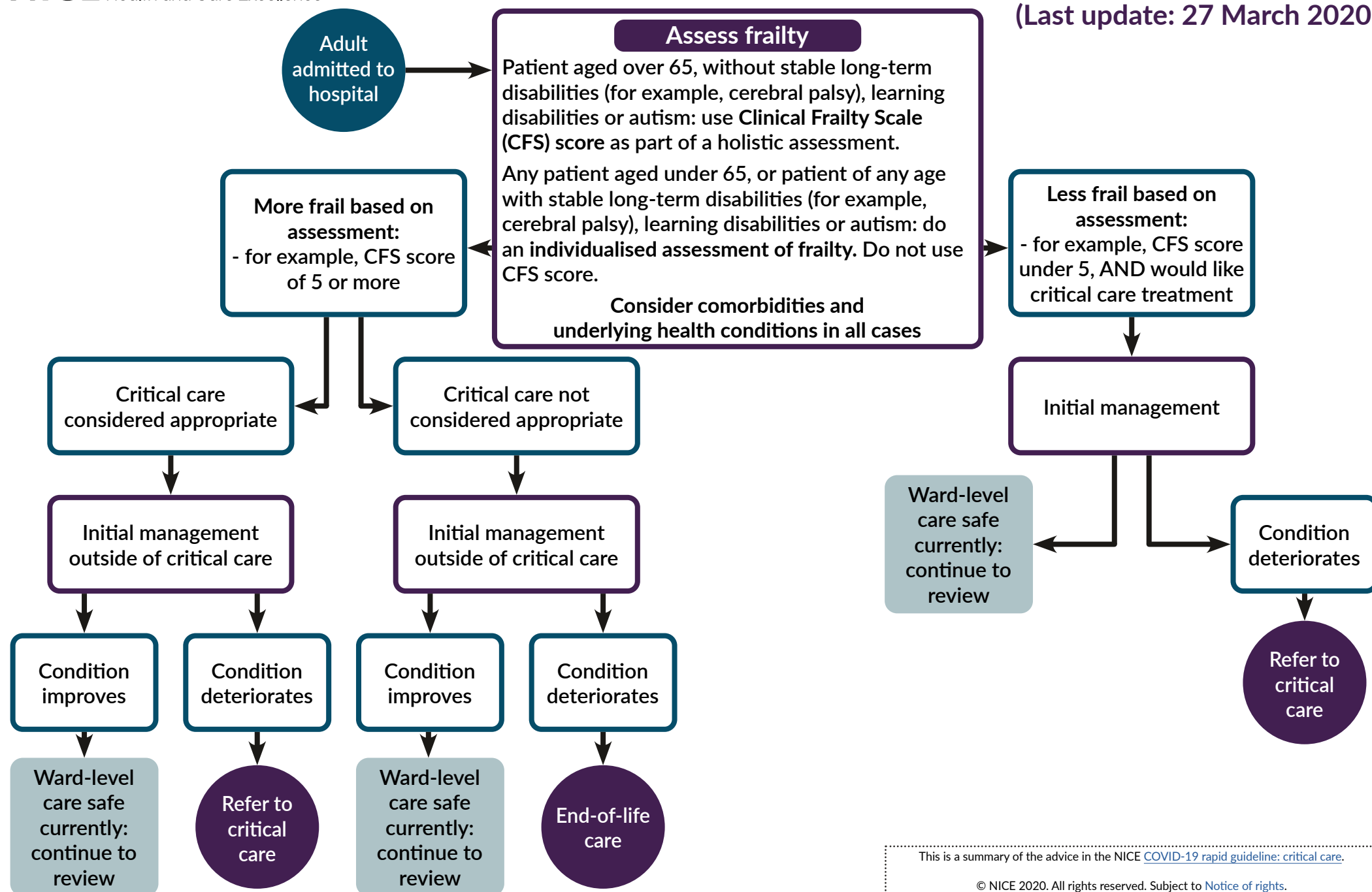
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REFERENCES

1. Società Italiana di Anestesia Analgesia Rianimazione e Terapia Intensiva (SIAARTI). SIAARTI web site. Clinical ethics recommendations for the allocation of intensive care treatments, in exceptional, resource-limited circumstances. <http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid-19%20-%20Clinical%20Ethics%20Recommendations.pdf>. Accessed October 7, 2020.
2. U.S. Department of Health and Human Services (HHS). *OCR Resolves Complaint with Utah After It Revised Crisis Standards of Care to Protect Against Age and Disability Discrimination* [News Release]. Washington, DC: U.S. Department of Health and Human Services; 2020. <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>. Accessed October 7, 2020.
3. National Academies of Sciences, Engineering, and Medicine. *Discussion Draft of the Preliminary Framework for Equitable Allocation of a COVID-19 Vaccine*. Washington, DC: The National Academies Press. <https://www.nap.edu/catalog/25917/framework-for-equitable-allocation-of-covid-19-vaccine#resources>. Published September 2020. Accessed October 7, 2020.
4. Farrell TW, Ferrante LE, Brown T, et al. AGS position statement: resource allocation strategies in the COVID-19 era and beyond. *J Am Geriatr Soc*. 2020;68(6):1143-1149. <https://doi.org/10.1111/jgs.16537>.
5. Harris J. *The Value of Life: An Introduction to Medical Ethics*. London and New York: Routledge & Kegan Paul; 1985.
6. National Academies of Sciences, Engineering, and Medicine. Framework for equitable allocation of COVID-19 vaccine. <https://www.nap.edu/catalog/25917/framework-for-equitable-allocation-of-covid-19-vaccine>. Published October 2020. Accessed October 7, 2020.
7. Persad G, Peek ME, Emanuel EJ. Fairly prioritizing groups for access to COVID-19 vaccines. *JAMA*. 2020. <https://doi.org/10.1001/jama.2020.18513>.
8. AARP and National Alliance for Caregiving. *Caregiving in the United States: 2020 Report*. <https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf>. Published May 14, 2020. Accessed October 7, 2020.





