Navigating Legalities in Crisis Standards of Care

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NAVIGATING LEGALITIES IN CRISIS STANDARDS OF CARE*

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As originally conceptualized by the Institute of Medicine in 2009, crisis standards of care (CSC) refers to significant changes in the delivery of health services during sustained public health emergencies (PHEs). Implementation of CSC among hospitals and health care providers arises when extended patient surges combined with scarce or limited resources overwhelm health systems and derail normal operations. Absent well-timed, organized, and critical interventions, excess patient morbidity and mortality may follow. Preventing the onset of CSC through advance planning and real-time effort is key. When CSC is justifiably invoked, saving lives and reducing morbidity through effective interventions are the end goals. Multiple national and regional PHEs shaped CSC in concept and practice over the decade since its inception. Yet, unprecedented public health impacts and resource scarcities during the COVID-19 pandemic necessitated repeated shifts to CSC in hospitals, localities, or entire states in a dynamic and unpredictable emergency legal environment. Profound law and policy repercussions emerged, centering on: (1) confusion over affirmative legal triggers for CSC invocation; (2) gaps and gaffes in regional coordination within and across jurisdictions; (3) discriminatory impacts of CSC allocation decisions based on race, disability, age, or other unwarranted factors; and (4) divergent criteria to resolve tie-breaking decisions over which patients should receive limited resources (e.g., ventilators, beds, and staff). Future solutions to these challenges are vital to assuring efficacious and equitable implementation of CSC whenever lives are on the line.

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INTRODUCTION

In the midst of the H1N1 pandemic in 2009, a Committee of the Institute of Medicine (IOM Committee) defined crisis standards of care (CSC) as a “substantial change in usual healthcare operations and the level of care... resulting from a pervasive or catastrophic disaster.” Abandoning prior, long-standing terminology focused on “altered standards of care,” the IOM Committee’s definition of CSC centered on making critical choices concerning the allocation of health services, supplies, treatments, or personnel in dire circumstances.3

CSC is not about how to respond to an uptick of patients on a busy night at the local hospital emergency room. Transitions from conventional to contingency standards of care are routine in U.S. hospitals and other major health care providers.4 CSC arises when more substantial changes in health care delivery are warranted over longer periods of time.5 It entails the shifts needed when extended patient surges coupled with scarce or limited resources in public health emergencies (PHEs) overwhelm health systems and make normal operations infeasible.6 IOM (now enveloped in the National Academies of Sciences, Engineering, and Medicine (NASEM)) observed that, absent critical interventions defying routine medical standards during PHEs, excess patient morbidity and mortality may result.7

As explored in Part I, two primary bases conceptually underlie CSC.8 First, prevention is vital—advance planning and preparedness can limit situations

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1. INST. OF MED. COMM. ON GUIDANCE FOR ESTABLISHING STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS, GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT 18 (Bruce M. Altevogt et al. eds., 2009) [hereinafter IOM, CSC LETTER REP.].
4. See John L. Hick et al., Refining Surge Capacity: Conventional, Contingency, and Crisis Capacity, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS s59, s60 (2009) (defining “conventional capacity” as “consistent with daily practices within the institution” and “contingency capacity” as “not consistent with daily practices but maintain[ing] or hav[ing] minimal impact on usual patient care practices”; see also James G. Hodge, Jr. & Brooke Courtney, Assessing the Legal Standard of Care in Public Health Emergencies, 303 J. AM. MED. ASS’N 361, 361–62 (2010) (proposing that a physician’s legal standard of care in a crisis situation “should be based on how a practitioner acts consistent with the need to protect community health in accordance with established national and state crisis standards of care plans or real-time emergency practices”).
5. See IOM, CSC LETTER REP., supra note 1, at 18 (explaining that CSC is “necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster” and is formally declared by “state government, in recognition that crisis operations will be in effect for a sustained period”).
6. Id. at 52–53.
7. Id. at 63–64.
8. See infra Part I.
requiring shifts to crisis modes. Second, saving lives is the end goal—when circumstances merit CSC implementation, allocating scarce health care resources focuses on preventing excess morbidity and maximizing lives saved. Determining when shifts to CSC are truly warranted is key. Although the genesis for conceiving CSC, the H1N1 pandemic proved to be little more than a glancing blow epidemiologically. Over the ensuing decade, other domestic public health crises (including Ebola viral disease, Zika virus, and illicit opioid use) led NASEM to revisit and reassess the concept and implementation of CSC.

Still, nothing could adequately prepare national public health and health care systems for the pervasive CSC-related challenges that arose during the COVID-19 pandemic, as examined in Part II. Unprecedented public health impacts from the worst infectious disease threat in modern history wreaked havoc on health systems and exposed major health disparities across subpopulations nationally. In the U.S. alone, COVID-19-related deaths exceeded 830,000 in less than two years. Massive patient surges coupled with insufficient onsite personnel, beds, treatments, or supplies necessitated repeated shifts to

9. See IOM, CSC LETTER REP., supra note 1, at 13–14 (explaining that health care facilities must create “surge plans that include efforts to increase and maximize use of available resources, as well as to manage demand for healthcare services”).
10. See id. at 30 (explaining the “duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives”).
11. See James G. Hodge, Jr., Global Legal Triage in Response to the 2009 H1N1 Outbreak, 11 MINN. J.L. SCI. & TECH. 599, 599–600 (2010) (noting that although the H1N1 pandemic was not as large a threat as predicted, it was the first time that the World Health Organization (WHO) declared a PHE internationally).
12. See Lawrence O. Gostin et al., Is the United States Prepared for Ebola?, 312 JAMA 2497, 2497 (2014) (explaining that “the handling of the first domestically diagnosed Ebola case in Dallas, Texas, raised concerns about national public health preparedness”).
13. See Michael A. Johansson et al., Zika and the Risk of Microcephaly, 375 NEW ENG. J. MED. 1, 2–3 (2016) (“Recent studies have revealed associations between symptomatic ZIKV infection during all trimesters and adverse pregnancy outcomes and potential peak risk during gestational weeks 14 to 17.”).
14. See Lawrence O. Gostin et al., Reframing the Opioid Epidemic as a National Emergency, 318 JAMA 1539, 1539–40 (2017) (arguing that states and the federal government have used limited emergency declarations to combat health crises such as the Zika virus and opioid epidemic).
17. See infra Part II.
18. See infra Part II.A.
CSC in specific hospitals, localities, or entire states (e.g., Alaska, Arizona, Idaho, Maryland, New Hampshire, New Mexico). Many health care personnel and hospitals experienced full-scale implementation of CSC for the first time while facing a dynamic and sometimes unpredictable legal environment that obfuscated decision-making.

Profound legal repercussions arose from efforts to avoid or effectuate CSC in real time. As assessed in Part III, despite a decade of advance planning, some state health officials and hospital executives were loath to implement CSC—or even admit it was needed—absent a definitive trigger for its invocation. Failure to uniformly execute CSC exacerbated poor health outcomes among subpopulations, especially in states where political leaders acted contrary to public health powers and science under principles of “COVID denialism.” Even when CSC was clearly authorized, a lack of intra-jurisdictional coordination as well as inter-jurisdictional boundary disputes across state lines impinged efforts to allocate scarce resources for the benefit of patient populations.

