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UPDATED: Key Considerations for COVID-19 Emergency Triage Policies in Connecticut *(as of September 8, 2020)*

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 Connecticut hospitals in unprecedented ways. Below are key considerations as hospitals and academic medical centers evaluate policies and procedures to guide these challenging decisions.

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1. **Review your written disaster plan to ensure it addresses the anticipated shortages.** In preparation for a health care "surge," 2010 guidance from the Connecticut Department of Public Health (DPH) recommends that you 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 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) 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. **Clear communication to patients and their families.** Consistent with guidance from the DPH, hospitals should keep the public informed of policy changes. 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.

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.** Guidance from the DPH recognizes that the Governor may issue an executive order to transition to crisis standard of care. As of September 8, 2020, the Governor has not done so. Hospitals can, nonetheless, request modifications or suspensions of statutes and regulations from the DPH and DPH may make recommendation to the Governor.

    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.

5. **Liability protection under state or federal emergency declarations.** In Connecticut, 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. In addition, current emergency declarations applicable to Connecticut offer the following protections:[1]

    - Connecticut hospitals and health care providers who, in good faith, provide care in support of the state's COVID-19 response are immune from civil liability, absent criminal, fraudulent, malicious, grossly negligent, or intentional misconduct. This protection is currently set to expire along with the public health emergency on February 9, 2021.
    - Connecticut health care providers employed by either the state or local government who render service during an emergency are statutorily immunized from civil liability, absent willful misconduct.
    - Connecticut health care providers who, acting on behalf of the state and within the scope of their practice, render service during an emergency are statutorily immunized from personal liability, absent wanton, reckless, or malicious conduct.

[1] These are the March 10, 2020, Declaration of Public Health and Civil Preparedness Emergencies by Governor Lamont; March 13, 2020, National Emergency Determination by President Trump; March 29, 2020, Connecticut Major Disaster Declaration by President Trump; and April 7, 2020, Connecticut Protection of Public Health and Safety During COVID-19 Pandemic and Response.

- The Connecticut Good Samaritan law provides civil immunity for negligence — except for gross, willful, or wanton negligent acts or omissions — to persons who render emergency medical or professional assistance voluntarily, without compensation, and outside the ordinary course of their employment or 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. 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.