



Center for Public  
Representation

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By Electronic Mail

Steve Walsh, President and CEO  
Massachusetts Health & Hospital Association (MHA)

Patricia McMullin, Executive Director  
College of Boston Teaching Hospitals

Maryanne C. Bombaugh, President  
Massachusetts Medical Society

We write to share our coalitions' response to the revised Massachusetts Crisis Standards of Care, issued on April 20, 2020, and to offer our support as hospital systems review and integrate these changes into their existing triage protocols.

We recognize the strain on our medical system during this surge, and that hospital systems across the Commonwealth are reviewing these important revisions at the same time they are attending to the critical needs of patients and medical staff. As with our past correspondence, we hope to support those efforts by highlighting the most significant revisions to the Standards; and by identifying the criteria that we believe continue to violate federal civil rights laws. We would welcome the chance to speak with you about these issues, including how best to avoid inequities in the allocation of care based on disability, age, race, or other protected status.

Despite encouraging changes in the Standards, there remain serious problems requiring additional, substantive revisions in order to avoid discrimination. Those problems, and the rationale for further revisions, are described in the enclosed letter. One primary concern is the revised Standard's continued reliance on predictions of prognosis up to five years after treatment of the acute care episode.

Attempts to predict intermediate prognosis can lead to erroneous, inconsistent, and subjective decision-making in violation of federal anti-discrimination laws. Accurate predictions of life expectancy of less than 5 years are extremely difficult, even under normal circumstances. In the context of expedited emergency triage decision-making, it is near impossible. There is little evidence in the medical literature and professional research to support the reliability of such predictions. Moreover, a number of doctors with whom we have conferred expressed their rejection of the reliability of such projections and their concern about the associated risk of implicit bias toward, and discriminatory impact on, people with disabilities, older persons, and individuals from communities of color who are more likely to have underlying, co-morbid conditions.

We recommend hospitals eliminate any consideration of intermediate term prognosis (5 year life expectancy), and limit any consideration of individual patient longevity to medical conditions that are highly likely to result in death in less than one year. Hospitals should adopt the New York State triage model<sup>1</sup> which assesses “the short-term likelihood of survival of the acute medical episode,” and not whether a patient may survive another illness or disease years after the pandemic. Under this approach, every patient is treated in accordance with a consistent standard of care, and triage decision-makers are not asked to make predictions based on insufficient information, or subjective assumptions about survival in the years following treatment.

In addition to eliminating criteria that attempt to predict 5 year prognosis, we urge all hospitals to remove triage provisions that discriminate on the basis of age, including the Standard’s “life span” tie breaker, and to clarify that facilities’ affirmative obligation to make reasonable accommodations for persons with disabilities extends to hospital visitor policies.

Finally, hospitals should take the following steps to ensure recent revisions to the Standards are reflected in their triage protocols:

- 1) remove criteria that penalize individuals with underlying co-morbid conditions believed to impact their long-term prognosis;
- 2) require training about, and include explicit references to, the need to guard against disproportionate impacts on disadvantaged populations, including by unconscious bias, in triage decision-making;
- 3) affirmatively state that no patient is disqualified from being evaluated for life saving treatment solely based on pre-existing disabilities, underlying conditions or short term survivability; and that all patients other than those who are thought to be imminently dying regardless of critical care interventions will be *eligible* to receive critical care beds and services regardless of their priority score.
- 4) instruct triage officers that baseline levels of impairment prior to an acute care episode (including chronic but stable underlying conditions and disabilities) cannot be used to increase patient’s SOFA score unless those conditions directly impact an individual’s short-term survivability with treatment;
- 5) emphasize the importance of making conservative judgments regarding prognosis, based on individualized assessments, and the most expert clinical judgment available;
- 6) make clear that any predicted prognosis cannot be based on the mere existence of certain underlying conditions or disabilities, and that triage officers should not assign points based on the patient’s underlying conditions when the prognosis is uncertain.

