ROPES & GRAY

# CORONAVIRUS
## INFORMATION & UPDATES

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# UPDATED: Key Considerations for COVID-19 Emergency Triage Policies in California

Ropes & Gray offers immediate practical guidance on how to navigate the legal and ethical issues raised by the need to have a clear plan for allocating scarce resources as COVID-19 strains California hospitals in unprecedented ways. Below are key considerations as hospitals and academic medical centers evaluate policies and procedures to guide these challenging decisions.

1. **Review your written disaster plan to ensure it addresses the anticipated shortages.** California law requires hospitals to have disaster plans. In preparation for a health care "surge," this includes a plan for allocating scarce resources in cases of extreme shortages. A triage plan should include a clear statement of goals, be developed in an open and transparent manner, provide appropriate accountability for all decisions made, and clearly indicate the parties responsible for developing and updating the plan. At a minimum it should address:
    - What triggers the plan,
    - How treatment and supplies are allocated,
    - Whether the plan may result in withdrawing or withholding care, or in any combination of the two, and
    - Who will make allocation decisions for and among specific patients.
2. **Your plan should comply with non-discrimination laws**. The federal Office for Civil Rights (OCR) and the California Departments of Health Care Services (DHCS), Public Health (CDPH), and Managed Health Care all recently issued guidance warning that supply shortages do not suspend anti-discrimination laws. Your triage plan should account for the following:
    - The triage plan should be facially neutral, meaning it does not discriminate against any protected class as written, and that its various measures and procedures are justified by necessity. Any plan should include a statement explaining why that specific plan is necessary to provide the applicable standard of care and the rationale behind it.
    - The greatest discrimination risk in triage plans is that they unfairly – and perhaps illegally – distinguish among patients based on underlying disabilities. In some cases, disabling conditions are co-morbidities that are appropriately considered in allocation of scarce medical resources, but those priorities should be established by clinical experience and ratified by senior medical staff, preferably by reference to professional or government guidelines. CDPH is currently drafting guidance that may explain how co-morbidities can be considered during the triage process.[1]

[1] On April 19, 2020, CDPH issued SARS-CoV-2 Pandemic: Health Care Surge Crisis Care Guidelines that referenced how co-morbidities could be considered as part of the patient scoring process. On April 23, CDPH relabeled this document as a draft, and stated that the guidance would be revised to ensure it complies with state laws and policies, including those prohibiting discrimination.

3. **Clear communication to patients and their families.** California requires that hospitals establish a public information center in the event of a disaster. Clear, accurate communication will ensure patients and their families know that care is being provided under an altered or crisis standard and that the hospital can decline a patient admission. Under California's draft guidance, decisions about withholding or withdrawing care from an individual patient should be communicated by the attending physician, the triage officer, or both, and palliative care clinicians and social workers should be made available if resources permit.
4. **The transition to alternate or crisis standards of care**. Transitioning to crisis standards of care is forced by the exhaustion of other options.
    - **Facility steps to confirm need to transition.** Transition along the continuum of care to crisis standards should not occur until allocation or rationing becomes necessary. A triage plan should be followed only as long as the circumstances require. Before implementing your plan, the hospital should confirm and document:
        - Which resources and infrastructure are critically limited;
        - The hospital has maximized its efforts to conserve, reuse, adapt, and substitute conventional therapies;
        - Available supply is insufficient to meet demand for conventional standard of care therapy;
        - Patient transfer is not feasible or creates undue strain, with provisions made for discussing individual cases with, and gaining consent from, patients and/or legally-authorized representatives; and
        - The hospital has requested necessary resources from appropriate government health officials, but these resources are insufficient to meet demand.
    - **Governmental recognition of need to transition**. CDPH's draft guidance states that during prolonged incidents, CDPH may convene a Science Advisory Team (SAT) to provide recommendations about the allocation of scare resources to the State Public Health Officer, who will in turn provide recommendations to the health system. As of April 21, there have been no announcements regarding the need to triage resources. The draft guidance also contemplates that individual institutions will have "triggers" built into their emergency plans that will indicate when the hospital needs to transition to contingency or crisis standards.

      CDPH's draft guidance advises that prior to a transition, every effort should be made to notify local and regional partners to ensure outside resources and assistance are not available, including the Medical and Health Operational Area Coordinator (MHOAC), the Regional Disaster Medical and Health Specialist (RDMHS), the CDPH, and the Emergency Medical System Authority (EMSA).

5. **Liability Protection under state or federal emergency declarations**. In California, providers are not generally civilly or criminally liable provided they act in good faith, in accordance with generally accepted standards of care under the circumstances, and use such skill, prudence, and diligence as other members of the profession

commonly possess and exercise. In addition, current emergency declarations applicable to California offer the following protections:[2]

- California hospitals and health care providers who render service during the emergency at the request of any state or local official or agency are statutorily immunized from liability for injuries sustained because of the request. This protection will end when the Governor declares an end to the current public health emergency. Currently an end date has not been set.
- Hospitals are statutorily immune from liability for refusing to render emergency care if they do not have the appropriate facilities or qualified personnel available.
- The California "good Samaritan" law protects physicians who act in the event of a sudden medical emergency.
- Protection from tort claims may be available under the federal Public Readiness and Emergency Preparedness Act (PREP Act), 42 U.S.C. § 247d-6d. PREP protects the manufacture, distribution, administration, or use of medical countermeasures. Key questions are whether the hospital and its agents are "covered persons" and whether the specific care being providing is a "covered countermeasure." Any protection that is available under the PREP Act is expected to extend until 2024.

[2] These are the March 4, 2020, Proclamation of a State of Emergency by Governor Newsom; March 13, 2020, National Emergency Determination by President Trump; and March 22, 2020, California Major Disaster Declaration by President Trump.