Resource allocations based on divergent criteria or varying prognostic scores across states contributed to widespread, disparate impacts on the basis of race, age, disability, and socioeconomic status. Decision-makers likely did not intentionally discriminate against subgroups when distributing resources. Yet, the disparate results of such decisions cannot be ignored. Persons of color, certain ethnic groups, and those of advanced age or with specific disabilities all experienced higher levels of mortality during the COVID-19 pandemic.

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23. See James G. Hodge, Jr. & Jennifer L. Piatt, Legal Decision-making and Crisis Standards of Care, JAMA HEALTH F., Jan. 21, 2022, at 2 [hereinafter Hodge, Jr. & Piatt, Legal Decision-making] (noting reticence among specific hospitals to implement CSC); Hick et al., supra note 16, at 3 (describing varied circumstances and reasons why jurisdictions varied on their authorization of CSC or invocations of their plans); see also Anuj B. Mehta & Matthew K. Wynia, Crisis Standards of Care—More Than Just a Thought Experiment, HASTINGS CTY. REP. 53, 53 (2021) (arguing that activation of CSC plans “remains a political decision”).

24. See James G. Hodge, Jr. et al., Legal Interventions to Counter COVID-19 Denialism, 49 J.L., MED. & ETHICS 675, 677 (2021) [hereinafter Hodge, Jr., Legal Interventions] (explaining that, during the pandemic, states “dismissed emergency declarations, banned mask requirements, prohibited vaccine mandates or passports, limited social distancing, and [forbade] school or business closures”).

25. See infra Part III.B.


27. See infra Part II.A, Figure 3.
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Underlying reasons for these disparities were numerous, including CSC implementation. To address certain emerging disparate outcomes, federal and state health authorities mandated mid-pandemic legal adjustments to public or private sector CSC plans and approaches. These new approaches, while necessary, further obfuscated CSC execution.

Allocating scarce resources proved exceedingly difficult and controversial in “tie-breaking” scenarios, where multiple COVID-19 patients simultaneously needed access to intensive care unit (ICU) beds, ventilators, or health care personnel, all of which were in short supply. Rapid, consistent decisions based on solid legal and ethical guidance were called for. In reality, such guidance was confusing or missing entirely. Tie-breaking criteria set forth in state-based CSC plans varied extensively. Lacking definitive legal and ethical guidance, some clinicians resorted to ad hoc or ill-advised decision-making—the antithesis of CSC.

Our proposed solutions to the primary legal challenges underlying CSC—(1) triggers for invocation; (2) regional coordination; (3) discriminatory impacts; and (4) tie-breaking decisions—are designed to guide current and future exercises of CSC in furtherance of the ultimate public health goal: saving lives.

I. CSC in Concept and Practice

As the spread of novel H1N1 influenza threatened the nation in the late summer months of 2009, fifteen members of the IOM Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations gathered in Washington, D.C. over four days. Led by co-chairs Lawrence O. Gostin, J.D., and Dan Hanfling, M.D., the Committee was tasked by the Assistant Secretary

28. Emily Cleveland Manchanda et al., Inequity in Crisis Standards of Care, 383 NEW ENG. J. MED. 1, 1–2 (2020) [hereinafter Manchanda et al., Inequity in Crisis Standards of Care].
30. See infra Part III.C.
32. Id.
33. See infra Part III.D.
34. See infra Part III.D, Figure 6.
35. See Hick et al., supra note 16, at 8 (suggesting that during the pandemic many clinicians “felt forced to make ad hoc decisions at the bedside,” including “implicit or covert triage decisions being made by clinicians who believed that the resource situation was worse than it was, and/or determined on their own accord that a patient should not be offered certain interventions”); Mehta & Wynia, supra note 23, at 54 (lacking CSC activation, “soul-crushing decisions were left to bedside medical teams, potentially poisoning the therapeutic bond between patients and clinicians and contributing to psychological and moral distress”).
36. IOM, CSC LETTER REP., supra note 1, at 16.
for Preparedness and Response (ASPR) with “developing guidance to establish standards of care that should apply to disaster situations . . . under conditions in which resources are scarce.”37 What the IOM Committee generated in its draft Letter Report later that month,38 and subsequently revised over the following decade, would have enormous impacts in the greatest public health challenge the nation would ever experience.

A. Conception

The IOM Committee’s conception of CSC in 2009 began with a newly formalized definition.39 After receiving extensive input through an initial public workshop, Committee members looked beyond previous conceptions of “altered standards of care.”40 They sought medical and public health clarity amid chaos when extensive patient surges coupled with dwindling resources necessitated sustained shifts in standards of care. CSC was defined and framed as:

“[A] substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that [CSC is] in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.”41

Basic conceptual parameters of CSC emerged from this definition. It is not about shifts from conventional to contingency care on a hectic day at the hospital emergency room or clinic. Hospitals and other health care providers frequently experienced limited patient surges and knew how to handle them.42 To the contrary, CSC involves (1) “substantial changes” in routine “healthcare operations” and “level of care” (2) due to “pervasive” or “catastrophic” disasters.43 Shifts to CSC are purposeful, not happenstance. They are (3) justified by “specific circumstances” through “formal declarations” by state

37. Id. at 10.
39. IOM, CSC LETTER REP., supra note 1, at 3.
40. See AGENCY FOR HEALTHCARE RSCH. & POL’Y, supra note 2, at 2 (finding that many health systems lacked proper planning and guidance necessary to implement “altered standards of care” in the event of mass casualty).
41. IOM, CSC LETTER REP., supra note 1, at 3.
42. See id. at 14–15 (explaining the differences between “conventional,” “contingency,” and “crisis care”).
43. Id. at 18.
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Governments. Such declarations can be pivotal to (4) enable legal “powers and protections” essential to (5) “allocating and using scarce medical resources” and (6) “implementing alternate care facility operations.” In sum CSC entails the organized shift to a different standard of care during emergencies, facilitating specific interventions for patients to protect the public’s health.

How to operationalize CSC based on these definitional criteria in major disasters or PHEs dominated the IOM Committee’s deliberations. Members outlined and crafted a series of recommendations to enable identification, uptake, and implementation of CSC across public and private sectors. As per Figure 1, the Committee developed a systems approach to CSC built on foundational ethical and legal principles.

Equity was essential. CSC had to be fair, evidence-based, procedurally-sound, transparent, and grounded in assuring patient care. Implementing CSC should not focus on denying or diminishing patient care or ignoring health care workers’ (HCWs) ethical responsibilities to provide the highest level of medical care.