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<sup>1</sup> New York State Department of Health, “Ventilator Allocation Guidelines,” by the New York Taskforce on Life and the Law, November 2015, 34, available at [https://www.health.ny.gov/regulations/task\\_force/reports\\_publications/docs/ventilator\\_guidelines.pdf](https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf).

- 7) direct hospital staff and triage teams to provide reasonable accommodations to triage protocols;
- 8) instruct clinicians to allow for variations in recovery time during the reassessment process, including extension of a therapeutic ventilator trial, when underlying conditions or disabilities are present;
- 9) take steps to ensure reasonable accommodations in the communication of treatment and triage decisions to patients and families, including access to interpretive services, specialized assistive technology, and other adaptive methods for communication.
- 10) clarify that a patient presenting at the hospital with personal medical equipment, such as a ventilator, will not have that equipment confiscated or used for any other patient; and
- 11) collect and report real time data to DPH, including data on rationing of care and the utilization of triage appeals procedures, in the event crisis standards are implemented in the future.

We want to reiterate our thanks to you and your members for their efforts to provide all needed care and to avoid potential rationing. We would welcome the chance to speak with you and members of your associations as they revise their triage protocols.

Sincerely,

Kathryn L. Rucker  
Cathy E. Costanzo  
Steven J. Schwartz  
Robert D. Fleischner  
Center for Public Representation  
22 Green Street  
Northampton, MA 01060  
[krucker@cpr-ma.org](mailto:krucker@cpr-ma.org)  
[ccostanzo@cpr-ma.org](mailto:ccostanzo@cpr-ma.org)  
[sschwartz@cpr-ma.org](mailto:sschwartz@cpr-ma.org)

Linda Landry  
Rick Glassman  
Disability Law Center  
11 Beacon Street, Suite 925  
Boston, MA 02108  
[llandry@dlc-ma.org](mailto:llandry@dlc-ma.org)  
[rglassman@dlc-ma.org](mailto:rglassman@dlc-ma.org)

Matt Selig  
Justin J. Lowe  
Health Law Advocates  
One Federal Street, 5<sup>th</sup> Floor  
Boston, MA 02110  
[jlowe@hla-inc.org](mailto:jlowe@hla-inc.org)

Phillip Kassel  
Caitlin Parton  
Mental Health Legal Advisors Committee  
24 School Street, Suite 804  
Boston, MA 02108  
[pkassel@mhlac.org](mailto:pkassel@mhlac.org)  
[cparton@mhlac.org](mailto:cparton@mhlac.org)

Daniel S. Manning  
Greater Boston Legal Services  
197 Friend Street  
Boston, MA. 02114  
[dmanning@gbls.org](mailto:dmanning@gbls.org)

Regan Bailey  
Denny Chan  
Gelila Selassie  
Justice In Aging  
1101 I Street, NW, Suite 1100  
Washington, DC 20036  
[rbailey@justiceinaging.org](mailto:rbailey@justiceinaging.org)  
[dchan@justiceinaging.org](mailto:dchan@justiceinaging.org)  
[gselassie@justiceinaging.org](mailto:gselassie@justiceinaging.org)

Ivan Espinoza-Madrigal  
Lawyers for Civil Rights  
61 Batterymarch Street  
5<sup>th</sup> Floor  
Boston, MA 02110  
[iespinoza@lawyersforcivilrights.org](mailto:iespinoza@lawyersforcivilrights.org)

Ruth A. Bourquin  
Jessica Lewis  
American Civil Liberties Union  
Foundation of  
Massachusetts, Inc.  
211 Congress Street  
Boston, MA 02110  
[RBourquin@aclum.org](mailto:RBourquin@aclum.org)  
[JLewis@aclum.org](mailto:JLewis@aclum.org)

Mark Larsen  
Mental Health Litigation Division  
Committee for Public Counsel Services  
44 Bromfield Street  
Boston, MA 02108  
[mlarsen@publiccounsel.net](mailto:mlarsen@publiccounsel.net)