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

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 Texas 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.** The Texas Department of Health and Human Services anticipates that hospitals will maintain a preparedness plan.

   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 any combination of the two, and
   - Who will make allocation decisions for and among specific patients, and
   - How and when the policies will be communicated to patients and their families.

2. **Your plan should comply with non-discrimination laws.** The federal Office for Civil Rights ("OCR") 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.

3. **Confirmation of the need to transition to alternate or crisis standards of care.**

   - 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.** Guidance from the Texas Department of State Health Services explains that during incidents involving the potential for mass casualties, crisis standards of care and triage may be implemented to provide the highest level of medical care possible. If and when circumstances dictate, local Emergency Medical Services (EMS) organizations may suggest that crisis care standards be implemented. As of June 25, 2020, this had not happened.

  When the hospital is ready to implement its triage plan, be sure to check local laws and regulations to confirm mandates to coordinate with local authorities, if any.

4. **Liability Protection under state or federal emergency declarations.** In developing triage policies and procedures, it could be important to understand the contours of potential legal liability for certain decisions. In Texas, providers are not generally civilly liable provided they act in good faith, and in accordance with generally accepted methods used by other area health care professionals on similarly situated patients with similar conditions. In addition, current emergency declarations and Texas statutes offer the following protections:[1]

   - In Texas, a person who provides emergency care as a volunteer is immune from civil liability unless he or she performs an act in a willfully or wantonly negligent manner.
   - Texas hospitals and health care providers are immune from civil liability related to the provision of emergency care in a hospital emergency department, unless the treatment involved willful or wanton negligence.
   - 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.

[1] These are the March 13, 2020, Declaration of a State of Disaster in Texas; National Emergency Determination by President Trump; and March 25, 2020 Texas Major Disaster Declaration by President Trump.

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