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44. Id. at 17–18.
45. Id. at 18.
46. Id.
47. Id. at 18–20.
48. Id. at 18–20, 24–26.
49. INST. OF MED. OF NAT’L ACADS., CRISIS STANDARDS OF CARE: A TOOLKIT FOR INDICATORS & TRIGGERS 18, fig. 1–2 (Dan Hanfling et al. eds., 2013).
50. Id.
51. IOM, CSC LETTER REP., supra note 1, at 6.
care and services. Rather, during crises, scarce resources should be used “to sustain life and well-being to the greatest extent possible.” Meeting this objective requires responsivity to community needs and trust through active engagement and avoidance of discrimination, especially concerning populations that have historically been marginalized, persons with special medical needs or disabilities, and children.

Additional guidance and facets essential to effective CSC implementation were articulated. While state or tribal public health agencies were tapped to lead CSC development within each jurisdiction, contributions from other governmental agencies were also anticipated. As illustrated by the architectural columns depicted in Figure 1, diverse health care providers had roles to play in planning for and effectuating CSC, including “emergency medical services and dispatch, public health, hospital-based care, home care, primary care, palliative care, [and] mental health.” This purposeful “all hands on deck” approach to CSC was intended to help assure consistency in resource allocations and decision-making within and across states.

Proper execution of CSC should avoid ad hoc decision-making over allocations of limited, life-sustaining resources to the degree that such choices contribute to excess mortality. Use of advisory committees, triage teams, or other entities capable of vetting evidence-based critical care options and tools were suggested to improve consistency in making tough choices. Assuring situational awareness capacities to wield and share real-time data was a core obligation of state or tribal CSC planners tasked with generating plans based on the IOM Committee’s deliberations. To date, roughly 30 states have crafted their own CSC plans, many with the support of federal hospital preparedness funds.

52. Id.
54. IOM, CSC LETTER REP., supra note 1, at 42.
55. Id.
56. Id. at 4.
57. See U.S. GOV’T ACCOUNTABILITY OFF., GAO-08668, EMERGENCY PREPAREDNESS: STATES ARE PLANNING FOR MEDICAL SURGE, BUT COULD BENEFIT FROM SHARED GUIDANCE FOR ALLOCATING SCARCE MEDICAL RESOURCES 6 (2008) (recommending that the federal government “serve as a clearinghouse for sharing [. . .] altered standards of care guidelines that have been developed by individual states or medical experts” to increase consistency and uniform guidance).
58. IOM, CSC LETTER REP., supra note 1, at 60.
59. Id. at 24–25.
60. Id. at 60–61.
61. There is some disagreement as to exactly how many states have formally developed and posted CSC plans. For example, Kaiser Health News reported that, as of March 2020, 36 states have CSC plans. Markian Hawryluk, During a Pandemic, States’ Patchwork of Crisis Strategies Could Mean Uneven Care, KAISER HEALTH NEWS (Mar. 5, 2020), https://khn.org/news/during-a-pandemic-states-patchwork-of-crisis-plans-could-mean-uneven-care/. However, other sources published in similar time frames indicated
B. Legal Assessment

In addition to emphasizing various ethical and organizational factors, the IOM Committee also highlighted pivotal legal considerations undergirding the successful invocation and implementation of CSC.\textsuperscript{62} As per Figure 1, “legal authority and environment” constituted cornerstones of CSC.\textsuperscript{63} Laws were deemed essential in clarifying “prevailing standards of care” and incentivizing actors to “protect the public’s health and respect individual rights.”\textsuperscript{64} Through its deliberations and recommendations, the IOM Committee outlined an expansive slate of legal issues for assessment by state or tribal CSC planning committees, selectively encapsulated in Table 1.

\textit{Table 1. Select Legal Issues Regarding CSC Implementation}\textsuperscript{65}

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>LEGAL ISSUES</th>
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| Organization of Personnel | • How are employees, independent contractors, and volunteers legally distinguished for the purpose of coordinating services and benefits?  
• Do existing labor contracts or union requirements affect the ability of the entity and its personnel to respond to an emergency?  
• Have appropriate contractual or other mechanisms been executed to facilitate the delivery of services by employed or volunteer personnel, ensure worker safety, or make available workers’ compensation or other benefits? |

\textsuperscript{62} IOM, CSC LETTER REP., supra note 1, at 44.  
\textsuperscript{63} See supra Figure 1 (depicting the other cornerstone of CSC as “ethical considerations”).  
\textsuperscript{64} IOM, CSC LETTER REP., supra note 1, at 6.  
\textsuperscript{65} Hodge, Jr. et al., supra note 3, at 53, tbl. 1.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>LEGAL ISSUES</th>
</tr>
</thead>
</table>
| Access to Treatment     | • Has the entity assessed its strategy for conducting medical triage under legal requirements for treating existing and forthcoming patients?  
                          • Is the entity prepared to screen and potentially divert excess numbers of patients during an emergency consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), absent its waiver?  
                          • Do healthcare personnel who are designated to treat existing and forthcoming patients pose any risks to patients? |
| Coordination of Health Services | • Are healthcare personnel aware of the legal effects of a shift to CSC and changes relating to scopes of practice during a declared emergency?  
                          • What is FDA’s authority to issue emergency use authorizations, including accompanying mandatory information for patients and providers?  
                          • Are adequate mechanisms in place to ensure compliance with surveillance, reporting, testing, screening, partner notification, quarantine, isolation, or other public health mandates? |
| Patients’ Interests      | • Can patients with physical or mental disabilities be accommodated during the emergency consistent with disability protection laws?  
                          • Are there appropriate measures to ascertain patients’ informed consent?  
                          • Barring waiver, are the entity and its personnel prepared to respect patients’ health information privacy rights? |
| Allocation of Resources  | • Is the process for allocating scarce resources fair, reasonable, nondiscriminatory, and credibly based on protecting the public’s health?  
                          • Are federal, state, or local policies regarding resource allocation followed?  
                          • Can governments appropriate existing resources (with just compensation) for communal purposes during an emergency? |
The capacity of CSC implementers to properly assess and wield law depends substantially on the extant legal environment during crises. The IOM Committee expressly tied CSC invocation and implementation in part to formal declarations of emergency at the federal, state, tribal, or local levels.\(^{66}\) This was designed to assure available legal options needed to effectuate shifts to CSC. As seen during the 9/11 terrorist attacks in 2001 and Hurricane Katrina in 2005, governmental declarations of states of emergency, disaster, or PHE authorize a plethora of options supporting CSC execution, including: (1) expedited powers to acquire and allocate scarce resources; (2) waivers of existing laws impeding public health or healthcare efforts; (3) emergency executive orders allowing licensure reciprocity of HCWs across states; (4) expansions of HCWs’ scope of practice to increase their utilities during emergencies; and (5) liability protections to insulate specific actors or entities against patient claims alleging ordinary acts

\(^{66}\) Id. at 52.
of negligence. These emergency powers, however, are not instantaneous, assured, or uniform. Within the U.S. federalist legal infrastructure, there is no single, national means to authorize all of the core powers needed to operationalize CSC. Their invocation relies on the specific type of emergency declared (e.g., “emergency,” “disaster,” “PHE”) in each jurisdiction as well as real-time “legal triage” efforts to identify and overcome perceived or actual barriers.