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Original Study - Brief Report

Frailty and Mortality in Hospitalized Older Adults With COVID-19: Retrospective Observational Study



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ABSTRACT

Keywords:

COVID-19
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Objectives: To determine the association between frailty and short-term mortality in older adults hospitalized for coronavirus disease 2019 (COVID-19).

Design: Retrospective single-center observational study.

Setting and participants: Eighty-one patients with COVID-19 confirmed by reverse-transcriptase polymerase chain reaction (RT-PCR), at the Geriatrics department of a general hospital in Belgium.

Measurements: Frailty was graded according to the Rockwood Clinical Frailty Scale (CFS). Demographic, biochemical, and radiologic variables, comorbidities, symptoms, and treatment were extracted from electronic medical records.

Results: Participants (N = 48 women, 59%) had a median age of 85 years (range 65–97 years) and a median CFS score of 7 (range 2–9); 42 (52%) were long-term care residents. Within 6 weeks, 19 patients died. Mortality was significantly but weakly associated with age (Spearman $r = 0.241$, $P = .03$) and CFS score ($r = 0.282$, $P = .011$), baseline lactate dehydrogenase (LDH; $r = 0.301$, $P = .009$), lymphocyte count ($r = -0.262$, $P = .02$), and RT-PCR cycle threshold (Ct, $r = -0.285$, $P = .015$). Mortality was not associated with long-term care residence, dementia, delirium, or polypharmacy. In multivariable logistic regression analyses, CFS, LDH, and RT-PCR Ct (but not age) remained independently associated with mortality. Both age and frailty had poor specificity to predict survival. A multivariable model combining age, CFS, LDH, and viral load significantly predicted survival.

Conclusions and Implications: Although their prognosis is worse, even the oldest and most severely frail patients may benefit from hospitalization for COVID-19, if sufficient resources are available.

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Coronavirus disease 2019 (COVID-19) is a global pandemic caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).¹ Older adults are at increased risk of hospitalization and mortality due to COVID-19.^{2–5}

Different ethical guidelines deal with triage in case a surge in hospital admissions due to COVID-19 overwhelms scarce hospital resources.^{6–8} Likelihood of benefit, age, and frailty are among the

most commonly used triage criteria.^{9,10} In the United Kingdom and in Belgium (among other countries), intensive care unit (ICU) admission is not recommended for frail older adults aged 65 years and older.^{11,12} These guidelines rely on frailty assessment according to the Rockwood Clinical Frailty Scale (CFS). Patients can be classified on the CFS as not frail (scores 1–4), mildly frail (score 5), moderately frail (score 6), or severely frail (score 7–9).¹³ ICU admission is discouraged for frail older adults, that is, those with a CFS score of 5 or higher, in the United Kingdom and Belgium.^{11,12} Hospital admission is discouraged for nursing home residents with suspected or confirmed COVID-19 and a CFS score of 7 or higher.¹²

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Previous studies have shown that frailty is associated with worse outcomes in hospitalized older adults.^{13,14} However, little is known about the outcomes in frail older adults or long-term care residents hospitalized for COVID-19. Therefore, the aim of this retrospective observational study was to describe outcomes in hospitalized geriatric COVID-19 patients according to their age, degree of frailty, and place of residence.

Methods

Study Design

A retrospective, single-center observational study was performed among COVID-19 patients at the geriatrics department of our General Hospital in Belgium, admitted between March 12 and April 30, 2020. Demographic, clinical, laboratory, and radiographic parameters were extracted from electronic health records. Laboratory values included C-reactive protein (CRP; reference values <5 mg/L); ferritin; D-dimers; lactate dehydrogenase (LDH); 25-hydroxyvitamin D levels; and white blood cell, platelet, and lymphocyte counts. Polypharmacy was defined as the use of 5 or more medications.

Ethics

The Ethical Committee approved the research protocol and waived the need for informed consent, because it did not constitute a clinical study according to national and European regulations.

Clinical Procedures

COVID-19 was confirmed by reverse transcriptase–polymerase chain reaction (RT-PCR) testing on nasopharyngeal swabs, using protocols validated within our national SARS-CoV-2 reference network.¹⁵ All patients admitted through the emergency department were screened for COVID-19 by low-dose chest computed tomography (CT). Findings on COVID-19 likelihood and extent of pulmonary

involvement (CT score ranging 0–25) were reported using a standardized radiologic protocol as described previously.¹⁵

All COVID-19 patients in our hospital were hospitalized on dedicated wards under the care of a staff pulmonologist, nephrologist, infectious disease specialist or geriatrician, depending on their usual care team (eg, nephrology in dialysis patients). Additional local criteria to admit patients under geriatric care were age 85 years or older, long-term care residence or equivalent home care (ie, complete dependency on assistance for activities of daily living), patients with dementia or delirium, or patients aged 75 years and older with multiple comorbidities and polypharmacy.

On admission, an experienced geriatrician scored premonitory frailty according to the CFS based on information from patients, their families, and caregivers, primary care referral letters, or long-term care records.

Statistics

Results for continuous and categorical variables are reported as median and interquartile range and number (percentage), respectively. Differences between survivors and nonsurvivors were examined using Mann-Whitney *U* test and chi-square test for continuous and categorical variables, respectively. Association of age, frailty, and other baseline characteristics with mortality were evaluated by Spearman *r* and multiple logistic regression. Survival according to frailty status was examined using odds ratios, survival analyses (log-rank Mantel-Cox test) and receiver operating characteristic (ROC) curve analysis. Two-tailed *P* values <.05 were considered significant. All analyses were performed using GraphPad Prism v8.4.2.

Results

Baseline characteristics of our cohort are shown in Table 1. Median age was 85 years (minimum 65, maximum 97 years), and 48 were women (59%). Median CFS score was 7 (range 2–9). Dementia had been diagnosed in 36 patients (44%), and 42 (52%) were long-term care residents. Polypharmacy was present in 52 (64%) subjects.

