Center for Public Representation

October 12, 2020

Governor Charles Baker
Lt. Gov. Karyn Polito
Secretary Marylou Sudders
Acting Secretary Daniel Tsai
DPH Commissioner Monica Bharel
Attorney General Maura Healy
Senate President Karen Spilka
Speaker of House Robert DeLeo

Dear Governor Baker and other distinguished State officials:

On behalf of the undersigned organizations and individuals, we express our appreciation for the most recent revisions to the Crisis Standards of Care (CSC). We want to acknowledge the hard work of the Governor's Advisory Committee, and the importance of a public comment process in finalizing this document. These comments have been uploaded to the designated link, and are provided to State officials here as a courtesy copy.

Like all involved in this process, our objective is that the CSC never be invoked, and we urge the administration to continue to work tirelessly to prevent such an outcome. We have months of experience managing the transmission of COVID-19, and we cannot accept the inevitability of a second wave of infections. As the wealthiest country in the world, and in a State with nationally recognized health care systems, these standards – and the avoidable loss of human life they portend - should never become necessary.

The revised Massachusetts CSC contain important improvements that will help reduce the potential for discriminatory allocation of scare medical resources, and limit the exacerbation of existing health inequalities. In particular, our coalition strongly supports the following revisions:

1) the removal of 2-5 year prognosis as criteria for prioritizing access to care;

2) the removal of "saving the most life years" as a primary CSC goal, and corresponding changes to the tie breaker provisions that prohibit relying solely on age as a distinguishing characteristic between similarly situated patients;

3) the additional emphasis on reasonable accommodations for persons with disabilities throughout the triage process, and directives to avoid discriminatory assumptions based on disability;

4) new requirements for competency-based training of hospital staff and triage teams, including training on implicit bias; and

5) provisions on health care decision-making, stating that no individual or their families shall be coerced or required to commit to a DNR and/or DNI order as a prerequisite to receiving treatment, regardless of the level of strain on hospital resources or the individual's disability, or pre-existing health condition.

While we appreciate these changes, several important issues remain in the latest draft, requiring further revision. For ease of review, we have attached a redlined version of the CSC containing these additional changes.

Foremost among these revisions is the recommendation that initial triage criteria focus on patients' short term survivability with treatment, and that predictions regarding prognosis only be considered as an additional factor within the revised tiebreaker provisions. OCR's position on the potential discriminatory impact of life expectancy predictions has evolved in recent months. In the most recent OCR resolution involving Utah's CSC, it only accepted imminent or short term mortality risk as the triage standard. While clearly better than 5 year prognosis, studies regarding the reliability and accuracy of one year life expectancy predictions are still questionable, with some showing significant over prediction of the likelihood of death within one year. Assessments of one year prognosis also remain vulnerable to implicit bias. These concerns have been further validated through our consultations with emergency room physicians, ethicists and other medical professionals focused on health equity.

In the event any prognostication occurs in the initial triage process, it should be limited to tiebreaker situations, and then only pursuant to clear safeguards to ensure decisions are fully informed, reliable, and insulated from unconscious bias. In these limited situations, prognosis should then focus only on whether there is clear evidence that the individual would not survive beyond 6 months – the same predictive standard commonly applied by physicians in the context of hospice referrals. Physicians should be directed to refrain for adding additional points whenever there is insufficient evidence in the existing medical record to make such a determination to a high degree of medical certainty.

We also urge the State to create a virtual panel of medical experts who can be called upon to inform triage team decisions for special populations, including older adults, people with disabilities, and communities of color. This resource is necessary in order to ensure equal access to expert clinical judgment and consultation across all Massachusetts hospitals, be they large or small, urban or rural.

In addition, we want to underline the importance of prohibiting age discrimination in the implementation of crisis standards. Relying solely on age as a criterion for prioritizing patients is inconsistent with the anti-discrimination framework articulated within the CSC, and its reliance on individualized medical evidence, rather than assumptions about a condition or protected group. OCR has made clear that the Age Discrimination Act and Section 1557 of the ACA are applicable to crisis standards, and that older persons should not be deprioritized for health care based on stereotypes or other impermissible factors. Age should only be considered as one of many factors that may impact an individualized assessment of survivability. For this reason, and to avoid any violation of the Age Discrimination Act, we request that the CSC make this anti-discrimination principle clear in both its introduction, and within the relevant sections of the

triage protocol. Any consideration of age must be limited to individualized medical assessments, as recommended in the attached redline document.

Finally, there are additional revisions needed to ensure diversity and health equity. Among them is the removal of language which makes diversity within triage teams and oversight committees optional or aspirational, and an alternative triage team nomination process designed to better achieve this outcome. We also recommend removing provisions on the "blinding" of patient demographic information. The concept of "blindness" to characteristics that place an individual into a disadvantaged group has led to the continuation of profound health disparities and may be viewed as license to ignore rather than work to identify and eliminate these inequalities.[1]

In sum, we continue to believe that the 1 year prognosis standard is likely to penalize many individuals who may well survive beyond that time with access to treatment. Research demonstrates that errors in these determinations tend to under-estimated survivability, and they are susceptible to bias. As OCR has endorsed in other jurisdictions, short-term survivability of the acute illness (i.e. to discharge) is the most accurate and least discriminatory approach to prioritization. If the CSC include any future prognosis beyond immediate survivability, it should only be used in tiebreaker situations and then only for 6 months, a standard that physicians are accustomed to applying when making decisions about referral to hospice care.

Thank you for this opportunity to provide input into the revision process, and for the Commonwealth's decision to allow for public comment on the proposed revisions. Our coalition is available to answer any additional questions related to this letter or the attached redline changes.

Sincerely,

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[1] *See* Policy Solutions for Reversing the Color-blind Public Health Response to COVID-19 in the US, Marisa K.Dowling, MD, MPP, JAMA July 21, 2020 Volume 324, Number 3; see also Preliminary Framework for Equitable Allocation of COVID 19 Vaccine, the National Academies of Science, Engineering, and Medicine, page 39 (demograph info appropriate to ensure equity) https://www.nap.edu/catalog/25914/discussion-draft-of-the-preliminary-framework-for-equitable-allocation-of-covid-19-vaccine

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