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

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 Massachusetts 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.** Massachusetts regulations require hospitals to meet the Medicare Conditions of Participation, under which hospitals are required to have an emergency plan, policies, and procedures. The Massachusetts Department of Public Health ("MDPH") recently issued its crisis standards of care-planning guidance, which includes key triage principles that healthcare facilities should adhere to.

   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,
   - The creation of a triage team that will make allocation decisions for specific patients,
   - A critical care allocation framework that determines how resources will be prioritized,
   - Reassessment of patients receiving critical care with reallocation of resources where appropriate, and
   - An appeals process for individual triage decisions, including the decision to withdraw life-sustaining treatment.

2. **Your plan should comply with non-discrimination laws.** The federal Office for Civil Rights recently issued guidance warning that supply shortages do not suspend anti-discrimination laws. The MDPH guidance similarly states that health care providers should not make allocation decisions based on protected classes, including disability. 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.

3. **Clear communication to patients and their families.** Under the MDPH guidance, once hospital leadership has activated the allocation framework, clinicians should communicate in transparent language with patients and families about the public health emergency and the need to triage resources. Clear, accurate communication will ensure patients and their families know that care is being provided under an altered or crisis standard.

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 to an alternate or crisis standard 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.
        - **Governmental recognition of need to transition.** The MDPH guidance recognizes that the health care system may be forced to transition from conventional standards to crisis care, if available resources are inadequate to meet all important patient needs. Under the guidance, if a health care facility becomes, or anticipates becoming, unable to provide the usual standard of care, the facility must contact the MDPH so that the statewide incident command can either direct patients to an alternative facility or coordinate the reallocation of resources to the facility in need. The goal is to avoid, if possible, the need to transition to crisis standards.

5. **Liability protection under state or federal emergency declarations.** In Massachusetts, medical practitioners are generally not civilly liable if they exercise the degree of care and skill of the average similarly qualified practitioner under like circumstances. In addition, current emergency declarations applicable to Massachusetts offer the following protections:[1]

    - Health care providers are immune from civil liability for any acts or omissions in the course of providing services during the COVID-19 emergency period, assuming the care was provided in good faith and in accordance with

[1] These are the March 10, 2020, Declaration of a State of Emergency to Respond to COVID-19 by Governor Baker; March 13, 2020, National Emergency Determination by President Trump; and March 28, 2020, Massachusetts Major Disaster Declaration by President Trump.

applicable law. The immunity does not apply to acts or omissions constituting gross negligence, recklessness, or conduct with an intent to harm or discriminate based on protected grounds, to consumer protection actions brought by the Attorney General, or to false claims actions brought by or on behalf of the Commonwealth. This protection will end when the Governor declares an end to the current state of emergency. Currently that date has not been set.

- Physicians and nurses are not liable in suits for damages resulting from their acts or omissions if they render emergency care or treatment in good faith, as volunteers and without fee, outside the ordinary course of their practice.

- 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." Governor Baker recently issued a Directive clarifying that particular activities would be covered by the PREP Act, including distributing and administering tests, drugs, and devices to diagnose or treat COVID-19. Any protection that is available under the PREP Act is expected to extend until 2024.