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Key Considerations for COVID-19 Emergency Triage Policies in Virginia

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 Virginia 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.** In preparation for a public health emergency, the Virginia Department of Health (VDH) issued non-binding guidance recommending that entities have 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 both activation and termination of the plan, and who decides when these triggering events have occurred;
    - How treatment and supplies are allocated and/or modified;
    - Whether the plan may result in withdrawing or withholding care, or in any combination of the two, and what palliative resources will be provided;
    - Who will make allocation decisions for and among specific patients; and
    - When and how often the plan will be re-evaluated during the shortage to account for new circumstances.

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 appropriately are 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.** Consistent with guidance from the VDH, hospitals should develop a communication plan that addresses the activation of the triage plan with both patients and the general public. Clear, accurate communication will ensure that 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 certain circumstances.

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, and 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 VDH contemplates that absent a government mandate regarding the need to transition, an internal decision-maker will be authorized to activate the triage plan once the plan's triggering events are reached.

     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. VDH guidance suggests that providers ensure a coordinated response to a surge by engaging in increased communication with other health care entities in the region, including discussing whether any providers can increase their scope of services, or engage in cooperative initiatives.

5. **Liability protection under state or federal emergency declarations.** In Virginia, providers generally are not civilly liable provided they act in good faith, in accordance with generally accepted standards of care under the circumstances, and use such skill and diligence as is normally practiced by a reasonably prudent practitioner in the field or specialty. In addition, current emergency declarations applicable to Virginia offer the following protections:[1]

   - During a state or local emergency, health care providers are immune from civil liability–absent gross negligence or willful misconduct–for any injury or death arising from (1) the abandonment of a person to whom the provider owed a duty of care because that provider was responding to the disaster, or (2) the delivery or withholding of health care when the emergency causes a lack of resources and an inability to provide the typical standard of care.

[1] These are the March 12, 2020, Declaration of Public Health and Civil Preparedness Emergencies by Governor Northam; the March 13, 2020, National Emergency Determination by President Trump; and the April 2, 2020, Virginia Major Disaster Declaration by President Trump.

- The Governor has clarified that these liability protections apply to providers rendering care in response to the COVID-19 health emergency, including where providers execute triage protocols.[2] These protections will end when the Governor rescinds the current state of emergency. Currently that date has not been set.

- The Virginia Good Samaritan law grants immunity from civil liability–absent gross negligence–to any person who, in good faith and without compensation, renders emergency care or assistance to any ill person at the scene of an emergency, at a screening location, or en route to a hospital, medical clinic, or doctor's office.

- Protection from tort claims may be available under the federal Public Readiness and Emergency Preparedness Act (PREP Act), 42 U.S.C. § 247d-6d. The PREP Act 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] Virginia Clarification of Certain Immunity from Liability for Healthcare Providers in Response to Novel Coronavirus (COVID-19), April 28, 2020, *available at* https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-60-Clarification-of-Certain-Immunity-From-Liability-For-Healthcare-Providers-in-Response-to-Novel-Coronavirus-(COVID-19).pdf.