Table 1
Characteristics of the Population According to Survival Status

	All (N = 81)	Survivors (n = 62)	Nonsurvivors (n = 19)	<i>P</i>	Spearman <i>r</i>
Sex				.89	
Men	33 (41)	25 (40)	8		
Women	48 (59)	37 (60)	11		
Age	85 (81–90)	84.5 (79–89)	88 (84–90)	.03	0.241
LTC resident				.27	
Yes	42 (52)	30 (48)	12		
No	39 (48)	32 (52)	7		
CFS score	7 (5–7)	6 (4–7)	7 (6–8)	.011	0.282
Dementia				.77	
Yes	36 (44)	26 (43)	10		
No	45 (56)	36 (57)	9		
Polypharmacy				.52	
Yes	52 (64)	41 (65)	11		
No	29 (36)	21 (35)	8		
CT score	9 (5–12)	9 (5–12)	9.5 (5–16.5)	.39	
RT-PCR Ct value	24.65 (20.25–28.78)	25.95 (21.50–29.38)	21.65 (19.28–22.95)	.015	–0.285
CRP, mg/L	58 (32–89)	56 (32–88)	75 (39–130)	.20	
CRP _{max} , mg/L	110 (59–155)	88 (47–140)	190 (110–270)	<.001	0.453
LDH, U/L	305 (235–396)	286 (229–367)	390 (315–493)	.009	0.301
Lymphocytes, 10 ³ /μL	0.9 (0.6–1.2)	0.9 (0.7–1.25)	0.55 (0.4–1.05)	.020	–0.262
Lymphocyte nadir, 10 ³ /μL	0.7 (0.5–0.95)	0.8 (0.6–1.1)	0.4 (0.275–0.65)	<.001	–0.419
Delirium				.88	
Yes	34 (42)	26 (42)	8		
No	47 (58)	36 (58)	11		
Length of stay, d	13 (8–18.5)	13 (8–21)	7 (3.75–15)	.050	

LTC, long-term care.

Values are median (interquartile range) or n (%).

Table 2
Odds Ratios of 4 Independent Variables That Predict Mortality (Outcome Variable) in a Univariate and 2 Multivariate Models (Logistic Regression Analyses)

	Single-Factor Model	Model Age + CFS	Four-Factor Model
Age			
OR	1.117 (1.021–1.240)*	1.096 (1.002–1.218)	1.134 (1.002–1.333)
AUROC	0.664 (0.531–0.797)*		
CFS score			
OR	1.705 (1.173–2.750)*	1.588 (1.105–2.524)*	1.752 (1.096–3.435)*
AUROC	0.688 (0.555–0.821)*		
RT-PCR Ct value			
OR	0.897 (0.798–0.994)*		0.850 (0.723–0.972)*
AUROC	0.698 (0.559–0.836)*		
LDH (U/L)			
OR	1.005 (1.001–1.010)*		1.005 (1.000–1.011)*
AUROC	0.7124 (0.571–0.853)*		

OR, odds ratio; AUROC, area under the receiver operating characteristic curve.

Values are listed with 95% confidence intervals between brackets.

* $P < .05$.

Sex, place of residence, dementia, polypharmacy, extent of affected lung tissue on CT, or CRP values at baseline did not differ between survivors and nonsurvivors. However, compared to survivors of COVID-19, nonsurvivors were significantly older (88.5 vs 85 years, median age) and frailer (median CFS 7 vs 6). Their RT-PCR cycling threshold (Ct) values were also significantly lower (indicating higher viral load). Baseline LDH was significantly higher and baseline lymphocyte count lower in nonsurvivors. Baseline CRP, ferritin, D-dimer, white blood cell, platelet, or 25-hydroxyvitamin D levels were not different (latter data not shown). Lymphopenia was present on admission in 48 patients (60%) and occurred during admission in 60 of 80 patients (75%; 1 patient was excluded because of chronic lymphocytic leukemia). The peak CRP and lymphocyte nadir reached during admission was higher among nonsurvivors, and these differences were highly significant. Length of stay tended to be shorter in those who died ($P = .05$).

Among these variables, the CFS score was associated with dementia ($P < .0001$, $r = 0.602$), long-term care residence ($P < .0001$, $r = 0.465$), and weakly with sex (lower frailty in males, $P = .007$, $r = -0.296$) and incident delirium ($P = .043$, $r = 0.230$). There was no significant association between CFS and older age in our cohort.

One of 17 patients died in the nonfrail group (CFS score 1–4), compared with 18 deaths among 64 frail patients; however, this

difference did not reach significance ($P = .054$). [Supplementary Figure 1A](#) shows survivors and nonsurvivors according to their age and CFS. Most deaths occurred in older, frailer patients. However, this group overlapped considerably with many surviving frail older patients. Kaplan-Meier curves also showed only a trend towards higher mortality in frail vs nonfrail subjects (Mantel-Cox log-rank $P = .06$, [Supplementary Figure 1B](#)).

Next, we examined the clinical diagnostic utility of the individual variables that were significantly associated with mortality, in multiple logistic regression analyses. Again, age, CFS, RT-PCR Ct values, and LDH were significantly associated with higher odds of mortality ([Table 2](#) and [Supplementary Figure 1 C–F](#)), whereas baseline lymphocyte count was no longer significant. In a bivariate model with age and CFS score combined, only the CFS remained significantly associated with mortality. The area under the ROC curve (AUROC) was 0.7443 (95% confidence interval 0.6213–0.8673) for this model ([Figure 1A](#)), with a positive and negative predictive value of 57% and 80%, respectively. When age and CFS were combined with RT-PCR Ct values and LDH, the latter 3 variables remained significantly associated with mortality. The 4-factor model predicted the probability of mortality (range 0–1) as follows (intercept + β_1 *age + β_2 *CFS + β_3 *RT-PCR Ct value + β_4 *LDH): $-13.89 + 0.126$ *years + 0.561 *CFS-score + (-0.1623) *Ct + 0.5275 *[U/L]/100 ([Supplementary Table 1](#)). The AUROC for this model was 0.8824 (0.7384–1.000, $P < .0001$, [Figure 1B](#)), with a negative predictive power of 89.5% and a positive predictive power of 78%, sensitivity of 54% and specificity of 78%.

