ROPES & GRAY

CORONAVIRUS
INFORMATION & UPDATES

June 3, 2020

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

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 Illinois 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 Illinois Department of Public Health ("IDPH") has issued guidance that institutions, including hospitals, should each have their own written plan in place. IDPH's guidance includes a Catastrophic Incident Response Annex (the "CIR Annex"), which provides guidelines on allocating scarce resources if necessary.

A triage plan should include a clear statement of the goals, be developed in an open and transparent manner, provide appropriate accountability for all decisions made, and clearly state who was responsible for developing 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 on any combination of the two, and
- Who will make allocation decisions for specific patients.

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 federal 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. **Clear communication to patients and their families.** Under Illinois guidance, hospitals should provide patients and their families with information regarding the reasons for the implementation of crisis care and how care changes when the CIR Annex is activated. 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. Under Illinois guidance, institutions should inform IDPH, as appropriate, when the hospital's triage plan is activated and crisis care standards are being implemented. 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 Governor can activate the State Emergency Operations Center ("SEOC"). On March 9, 2020, Governor Pritzker issued a disaster proclamation and activated the SEOC. Under IDPH guidance, if and when circumstances dictate, IDPH can inform the SEOC that crisis care may need to be implemented. As of April 6, 2020, IDPH has not yet publicly suggested the use of crisis standards.
    - **Liability protection under state or federal emergency declarations.** In Illinois, 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, prudence, and diligence as other members of the profession commonly possess and exercise. If the government recognizes the need to transition to crisis standards of care, under IDPH guidance, providers are expected to follow a standard of reasonable practice based on public health principles. In addition, current emergency declarations and executive orders applicable to Illinois offer the following protections:[1]
        - Executive Order 2020-19 grants immunity from civil liability to health care professionals, facilities and volunteers providing health care services in support of Illinois' response to the COVID-19 outbreak. Unless renewed by the Governor, this protection is currently set to expire along with the state of emergency on June 27, 2020. A more detailed summary of the liability protections established by Executive Order 2020-19 is available here. A more detailed summary of liability protections specific to elective surgeries established by Executive Order 2020-37 is available here.

[1] These are the March 9, 2020 State of Emergency Declaration by Governor J.B. Pritzker; the March 13, 2020, National Emergency Determination by President Trump; and the March 26, 2020, Illinois Major Disaster Declaration by President Trump authorized under the Stafford Act.

- More generally, public hospitals and their employees in Illinois are statutorily immune from liability resulting from the policy decision to perform or not perform an act to promote the public health of the community by preventing disease or controlling the communication of the disease; failing to adequately physically examine a patient; or failing to diagnose a patient.
- The Illinois Good Samaritan law protects any licensed medical professional who, in good faith, provides care in the event of a sudden medical emergency without fee or compensation for doing so. It does not protect against willful or wanton misconduct.
- 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.