Thus, CSC planners must carefully consider varied approaches to shifting standards of care in jurisdictions that formally declare emergencies as well as those that do not. The IOM Committee observed the potential for legal conflicts to arise across jurisdictions through efforts to balance individual and communal interests in emergencies. Among the clearest illustrations of legal variances relates to liability risks and protections for health care providers. The risks of liability during catastrophic events rightly concern HCWs and entities. To the extent CSC may involve temporary set-asides of routine standards of care due to scarcity, clinicians may have to resort to providing patient care that does not resemble normal, efficacious interventions. Negative patient outcomes otherwise preventable in non-emergencies may result.

From patients’ perspectives, adverse health consequences may appear to fall below the standard of care, lending to claims of medical malpractice. High-profile cases involving health care practitioners and hospitals after Hurricane Katrina in 2005 and the Ebola outbreak in 2015 exacerbated liability concerns among many HCWs and hospitals. Two divergent law and policy approaches attempt to address these concerns over potential or actual liability during CSC by:

1. relying on shifts to CSC to ward off potential claims since actions deemed injurious to patients would be assessed under a different

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67. Id.
68. JAMES G. HODGE, JR., PUBLIC HEALTH IN A NUTSHELL 368 (4th ed. 2022) [hereinafter HODGE, JR., NUTSHELL].
70. IOM, CSC LETTER REP., supra note 1, at 6.
standard of care. So long as health care falls within the prevailing CSC, medical liability should not follow, or

(2) providing explicit statutory or regulatory protections for negligence claims against clinicians or entities involved in administering CSC.

Reliance on the “status quo” for assessing medical malpractice liability during crises under the first approach is premised on (a) scant evidence of extensive claims following emergencies (thus disclaiming the need for broad, sweeping protections proposed in the second approach), and (b) alterations in the standard of care as sufficient to obviate any claims that do arise. As the IOM Committee observed, these premises are debatable. Numbers of liability claims arising from major emergencies are largely indeterminate. What is much better known is how HCWs’ perceptions of significant threats of liability may militate against their overall willingness to respond in emergencies. Just because the medical standard of care may change in emergencies does not mean the legal standard aligns later. Assessing breaches of the standard of care in subsequent judicial settings is factually precarious.

Consequently, federal and state governments have implemented an array of liability protections via statutes, regulations, executive orders, or agreements immunizing health care clinicians, volunteers, and even entities from negligence claims resulting from actions undertaken during declared emergencies. Under a collective umbrella of liability protections, illustrated in Figure 2, healthcare providers are partly relieved of the specter of negligence or unfounded liability claims extending from their implementation of CSC.

75. See, e.g., Hall v. Hilbun, 466 So.2d 856, 866 (Miss. 1985) (“Medical malpractice . . . arises from the failure of a physician to provide the quality of care required by law. When a physician undertakes to treat a patient, he takes on an obligation enforceable at law to use minimally sound medical judgment and render minimally competent care in the course of the services he provides. A physician does not guarantee recovery. If a patient sustains injury because of the physician’s failure to perform the duty he has assumed under our law, the physician may be liable in damages.”), superseded by statute, MISS. CODE ANN. § 85-5-7 (West 1989), as recognized in Narkeeta Timber Co. Inc. v. Jenkins, 777 So.2d 39, 42 (2000).

76. HODGE, JR., NUTSHELL, supra note 68, at 392–402.

77. George J. Annas, Standard of Care – In Sickness and in Health and in Emergencies, 362 NEW ENG. J. MED. 2126, 2130 (2010).

78. IOM, CSC LETTER REP., supra note 1, at 45.

79. Hodge, Jr. & Courtney, supra note 4, at 361–62.

Advocates of the first approach are concerned that patients adversely affected via negligence lack recourse under the second approach. However, patients or their families may be entitled to emergency compensation funds or other remedies, including claims alleging willful, wanton, or criminal acts.\footnote{Id.} Virtually no legal immunities protect health care providers against such claims. In addition, not all providers are covered in every circumstance. For-profit health care entities and employees may not enjoy the same level of protection from liability as volunteer agencies or health personnel.\footnote{82. U.S. DEP’T HEALTH & HUM. SERVS., EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS, https://www.phe.gov/esarvhp/Pages/faq.aspx#Safety (last visited Feb. 12, 2022).} Finally, many of these protections endure only through the limited timeline of declared emergencies. Once an emergency is revoked via executive officials, legislators, or judges, many liability protections tied to the declaration fall away.

\section*{C. Legal Evolutions}

From the onset, legal issues underlying CSC in practice were seen by the IOM Committee as dynamic, not static. Evolutions were inevitable as CSC plans emerged from state and tribal governments offering their own ideas, concepts, criteria, and implementation. Table 2 illustrates diverse approaches among select jurisdictions’ plans in defining CSC. While these definitions of CSC resonate themes originally espoused by the IOM Committee, they also reveal differing approaches, justifications, and triggers.
**Table 2. Select Definitions of CSC in State Plans**

<table>
<thead>
<tr>
<th>STATE</th>
<th>CSC DEFINITION</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>“[A] substantial change in usual healthcare operations and the level of care possible to deliver due to severe shortages of critical resources causing the delivery system to be overwhelmed. It is a medico-legal term meaning the prudence and caution required of an individual or organization which is operating with a duty of care to people under the care of the individual or organization.”(^{83})</td>
</tr>
<tr>
<td>California</td>
<td>“Disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances.”(^{84})</td>
</tr>
<tr>
<td>Colorado</td>
<td>“[T]he demand for care surpasses resource supply despite contingency care strategies. Normal quality standards of care cannot be maintained.”(^{85})</td>
</tr>
<tr>
<td>Kansas</td>
<td>“[P]rinciples and practices that health care providers, acute care hospitals, and communities . . . can utilize . . . in the event that resources become scarce during a disaster or [PHE]” invoked “only after a declaration of emergency and only after other specified means of procuring additional resources and expanding surge capacity have been exhausted.”(^{86})</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>“Adaptive uses of space, staff, and supplies that are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).”(^{87})</td>
</tr>
<tr>
<td>Minnesota</td>
<td>“[W]hen scarcity of resources relative to demand becomes acute and it is no longer possible to provide care that is functionally equivalent to conventional care” such that the “response must focus on the overall benefit to the population, to try to minimize morbidity and mortality, while also...”(^{88})</td>
</tr>
</tbody>
</table>

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85. COLO. DEP’T OF PUB. HEALTH & ENV’T., CDPHE ALL HAZARDS INTERNAL EMERGENCY RESPONSE & RECOVERY PLAN 1, 19 (2021), https://drive.google.com/file/d/1pH6RF2W4h0vTe6bb5uBUZeTspUzhNhQ/view.