Seven patients were treated with hydroxychloroquine, 60 (74%) with antibiotics, 46 (57%) with intravenous fluid support, and 25 with glucocorticoids (31%). Seven patients were admitted to the ICU, 5 of whom died. The odds ratio for mortality was significantly higher in patients requiring ICU admission ($P = .0017$).

There were 13 cases of presumably hospital-acquired COVID-19 (taking into account negative RT-PCR on admission, incubation time, and a local outbreak in 1 of our non-COVID-19 wards). Four of these patients died. There was no significantly higher or lower mortality between presumed hospital-acquired or community-acquired COVID-19 cases.

Discussion

The current COVID-19 pandemic particularly strikes frail older adults and/or long-term care residents, posing considerable medical and ethical challenges for our overwhelmed health care systems.

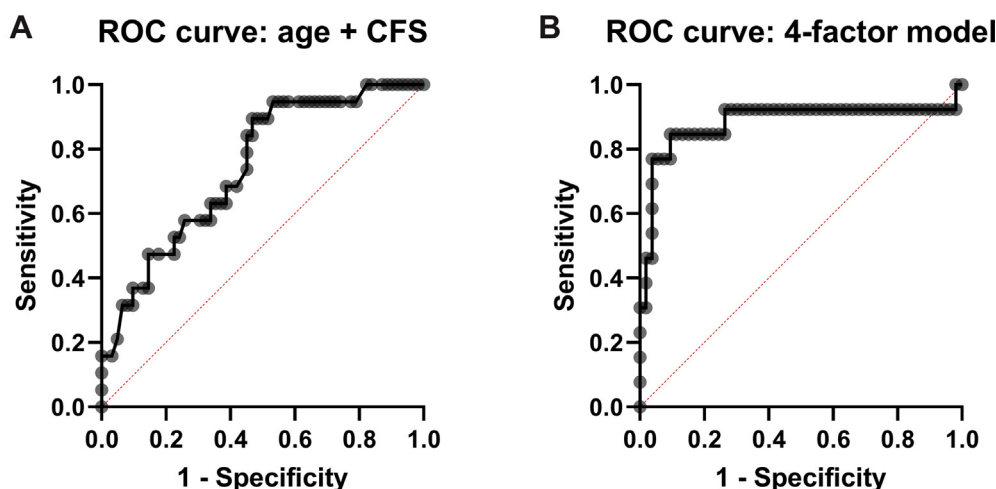


Figure 1. (A) Receiver operating characteristic curves for model with age + clinical frailty score (CFS). (B) Receiver operating characteristic curve for model including age, CFS, reverse-transcriptase polymerase chain reaction cycling threshold (RT-PCR Ct values), and lactate dehydrogenase (LDH) levels.

Different guidelines have been released to assist in the triage in this population.^{9,11,16} Belgian and UK guidelines recommend the CFS to inform decision making regarding hospital referral of nursing home residents with suspected or confirmed COVID-19. However, empirical evidence supporting the use of frailty instruments to predict treatment outcomes and thus apply triage restrictions has remained lacking.¹⁷

The short-term mortality (~23%) in this case series is similar to mortality rates reported for hospitalized older adults in Wuhan or California,^{3,4} but lower than that reported by Sun et al¹⁸ or than in the New York City area.² This may be considered unexpected, given the greater frailty and older age of our patients compared with previous cohorts. Similar or higher mortality rates have been reported in long-term care residents¹⁹ or in younger ICU populations.²⁰ These findings support the notion that it may be discriminatory and unethical to restrict hospital care based on age or frailty status alone.^{10,21} Still, mortality was higher in patients requiring ICU transfer in our cohort, suggesting that intensive care is of unclear clinical benefit in this population.²²

Older age was significantly but weakly associated with increased risk of mortality, confirming recent studies.^{1–4} Anecdotally, nonagenarians or centenarians have survived COVID-19.²³ Our main finding was that frailty was also significantly but weakly associated with a higher risk of mortality in COVID-19 patients (multivariate odds ratio for mortality with each higher CFS point: 1.75.) Still, many severely frail patients survived (72%), and the CFS by itself had poor specificity and no useful cut-off for mortality prediction. A recent study from Italy showed that in a sample of 105 COVID-19 patients, frailty as assessed by the Frailty Index was associated with in-hospital mortality or ICU admission, independent of age and sex.²⁴

Apart from age and frailty, LDH was the only circulating biomarker significantly associated with mortality in our cohort. This confirms prior studies.^{25–27} However, only a few patients met this criterion in our cohort, making it practically useless. Maximal CRP and nadir lymphocyte count during admission was significantly associated with mortality, but these parameters are not available at baseline. Interestingly, we observed a significant association between RT-PCR Ct values and mortality. Viral load peaks longer in patients with more severe COVID-19 and in older adults, as shown by Zheng et al.²⁸ We speculate that a higher viral load may also be a marker for increased risk of mortality, although sampling bias needs to be excluded before we can support this conclusion. Of note, our RT-PCR method was semi-quantitative rather than quantitative, precluding extrapolation to other settings. The 4-factor model combining clinical, host, and viral parameters showed the most promising characteristics but still remained inadequate from a clinical perspective. Sun et al reported a similar logistic regression model based on older age and lymphocyte count.¹⁸ Further work is needed to establish optimal clinical, viral, and host immune system characteristics to predict mortality among COVID-19 patients.²⁶

Our study provides the geriatric community with several novel insights into the outcomes of frail older COVID-19 patients. However, we recognize several limitations, mainly due to our retrospective study design. Because data were obtained retrospectively from electronic health records, missing data (eg, for CT scan or biochemical parameters) may have introduced bias, and follow-up was limited. However, selection bias is unlikely, because we had included consecutive cases in a country with universal health coverage. Caution should be applied to extrapolate findings from this single-center study to other health care settings. The associations we observed may not be causally related. Despite our robust findings on the association between frailty and mortality, some analyses were likely underpowered. A larger sample size would have helped reduce the size of our parameter estimate confidence intervals and increase the validity of our model; however, the first COVID-19 wave ended in our hospital

and no more deaths have accumulated. We chose not to include patients with so-called radiographically confirmed COVID-19, that is, with typical clinical features and radiographic evidence on chest CT but with repeatedly negative SARS-CoV-2 RT-PCR. However, only 3 such patients were excluded, which is unlikely to have influenced the results.

Many instruments to determine frailty are available.²⁹ We applied the CFS, which has been adopted in several national COVID-19 triage policies, most notably by UK NICE guidelines.¹¹ Previous research has shown that CFS scores can reliably be obtained in critically ill patients based on chart review and patient and/or family interview.³⁰ However, we recommend further research to ascertain the reproducibility and reliability before widespread implementation of the CFS during COVID-19 outbreaks. Importantly, we were unable to include younger, nonfrail patients, because frailty was not assessed in nongeriatric patients. The association between frailty and mortality would likely have been stronger if we included younger, less frail patients.

Conclusions and Implications

In summary, we showed that age and frailty were significantly but weakly associated with mortality among hospitalized older adults affected by COVID-19. However, both frailty and age alone have poor specificity to predict mortality, and many severely frail patients survived COVID-19. We recommend clinicians, ethicists, and policy makers to consider these empirical findings.

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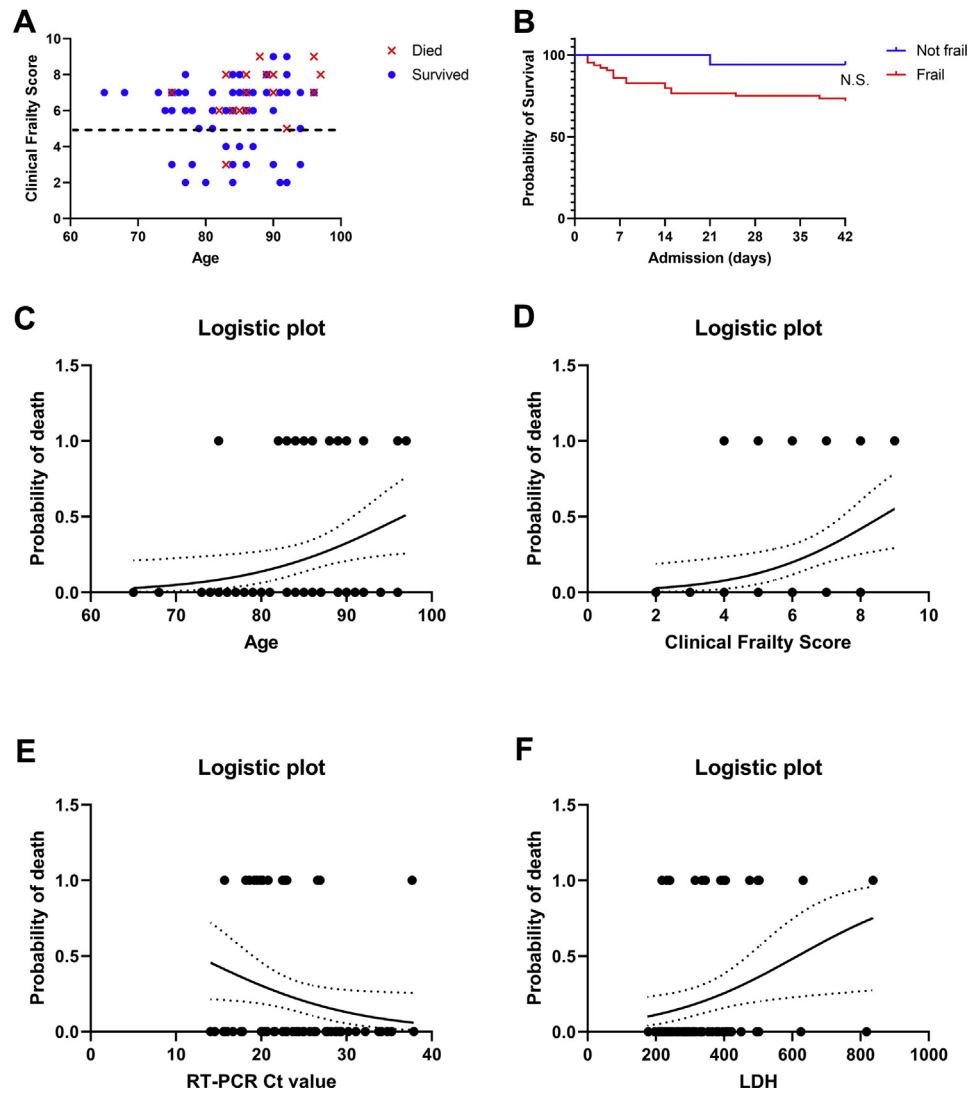
The remaining authors declare no conflicts of interest.