When NASEM convened a tenth anniversary workshop on November 21–22, 2019,92 participants (including multiple original members of the IOM Committee) raised prominent concerns over the utility of CSC. Two compelling law and policy issues focused on (1) indeterminate legal triggers justifying shifts to CSC; and (2) evidence underlying core medical and public health choices made during PHEs.93

As explored during the workshop, diverse health care crises are defined by their context, duration, and impacts. What constitutes a crisis can differ

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93. Id. at 43–44.
considerably between large metropolitan or smaller regional hospitals.\textsuperscript{94} Formally shifting to CSC is problematic, however, when definitive legal triggers (e.g., emergency declarations) are either unavailable, tenuous, or inconsistent.\textsuperscript{95} Dissimilarities related to the use, timing, scope, and breadth of emergency declarations and authorities across jurisdictions raise additional complications.\textsuperscript{96} In jurisdictions that engaged in advanced CSC planning and training, legal options to effectuate CSC may be relatively clear. Elsewhere, CSC implementation may be averted absent a clear trigger.

Even when CSC is legally authorized, substantiating the bases for allocations of medical or public health services is perilous. Although advance efforts to avoid the need for real-time resource allocations should be undertaken, CSC invocations may be inevitable in specific cases or environments. Resulting tough choices regarding population- and patient-based care must be made. Decisions like when to allocate or withdraw essential health care services are ethically thorny but legally substantiated by a need to allocate limited resources to improve health outcomes across affected populations.

What if the bases for implementing CSC decisions were contemporaneously or later proven to lack medical support in actually reducing morbidity or saving lives? In essence, what if triage committees or clinicians essentially get it wrong in allocating limited resources? Making “right” decisions during CSC is difficult when peoples’ lives are directly at stake. In 2009, the IOM Committee acknowledged these risks, highlighting how CSC fluctuates depending on existing conditions.\textsuperscript{97} Implementing CSC entails making defensible decisions to advance patient interests and protecting communal health based on the best available medical and public health evidence.\textsuperscript{98} If responses to crises follow sufficient processes and are guided by reliable medical or public health findings, they may be legally sustained despite negative impacts for select patients or subpopulations.

What if the entire foundation for making these critical choices in crisis lacks efficacy? Acknowledging a lack of strong, empirical evidence underlying CSC protocols or implementation, NASEM workshop participants called for more

\textsuperscript{94} Hodge, Jr., supra note 15, at 222 (“For large health systems or entities in metropolitan areas, a crisis might arise from a MCE like an explosive detonation (e.g., Boston Marathon bombing 2013) or active shooter tragedy (e.g., Las Vegas concert (2018)). Dozens, hundreds, or thousands of persons may be immediately imperiled by such acts, testing the surge capacity of even well-staffed and equipped hospitals . . . In smaller jurisdictions, HCWs may perceive a crisis following a surge of patients from a vehicular collision on a nearby highway.”).


\textsuperscript{96} HODGE, JR., NUTSHELL, supra note 68, at 390–92.

\textsuperscript{97} IOM, CSC LETTER REP., supra note 1, at 15.

\textsuperscript{98} Id.
Yet the premise was also raised whether to abandon CSC absent proof of effectiveness. This was a contentious point in late 2019. Without CSC planning and execution during PHEs, allocation decisions may be based on little more than ad hoc judgments, random selections, or physician favoritism. None of these factors should guide distributions of routine medical care, much less care in crises. Determining how to make allocation decisions without complete data or proof of medical efficacy would soon dominate the nation against the backdrop of the most significant infectious disease threat the modern world had ever experienced.

II. CSC ON TRIAL: COVID-19

Debates over the underlying evidence and efficacy of CSC came to the forefront as COVID-19, the deadliest disease in U.S. history, enveloped the country in early 2020. Despite a decade of disaster planning and preparedness, repeated patient surges over months during the COVID-19 pandemic tested CSC efforts among health care providers. Hospitals struggled to garner essential resources to handle millions of COVID-19 patients, not all of whom could receive maximum levels of care. Repeated shifts to CSC arose. Extensive emergency powers authorized during the pandemic facilitated these efforts (as the IOM Committee predicted in 2009), but not without generating conflicts amid fluctuating legal and political environments.

A. Unprecedented Public Health Impacts

The COVID-19 pandemic devastated U.S. public health and health care systems. What started as a mysterious illness quickly emerged as a disastrous virus with health effects for millions that included flu-like...
symptoms, loss of taste or smell,\textsuperscript{107} lethargy, “brain fog,” lung damage, and respiratory failure.\textsuperscript{108}

As of January 5, 2022, the spread of COVID-19 led to over 57.1 million confirmed cases\textsuperscript{109} and killed over 830,000 persons in the U.S.\textsuperscript{110} Unconfirmed infections and deaths are likely far higher.\textsuperscript{111} Survivors occasionally suffered long-term effects such as chronic fatigue, organ damage, heart complications, and clotting diseases.\textsuperscript{112} While the impacts of COVID-19 disproportionately affected older individuals,\textsuperscript{113} deaths occurred in all age groups.\textsuperscript{114} Over 5,900 U.S. children contracted multisystem inflammatory syndrome, a life-threatening illness tied to COVID-19 infections;\textsuperscript{115} hundreds died.\textsuperscript{116} Despite the

\begin{itemize}
\item \textsuperscript{108} Panagis Galiatsatos, COVID-19 Lung Damage, JOHNS HOPKINS MED. (Apr. 12, 2021), https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/what-coronavirus-does-to-the-lungs (“COVID-19 can cause lung complications such as pneumonia and, in the most severe cases, acute respiratory distress syndrome, or ARDS.”).
\item \textsuperscript{109} COVID-19 Dashboard, supra note 19.
\item \textsuperscript{110} Id.
\item \textsuperscript{111} Mary Van Beusekom, Study: US COVID Cases, Deaths Far Higher Than Reported, UNIV. OF MINN. CTR. FOR INFECTIOUS DISEASE RSCH. & POL’Y (Jan. 5, 2021), https://www.cidrap.umn.edu/news-perspective/2021/01/study-us-covid-cases-deaths-far-higher-reported (“An estimated 14.3% of the US population had antibodies against COVID-19 by mid-November 2020, suggesting that the virus has infected vastly more people than reported . . . .”); A study of COVID-19 cases through November 15, 2020, estimated that nearly 35% of COVID-19 deaths were unreported. Id. Furthermore, antibody analysis of blood samples collected between March and May 2020 suggested that COVID-19 infection case numbers were likely 6–24 times higher than reported case numbers. Fiona P. Havers et al., Seroprevalence of Antibodies to SARS-CoV-2 in Six Sites in the United States, March 23-May 3, 2020, 180 JAMA 1576, 1579 (2020).
\item \textsuperscript{113} As of December 29, 2021, almost 75% of all COVID-19 deaths occurred in the 65-and-over age group. COVID-19 Mortality Overview: Death by Age Group, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/covid19/mortality-overview.htm (last visited Jan. 5, 2022).
\item \textsuperscript{114} See COVID 19 Death Data and Resources: Weekly Updates by Select Demographic and Geographic Characteristics: Sex and Age, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsr/covid_weekly/index.htm (last visited Jan. 5, 2022) (reflecting number of deaths occurring in all age groups, from ages 0-17 to 85 and older).
\end{itemize}
development and extensive distribution of safe, free, and efficacious COVID-19 vaccines starting in December 2020,\textsuperscript{117} millions of unvaccinated individuals continued to be at significant risk into 2022.\textsuperscript{118} Viral mutations lent to increasing frequency of breakthrough infections among vaccinated individuals, particularly those experiencing waning vaccine immunity.\textsuperscript{119}