References

- Shahid Z, Kalayanamitra R, McClafferty B, et al. COVID-19 and older adults: What we know. *J Am Geriatr Soc* 2020;68:926–929.
- Richardson S, Hirsch JS, Narasimhan M, et al. Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized with COVID-19 in the New York City area. *JAMA* 2020;323:2052–2059.
- Myers LC, Parodi SM, Escobar GJ, et al. Characteristics of hospitalized adults with COVID-19 in an integrated health care system in California. *JAMA* 2020;323:2195–2198.
- Zhou F, Yu T, Du R, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: A retrospective cohort study. *Lancet* 2020;395:1054–1062.
- D'Adamo H, Yoshikawa T, Ouslander JG. Coronavirus disease 2019 in geriatrics and long-term care: The ABCDs of COVID-19. *J Am Geriatr Soc* 2020;68:912–917.
- Farrell TW, Ferrante LE, Brown T, et al. AGS position statement: Resource allocation strategies and age-related considerations in the COVID-19 era and beyond. *J Am Geriatr Soc* 2020;68:1136–1142.
- Farrell TW, Francis L, Brown T, et al. Rationing limited health care resources in the COVID-19 era and beyond: Ethical considerations regarding older adults. *J Am Geriatr Soc* 2020;68:1143–1149.
- Cesari M, Proietti M. COVID-19 in Italy: Ageism and decision making in a pandemic. *J Am Med Dir Assoc* 2020;21:576–577.
- Matheny Antommara AH, Gibb TS, McGuire AL, et al. Ventilator triage policies during the COVID-19 pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors. *Ann Intern Med* 2020 Apr 24. [Epub ahead of print].
- Bledsoe TA, Jokela JA, Deep NN, et al. Universal do-not-resuscitate orders, social worth, and life-years: Opposing discriminatory approaches to the allocation of resources during the COVID-19 pandemic and other health system catastrophes. *Ann Intern Med* 2020 Apr 24. [Epub ahead of print].
- National Institute for Health and Care Excellence (NICE). NICE guideline [NG159]: COVID-19 rapid guideline: Critical care in adults. 2020. Available at: <https://www.nice.org.uk/guidance/ng159>. Accessed April 24, 2020.
- Belgian Geriatric Society. Flowchart for decision making on hospital admission of possibly COVID-19 infected nursing home residents; 2020.
- Ellis HL, Wan B, Yeung M, et al. Complementing chronic frailty assessment at hospital admission with an electronic frailty index (FI-Laboratory) comprising routine blood test results. *CMAJ* 2020;192:E3–E8.

14. Muscedere J, Waters B, Varambally A, et al. The impact of frailty on intensive care unit outcomes: A systematic review and meta-analysis. *Intensive Care Med* 2017;43:1105–1122.
15. Dangis A, Gieraerts C, De Breucker Y, et al. Accuracy and reproducibility of low-dose submillisievert chest CT for the diagnosis of COVID-19. *Radiol Cardiothorac Imaging*; 2020:2.
16. Chong E, Chan M, Tan HN, et al. COVID-19: Use of the clinical frailty scale for critical care decisions. *J Am Geriatr Soc* 2020;68:E30–E32.
17. Hubbard RE, Maier AB, Hilmer SN, et al. Frailty in the face of COVID-19. *Age Ageing* 2020;68:E30–E32.
18. Sun H, Ning R, Tao Y, et al. Risk factors for mortality in 244 older adults with COVID-19 in Wuhan, China: A retrospective study. *J Am Geriatr Soc* 2020;68: E19–E23.
19. McMichael TM, Currie DW, Clark S, et al. Epidemiology of COVID-19 in a long-term care facility in king county, Washington. *N Engl J Med* 2020;382: 2005–2011.
20. Grasselli G, Zangrillo A, Zanella A, et al. Baseline characteristics and outcomes of 1591 patients infected with SARS-CoV-2 admitted to ICUs of the Lombardy Region, Italy. *JAMA* 2020;323:1574–1581.
21. White DB, Lo B. A framework for rationing ventilators and critical care beds during the COVID-19 pandemic. *JAMA* 2020 Mar 27. [Epub ahead of print].
22. Clarfield AM, Dwolatzky T, Brill S, et al. Israel ad hoc COVID 19 committee. Guidelines for care of older persons during a pandemic. *J Am Geriatr Soc* 2020 May 11. [Epub ahead of print].
23. Huang YM, Hong XZ, Shen J, et al. China's oldest coronavirus survivors. *J Am Geriatr Soc* 2020;68:940–942.
24. Bellelli G, Rebora P, Valsecchi MG, et al. Frailty index predicts poor outcome in COVID-19 patients. *Intensive Care Med* 2020 May 25. [Epub ahead of print].
25. Zhang JJY, Lee KS, Ang LW, et al. Risk factors of severe disease and efficacy of treatment in patients infected with COVID-19: A systematic review, meta-analysis and meta-regression analysis. *Clin Infect Dis* 2020 May 14. [Epub ahead of print].
26. Ji D, Zhang D, Xu J, et al. Prediction for progression risk in patients with COVID-19 pneumonia: The CALL Score. *Clin Infect Dis* 2020 Apr 9. [Epub ahead of print].
27. Henry BM, de Oliveira MHS, Benoit S, et al. Hematologic, biochemical and immune biomarker abnormalities associated with severe illness and mortality in coronavirus disease 2019 (COVID-19): A meta-analysis. *Clin Chem Lab Med* 2020;58:1121–1128.
28. Zheng S, Fan J, Yu F, et al. Viral load dynamics and disease severity in patients infected with SARS-CoV-2 in Zhejiang province, China, January–March 2020: Retrospective cohort study. *BMJ* 2020;369:m1443.
29. Faller JW, Pereira DDN, de Souza S, et al. Instruments for the detection of frailty syndrome in older adults: A systematic review. *PLoS One* 2019;14: e0216166.
30. Shears M, Takaoka A, Rochweg B, et al. Assessing frailty in the intensive care unit: A reliability and validity study. *J Crit Care* 2018;45:197–203.

Appendix



Supplementary Figure 1. (A) Visual outline showing survivors and nonsurvivors according to their age and clinical frailty score. (B) Kaplan-Meier curves for frail vs nonfrail individuals. Logistic plots showing probability of death from COVID-19 according to baseline (C) age, (D) CFS, (E) reverse transcriptase polymerase chain reaction cycling threshold (RT-PCR Ct) values, or (F) lactate dehydrogenase (LDH) plasma concentration in single-factor logistic regression models.

Supplementary Table 1
Four-Factor Model to Predict Mortality: Parameter Estimates

Parameter	Variable	Unit	Estimate	Standard Error	95% Confidence Interval
Intercept			−13.89	6.351	−28.27 to −2.674
β1	Age	Years	0.126	0.071	0.002 to 0.287
β2	CFS	—	0.561	0.281	0.092 to 1.234
β3	Ct value	—	−0.162	0.074	−0.325 to −0.029
β4	LDH	(U/L)/100	0.528	0.268	0.045 to 1.130

CFS, Clinical Frailty Score (range 1-9); Ct value = cycling threshold of reverse transcriptase polymerase chain reaction.



FOR IMMEDIATE RELEASE:

October 27, 2020

CONTACT: Alan Ormsby

(801) 739-3816

AARP Utah – Age must not Factor into Allocating Scarce Health Care Resources

As hospitals and health systems reach capacity and implement Crisis Standards of Care due to Covid-19, the age of a patient must not be a consideration for receiving care.

(Midvale, Utah) — AARP Utah opposes the use of age (or any other discriminatory factor) as a criterion for deciding who gets care during the pandemic and who doesn't. We have asked Governor Gary Herbert to take immediate action to remove any discrimination based on age in "tiebreaker" situations and reissue revised Crisis Standards of Care that reflect this change.

Based on Utah's current guidelines, an individual's age can be used as a factor after he or she has gone through the first three steps of triage and a tiebreaker is necessary:

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.

"The tiebreaker language in the current guidelines is directly at odds with the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act. These federal laws prohibit age-discrimination in HHS funded health programs or activities," said Alan Ormsby, AARP Utah State Director. "Using age to determine who gets care and who doesn't is wholly inappropriate."

AARP Utah has made the following recommendations to the Governor:

- Remove any language in the Crisis Standards of Care Guidelines that discriminates solely on the basis of age. So-called tiebreakers should not use as a factor age, "life years," life expectancy, or prognosis beyond immediate short-term survival.
- Ensure that the practical implementation of the Crisis Standards of Care do not use age as a discriminatory criteria by issuing clear guidelines to health care practitioners.
- Provide clear, easily understandable notice to patients, their families, and/or their caregivers that age-discrimination in COVID-19 care allocation is impermissible, with steps to appeal and remedy suspected age-discrimination.
- Implement an ongoing and fully transparent review process to verify that health care systems are adhering to correct policy/protocols when implementing Crisis Standards of Care to ensure that no group has been disproportionately excluded from life-saving treatment based on discrimination.

###

"No one's possibilities should ever be limited by age."

AARP Utah State Office 6975 Union Park Center # 320 Midvale, Utah 84047 (866) 448-3616

About AARP

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering people 50 and older to choose how they live as they age. With a nationwide presence and nearly 38 million members, AARP strengthens communities and advocates for what matters most to families: health security, financial stability and personal fulfillment. AARP also produces the nation's largest circulation publications: AARP The Magazine and AARP Bulletin. To learn more, visit www.aarp.org or follow @AARP and @AARPadvocates on social media.


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- ✓ Extra health and wellness services
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- New member health assessment and physical exam
- New member medication review from our pharmacist, plus ongoing monitoring of medication regimen and adherence
- Routine visits from our on-site nurse practitioner or physician assistant
- Clinical team on call 24/7, 365 days a year, who have a goal to respond within 15 minutes

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CLASS TOPIC	TIME	QUICK LINK
Effective Communication Strategies	Thursday, October 15 2:00 pm —3:30 pm	http://bit.ly/EC_oct_15
COVID-19 and Caregiving	Friday, October 16 11:00 am —12:00 pm	http://bit.ly/COV19_oct_16
Effective Communication Strategies	Wednesday, October 21 6:00 pm —7:30 pm	http://bit.ly/EC_oct_21
Understanding Alzheimer's and Dementia	Friday, October 23 10:00 am —11:00 am	http://bit.ly/UAD_oct_23
Healthy Living for Your Brain and Body: Tips from the Latest Research	Wednesday, October 28 6:00 pm —7:30 pm	http://bit.ly/HLBB_oct_28
Dementia Conversations	Thursday, October 29 6:00 pm —7:00 pm	http://bit.ly/DC_oct_29
Healthy Living for Your Brain and Body: Tips from the Latest Research	Tuesday, November 3 9:00 am —10:00 am	http://bit.ly/HLBB_nov_3
Effective Communication Strategies	Wednesday, November 4 12:00 pm —1:30 pm	http://bit.ly/EC_nov_4
Dementia Conversations	Wednesday, November 4 2:00 pm —3:00 pm	http://bit.ly/DC_nov_4
Understanding and Responding to Dementia-Related Behavior	Thursday, November 5 3:00 pm —4:00 pm	http://bit.ly/BEH_nov_5

NO COST TO ATTEND.

FOR MORE INFORMATION, CALL 800.272.3900 OR VISIT: ALZ.ORG/CO

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REGIONAL EDUCATION PROGRAMS

October—December 2020

Education Programs, continued

CLASS TOPIC	TIME	QUICK LINK
10 Warning Signs of Alzheimer's	Thursday, November 5 5:00 pm — 6:00 pm	http://bit.ly/10SIGN_nov_5
Understanding Alzheimer's and Dementia	Tuesday, November 10 11:00 am — 12:30 pm	http://bit.ly/UAD_nov_10
Effective Communication Strategies	Thursday, November 12 1:00 pm — 2:00 pm	http://bit.ly/ECS_nov_12
Dementia Conversations	Sunday, November 15 1:30 pm — 2:30 pm	http://bit.ly/DC_nov_15
Understanding Alzheimer's and Dementia	Tuesday, November 17 10:00 am — 11:00 am	http://bit.ly/UAD_nov_17
Advancing the Science: Alzheimer's and Dementia Research	Wednesday, November 18 10:00 am — 12:00 pm	http://bit.ly/RES_nov_18
Legal and Financial Planning for Alzheimer's	Wednesday, November 18 3:00 pm — 5:00 pm	http://bit.ly/LF_nov_18
10 Warning Signs of Alzheimer's	Thursday, November 19 11:00 am — 12:00 pm	http://bit.ly/10SIGN_nov_19
Healthy Living for Your Brain and Body: Tips from the Latest Research	Thursday, November 19 2:00 pm — 3:30 pm	http://bit.ly/HLBB_nov_19
COVID-19 and Caregiving	Friday, November 20 11:00 am — 12:00 pm	http://bit.ly/COV19_nov_20
Understanding and Responding to Dementia-Related Behavior	Friday, November 20 12:00 pm — 1:00 pm	http://bit.ly/BEH_nov_20
Effective Communication Strategies	Friday, November 20 11:30 am — 12:30 pm	http://bit.ly/ECSEV_nov_20
Dementia Conversations	Tuesday, November 24 12:00 pm — 1:30 pm	http://bit.ly/DC_nov_24
COVID-19 and Caregiving	Wednesday, December 2 6:00 pm — 7:00 pm	http://bit.ly/COV19_dec_2

NO COST TO ATTEND.