COVID-19 was the third leading cause of death in the U.S. in 2020, just behind annual causes like heart disease and cancer for which mortality may follow only after years of symptoms and treatments.\textsuperscript{120} In contrast, COVID-19 can kill victims rapidly, often within two to eight weeks of symptom onset.\textsuperscript{121} The highest number of deaths ever recorded in the U.S. occurred in 2020,\textsuperscript{122} reflecting profound health inequities in certain communities. As illustrated in Table 3, COVID-19-related hospitalizations and death rates among Black, Latino, and Indigenous populations were more than double the rates found in White populations (as of March 2021).\textsuperscript{123}

\begin{quote}
(“Since the start of the coronavirus pandemic, tens of thousands of children have been hospitalized with Covid, and 657 have died, according to data collected by the C.D.C.”).
\end{quote}


\textsuperscript{121} WORLD HEALTH ORG., REPORT OF THE WHO–CHINA JOINT MISSION ON CORONAVIRUS DISEASE 2019 (COVID-19) 14 (2020).

Table 3. U.S. Risks of COVID-19 By Race/Ethnicity124

<table>
<thead>
<tr>
<th>Rate Ratios Compared to White Persons</th>
<th>American Indian, Alaska Native, or Non-Hispanic Persons</th>
<th>Black or African American, Non-Hispanic Persons</th>
<th>Hispanic or Latino Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>1.7x</td>
<td>1.1x</td>
<td>1.9x</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>3.5x</td>
<td>2.8x</td>
<td>2.8x</td>
</tr>
<tr>
<td>Deaths</td>
<td>2.4x</td>
<td>2.0x</td>
<td>2.3x</td>
</tr>
</tbody>
</table>

Average U.S. life expectancy declined by one year in 2020 due mostly to COVID-19,125 one of the largest plunges ever measured in the U.S.126 People of color experienced even more catastrophic results over the same period.127 Life expectancies among Black and Hispanic populations declined by 2.7 years and 1.9 years, respectively.128

Extended periods of social distancing during the pandemic negatively affected the mental health of many Americans,129 especially HCWs.

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124. Id.
126. See id.
127. Id.
128. Id.
Overworked, understaffed, and under-protected, they suffered extreme burnout. Many providers considered retiring early or switching careers. Almost twenty percent of HCWs left their positions. Hundreds of public health workers vacated their offices in part due to mental anguish and duress by vocal opponents of their communal efforts.

Indirect health effects of the pandemic on the U.S. public health system defy measurement. To maximize the response to the pandemic, health care providers were asked to work overloading their mental, physical, and emotional limits. More than one third of HCWs considered work overload and burnout due to the pandemic.


135. See ASHLEY KIRZINGER ET AL., KAISER FAM. FOUND., KFF/THE WASHINGTON POST FRONTLINE HEALTH CARE WORKERS 2020Health %20Care%20Workers%20Full%20Report_FINAL.pdf (finding that at least one third of HCWs considered leaving the field due to COVID-19).


entities limited or eliminated many health functions. Hospitals redirected health care staff working in areas such as chronic disease, substance abuse, and maternal-child health to COVID-related duties. Focusing treatments on COVID-19 patients meant that other essential public health services were abandoned or temporarily abated. Reclaiming normalcy in the provision of public health services nationally after the pandemic may take years.

**B. Scarce Resources and Patient Surges**

The COVID-19 pandemic deeply exposed existing vulnerabilities of U.S. public health and health care systems. Hospitals experienced repeated deluges of COVID-19 patients and scarcities of essential resources over multiple waves of infections, as illustrated in Figure 3.

**Figure 3. U.S. Daily Confirmed Cases of COVID-19**

addition, widespread infections and uncertainty over use of organs from donors testing positive for COVID-19 limited donations nationally. See Roni Caryn Rabin, *She Died with Long Covid. Should Her Organs Have Been Donated?*, N.Y. TIMES (Nov. 7, 2021), https://www.nytimes.com/2021/11/07/health/covid-organ-transplants.html (documenting how medical professionals debate “whether the organs of people who survived Covid, and even of those who died with the illness, are really safe and healthy enough to be transplanted”).

139. See Kintziger, et al., supra note 138, at 2.
140. Id. at 4.
141. Id. at 6–7.
142. See id. at 9 (“The burden of the COVID-19 response on those working in public health practice is likely to impact the public health workforce, and by extension, public health, for years to come.”).
143. CDC, *Trends in Number of COVID-19 Cases and Deaths*, supra note 118.
144. Id.
The national health system began to destabilize at the inception of the pandemic in March 2020. Extensive numbers of patients presenting for emergency care overwhelmed health care facilities in New York City and other major metropolitan areas. Shortages of ventilators, beds, and space for the deceased exacerbated the precarious effects of the virus. Lacking effective pharmaceutical interventions early on in the pandemic, ventilator allocations often dictated patient survival. Facing droves of patients, hospitals could not maintain optimal staffing levels. They recruited staff from other parts of the hospital or relied on outside paid HCWs or volunteers, many of whom were not originally trained in critical care.

As patient numbers swelled, HCWs and emergency responders faced a massive shortage of personal protective equipment (PPE) (e.g., gloves, masks, goggles, face shields, gowns). By March 27, 2020, almost one-third of hospitals depleted their supply of face masks, requiring reuses of expired N95 masks. On April 1, 2020, federal officials reported that resources in the Department of Health and Human Services (HHS) strategic national stockpile of

146. See Robert D. Truog et al., The Toughest Triage—Allocating Ventilators in a Pandemic, 382 NEW ENG. J. MED. 1973, 1973 (2020) (noting the US medical system will have to ration ventilators and make “life-or-death” decisions like never before); Ramos & Chiwaya, supra note 145 (reporting that healthcare facilities were overwhelmed by shortages of tests, PPE, ventilators, beds, and space for the dead).
147. See Truog et al., supra note 147, at 1974 (“When patients’ breathing deteriorates to the point that they need a ventilator, there is typically only a limited window during which they can be saved.”).
148. See Truog et al., supra note 147, at 1974 (reporting that with the scarcity of ventilators, healthcare facilities were forced to consider rationing ventilators to patients in the most dire situations). See Robert D. Truog et al., Allocating Ventilators in a Pandemic, 382 NEW ENG. J. MED. 1973, 1973 (2020) (noting the US medical system will have to ration ventilators and make “life-or-death” decisions like never before).
150. See id. at 10, 12 (noting a shortage of specialized providers needed to respond to the pandemic, such as respiratory therapists and intensivists).
PPE were “nearly gone.” States were left to bid against each other (and the federal government) for PPE in a global marketplace already deluged with international orders. Several jurisdictions limited elective medical procedures to preserve PPE for COVID-19 patients.