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REGIONAL EDUCATION PROGRAMS

October—December 2020

Education Programs, continued

CLASS TOPIC	TIME	QUICK LINK
10 Warning Signs of Alzheimer's	Thursday, December 3 9:00 am — 10:30 am	http://bit.ly/10SIGN_dec_3
Effective Communication Strategies	Friday, December 4 10:00 am — 11:00 am	http://bit.ly/ECS_dec_4
Legal and Financial Planning for Alzheimer's	Friday, December 4 12:00 pm — 2:00 pm	http://bit.ly/LAF_dec_4
Understanding Alzheimer's and Dementia	Monday, December 7 5:00 pm — 6:00 pm	http://bit.ly/UAD_dec_7
Understanding and Responding to Dementia-Related Behavior	Tuesday, December 8 11:00 am — 12:30 pm	http://bit.ly/BEH_dec_8
Healthy Living for Your Brain and Body: Tips from the Latest Research	Tuesday, December 8 2:00 pm — 3:00 pm	http://bit.ly/HLBB_dec_8
Dementia Conversations	Thursday, December 10 2:00 pm — 3:00 pm	http://bit.ly/DC_dec_10
Understanding Alzheimer's and Dementia	Monday, December 14 10:00 am — 11:00 am	http://bit.ly/UAD_dec_14
Dementia Conversations	Monday, December 14 6:00 pm — 7:00 pm	http://bit.ly/DC_dec_14
10 Warning Signs of Alzheimer's	Tuesday, December 15 10:00 am — 11:00 am	http://bit.ly/10SIGN_dec_15
Understanding and Responding to Dementia-Related Behavior	Wednesday, December 16 10:00 am — 11:00 am	http://bit.ly/BEH_dec_16
Effective Communication Strategies	Thursday, December 17 10:00 am — 11:00 am	http://bit.ly/ECS_dec_17
Healthy Living for Your Brain and Body: Tips from the Latest Research	Monday, December 21 1:00 pm — 2:00 pm	http://bit.ly/HLBB_dec_21

NO COST TO ATTEND.

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REGIONAL EDUCATION PROGRAMS

October—December 2020

En Español

Visite a www.alz.org/crf o llame al 1-800-272-3900 para registrarse o para mas informacion.

CLASS TOPIC	TIME	QUICK LINK
Enfermedad de Alzheimer's: Las Señales de Advertencia (En Español)	Martes, 27 de Octubre 4:00 pm — 5:00 pm	http://bit.ly/10SIGNS_oct_27
Enfermedad de Alzheimer's: Las Señales de Advertencia (En Español)	Viernes, 11 de Diciembre 11:30 am — 12:30 pm	http://bit.ly/10SIGNS_dec_11

Specialized Programs

Specialized Programs are offered for the variety of needs specific to particular types of dementia and caregiving scenarios.

CLASS TOPIC	TIME	QUICK LINK
Living with Alzheimer's: For Care Partners Early Stage—Part 1	Monday, October 19 1:00 pm — 2:30 pm	http://bit.ly/LWACP1_oct_19
Living with Alzheimer's: For Care Partners Early Stage—Part 2	Monday, October 26 1:00 pm — 2:30 pm	http://bit.ly/LWACP2_oct_26
Living with Alzheimer's: For Care Partners Early Stage—Part 3	Monday, November 2 1:00 pm — 2:30 pm	http://bit.ly/LWACP3_nov_2
Living with Alzheimer's: For Caregivers Middle Stage—Part 1	Monday, November 9 1:00 pm — 2:30 pm	http://bit.ly/LWACGMS1_nov_9
Living with Alzheimer's: For Caregivers Middle Stage—Part 2	Monday, November 16 1:00 pm — 2:30 pm	http://bit.ly/LWACGMS2_nov_16
Living with Alzheimer's: For Caregivers Middle Stage—Part 3	Monday, November 23 1:00 pm — 2:30 pm	http://bit.ly/LWACGMS3_nov_23
Living with Alzheimer's: For Caregivers Late Stage—Part 1	Monday, November 30 1:00 pm — 2:30 pm	http://bit.ly/LWACGLS1_nov_30
Living with Alzheimer's: For Caregivers Late Stage—Part 2	Monday, December 7 1:00 pm — 2:30 pm	http://bit.ly/LWACGLS2_dec_7

NO COST TO ATTEND.

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THE UTAH GERIATRIC EDUCATION CONSORTIUM
INVITES YOU TO A

FIRESIDE CHAT PRESENTATION

Dr. Sarah Morimoto will be presenting
"Neuroplasticity in the Aging Brain:
How to Maintain and Enhance Function"

THURSDAY, DECEMBER 3, 2020

ZOOM MEETING

[HTTPS://UTAH.ZOOM.US/J/99932033377](https://utah.zoom.us/j/99932033377)

10:00 AM-11:00 AM MST

Can't make it at this time? The presentation will be recorded and posted on our website, utahgwebp.org.

Meet the speaker:



Dr. Sarah Shizuko Morimoto is Associate Professor in Population Health Sciences, Division of Health Systems Innovation and Research and Director of Cognitive Remediation in Psychiatry at the U of U School of Medicine. Dr. Morimoto completed a pre-doctoral internship at Harvard Medical School and post doctoral training in clinical neuropsychology, and research training at Weill Cornell Medical School. Dr. Morimoto was faculty at the Institute of Geriatric Psychiatry at Cornell for 10 years before joining the U of U medical school. Dr. Morimoto's research focuses on developing tech-based digital interventions to enhance plasticity in an aging brain. Her clinical research and clinic treat older adults who suffer from depression and cognitive impairment. The clinic's mission is to offer empirically supported treatments to help older adults maximize their cognitive and emotional brain health at any age.