With supplies scarce, some states activated their CSC plans during the summer of 2020 to give hospitals greater flexibility in allocating resources and determining patient outcomes. Not all hospitals complied. In Arizona, some Phoenix-based hospitals avoided implementing internal CSC plans after the state invoked its plan on June 29, 2020. Elsewhere, hospitals activated or generated their own policies for triaging patients based on qualifiers such as benefit, age, conservation of resources, or lottery-based mechanisms.

Premature societal re-openings, a massively contentious political environment, and increased travel and social gatherings around end-of-the-year holidays in 2020 fueled additional COVID-19 infections. As new records for numbers of COVID-19 cases, hospitalizations, and deaths arose, destructive, long-term effects on patient care emerged. In California, rising illnesses and fatigue among HCWs further depleted staff as hospitals overrode limits on

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staff workloads to assign more patients to each provider. Increasing numbers of non-emergency physicians were shifted to frontline responses. Nurses cared for more patients coextensively than typically recommended. Patients suffered long waits or were triaged through expanded telehealth efforts as hospitals struggled to locate beds and secure staff. In heavily impacted areas of the country, 9-1-1 call response times lagged by two to three minutes, often the difference between life and death for time-sensitive emergencies. Hospitals diverted emergent patients to mitigate immense backlogs. Ambulance transfers that previously took fifteen minutes on average extended into hours as responders searched for hospitals with available space.

In December 2020, New Mexico’s health department authorized hospitals to operate under CSC, allowing HCWs to assist in areas outside their normal scope of practice. In January 2021, California required its hospitals to develop and publish crisis plans, including algorithms governing decisions about which patients would receive life-saving resources such as ventilators. Capacity limits became so dire that Los Angeles County instructed emergency responders


163. See Abelson, supra note 161 (documenting that hospitals enlisted primary care and family doctors to treat COVID-19 patients).

164. Id.

165. Id.

166. JAMES G. HODGE, JR. ET AL., WESTERN REGION ALLIANCE PEDIATRIC EMERGENCY MEDICINE LEGAL RESOURCE GUIDE 22–25 (2021) [hereinafter HODGE, JR., WESTERN REGION ALLIANCE].


170. Yan, supra note 168 (denoting how some paramedic services had to transfer patients to out-of-state hospitals located hundreds of miles away).


not to take cardiac patients to the hospital if they could not be resuscitated with CPR.\textsuperscript{173}

The rise of the highly contagious Delta variant over the summer of 2021 staggered dozens of hospitals, especially in states with low vaccination rates.\textsuperscript{174} High-flow oxygen, effective in treating many COVID-19 patients, became scarce.\textsuperscript{175} Simultaneously, hospitals ran out of space in their ICUs.\textsuperscript{176} By September 2021, one-quarter of hospitals in multiple southern states reported that more than 95 percent of their beds were occupied.\textsuperscript{177} Some hospitals were forced to place patients in hallways and conference rooms or merge their ICUs.\textsuperscript{178} Shortages of monoclonal antibody treatments led HHS to commandeer and control national distributions against rising patient counts.\textsuperscript{179}

Idaho\textsuperscript{180} and Alaska\textsuperscript{181} formally activated their states’ CSC plans in September 2021, seeking outside assistance from HCWs around the country.\textsuperscript{182} Hospitals in Montana instituted CSC as cases spiked and vaccination rates fell, not to take cardiac patients to the hospital if they could not be resuscitated with CPR.\textsuperscript{173}

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\textsuperscript{174} See Kathy Katella, *5 Things to Know About the Delta Variant*, YALE MED., https://www.yalemedicine.org/news/5-things-to-know-delta-variant-covid (Mar. 1, 2022) (highlighting that the Delta variant caused the most severe damage in places with low vaccination rates).
\textsuperscript{176} Smart, supra note 20.
\textsuperscript{177} Id. In Alabama, no ICU beds were available on many days of September 2021. Id.
\textsuperscript{179} *See Lenny Bernstein, Biden Administration Moves to Stave Off Shortages of Monoclonal Antibodies*, WASH. POST (Sept. 14, 2021, 6:41 PM), https://www.washingtonpost.com/health/2021/09/14/monoclonal-antibodies-shortage/ (explaining that the Biden administration took over distribution of monoclonal antibodies and HHS announced that it would determine how many doses would be distributed to each state or territory on a weekly basis).
remained low.\textsuperscript{183} For the second time, New Mexico re-activated its CSC plans on October 18, 2021, in part to handle excessive numbers of patients seeking non-COVID-19 care whose medical procedures were set aside during the pandemic.\textsuperscript{184} Cases rose again nationally in the last quarter of 2021 due to the emergence of the highly contagious Omicron variant.\textsuperscript{185} On January 4, 2022, Maryland Governor Larry Hogan declared a 30-day state of emergency and catastrophic health emergency, expressly acknowledging the strain on resources demonstrated by certain hospitals “implement[ing] crisis standards of care.”\textsuperscript{186}

Through multiple waves of patient surges and insufficient or ill-matched resources, hospitals often resorted to hastily developed protocols for triage, admission, treatment, and resource allocation.\textsuperscript{187} Increased risk of patient mortality was strongly associated with inherent limitations in handling surges across the U.S.\textsuperscript{188} While final assessments of the impacts of the pandemic on hospital performance are still underway, between March and August 2020, strains on hospitals may have contributed to nearly one-quarter of COVID-19 deaths.\textsuperscript{189}

C. Dynamic Legal Environment

The magnitude and duration of the COVID-19 pandemic led to unprecedented governmental responses, political turmoil across two Presidential administrations, and substantial legal challenges. The most extensive use of emergency powers ever undertaken by federal, state, and local governments greatly facilitated CSC efforts during the pandemic. Resulting legal disputes and


\textsuperscript{187} Vineet Chopra, When COVID-19 Strikes Your Hospital, ANNALS OF INTERNAL MED. 1319, 1319 (2021).

\textsuperscript{188} See Sameer S. Kadri et al., Association Between Caseload Surge and COVID-19 Survival in 558 U.S. Hospitals, March to August 2020, ANNALS OF INTERNAL MED., Jul. 6, 2021, at 1 (summarizing statistics from hospitals nationally showing increases in mortality correlating with surges of COVID-19).

\textsuperscript{189} Id.
policy pushbacks, however, diminished governmental emergency authorities. Conflicts and uncertainties regarding emergency legal powers often left hospitals and HCWs at a loss for critical guidance.

A litany of emergency declarations arose during the pandemic. On January 31, 2020, HHS Secretary Alex Azar declared a national PHE. As cases escalated in the ensuing weeks, President Trump declared dual emergencies under the Stafford Act and the National Emergencies Act on March 13, 2020, to further mobilize essential public health responses. By the end of March 2020, every state and multiple territories had also declared their own emergency, disaster, or PHE—a first in U.S. history, as seen in Figure 4.

Collectively, these declarations fundamentally altered the legal landscape by authorizing: (1) sweeping social distancing measures (e.g., quarantine, isolation, shelter-in-place); (2) routine HCW licensing protocols and health care regulations; (3) expanded scopes of practice; (4) real-time acquisition, development, and allocation of extensive medical and other resources; and (5) shifts to CSC. 196

As the IOM Committee foretold in 2009, implementation of CSC raised extensive concerns about professional and institutional liability. 197 HHS Secretary Azar issued a declaration under the Public Readiness and Emergency

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Preparedness (PREP) Act (which took effect retroactively on February 4, 2020), in part to protect health care providers and others against negligence claims arising from the use of authorized medical countermeasures (MCMs) (e.g., antiviral medications, biologics, vaccines, diagnostics, and/or devices). The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed by President Trump on March 27, 2020, specifically insulated volunteer HCWs from liability. On March 24, 2020, HHS urged state governors to take their own steps to shield HCWs from medical liability. Several states complied via legislation, executive orders, or other measures, often tied to their emergency declarations. Political turmoil and federalism debates erupted as the virus gripped the nation. Misinformation along party lines led to divisive political views over preferred policies during the public health crisis. “Elevated friction” between


201. Letter from Alex Azar, Sec’y, U.S. Dep’t of Health & Hum. Servs., to Governors (Mar. 24, 2020) (on file with U.S. HHS), https://www.ncsbn.org/HHS_Secretary_Letter_to_Governors_caregiving waiver.pdf. In addition to seeking increased liability protections, Secretary Azar also asked states to allow interstate practice, relax scope of practice requirements, expand telehealth, and increase authority of medical students. Id.

202. For example, Arizona enacted legislation protecting health care providers responding to the PHE from ordinary negligence. ARIZ. REV. STAT. ANN. § 12-516(E) (2021) (“This section applies to all claims that are filed before or after September 29, 2021, for an act or omission by a person that occurred on or after March 11, 2020, and that relates to a public health pandemic that is the subject of the state of emergency declared by the governor.”) (emphasis added). More than half of the states enacted liability protections for long-term care facilities. Samuel Brooks et al., States Move to Shield LTC Facilities from Civil Liability, AM. BAR ASS’N (July 22, 2020), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-41/vol-41—issue-no-6—july-august-2020/states-move-to-shield-ltc-facilities-from-liability.

federal, state, and local governments over who specifically was in control resulted in a patchwork of pandemic response efforts. With drastically different legal approaches across states and a paucity of federal guidance early in the pandemic, waves of infection arising in distinct areas of the country fueled outbreaks elsewhere.

State legislative challenges and select judicial invalidations of PHE powers altered response capabilities midstream in specific jurisdictions. After the Wisconsin Supreme Court invalidated the authority of the state’s secretary of health to issue stay-home orders on May 13, 2020, COVID-19 cases escalated. When Arizona Governor Doug Ducey lifted his stay-at-home order on May 15, 2020, daily cases increased by 151% over the following weeks. Infections exploded in Florida in July of 2020 as Governor Ron DeSantis resisted calls for mask mandates. Local government dissension arose to countervailing state approaches. Some larger municipalities challenged state Governors and legislatures head-on over policies and laws lacking efficacy, rejecting epidemiologic evidence, and shelving proven public health interventions.

As the pandemic continued into its second year, the role of the federal government amplified under President Biden’s “wartime” stance to the


Ramos & Chiwaya, supra note 145.


Wis. Legislature v. Palm, 942 N.W.3d 900, 905 (Wis. 2020).


M. Shayne Gallaway et al., Ctrs. for Disease Control & Prevention, Trends in COVID-19 Incidence After Implementation of Mitigation Measures — Arizona, January 22–August 7, 2020, 69 MORBIDITY & MORTALITY WKLY. REP. 1460, 1460 (2020) (“The average number of daily cases increased approximately 151%, from 808 on June 1, 2020 to 2,026 on June 15, 2020 . . .”)

Ramos & Chiwaya, supra note 145.

pandemic.\textsuperscript{212} His administration’s aggressive approach was enunciated in a seven-point COVID-19 game plan and punctuated by a national vaccination campaign and extensive federal mandates,\textsuperscript{213} intended to preempt contrary state laws and policies.\textsuperscript{214} Many states welcomed the enhanced public health measures, but others resisted through a series of COVID-19 deniastistic laws and policies.\textsuperscript{215} Governors in select jurisdictions (e.g., AZ, FL, TX) banned mask mandates, vaccine requirements, and vaccine passports.\textsuperscript{216} Legislatures in some states introduced manifold bills to limit current or future exercises of public health powers, although many of these measures did not pass or were vetoed.\textsuperscript{217} With a temporary lull in infections experienced in late spring 2021, multiple states rescinded their emergency declarations even as the highly contagious Delta variant emerged.\textsuperscript{218} Mass spread of the variant led to the third largest wave of infections throughout the pandemic, requiring several states to re-issue their emergency declarations and orders by early fall 2021.\textsuperscript{219} The Omicron variant—emerging late in 2021—caused U.S. case numbers to spike in January 2022 to the highest peak seen throughout the pandemic.\textsuperscript{220}

Legal variances and political clashes across all levels of government reflected fragmented approaches and repeated cycles of authorizing and


\textsuperscript{213} See id. (explaining that the Biden Administration’s national strategy for the COVID-19 response sets forth concrete steps for fighting the virus through six domestic strategic goals and one overarching global health goal, as well as the establishment of a federal office responsible for coordinating the pandemic response across all federal departments and agencies).


\textsuperscript{216} Hodge, Jr., Legal Interventions, supra note 24, at 678.

\textsuperscript{217} See Hodge, Jr. & Piatt, COVID’s Counterpunch, supra note 214, at 34 (documenting that as of April 30, 2021, states introduced over 300 bills or resolutions aimed to limit emergency powers).

\textsuperscript{218} See Email from Lauren Dedon, Nat’l Governors Ass’n, to James G. Hodge, Jr, Jennifer L. Piatt, & Rebecca Freed (Dec. 16, 2021) (on file with author) (stating in a spreadsheet document that as of December 16, 2021, 25 states had rescinded their emergency declarations).


\textsuperscript{220} CDC, Trends in Number of COVID-19 Cases and Deaths, supra note 118.
invalidating public health powers. HCWs and entities, exhausted by continuous
months of patient surges and limited resources, sought clarity in guidance to
effectuate CSC where needed. Reaching such accord in the extant legal
environment was a defining challenge of the entire COVID-19 pandemic.

III. ASSESSING AND RESOLVING LEGAL CHALLENGES UNDERLYING CSC

The need for clear and consistent legal pathways to ensure efficient and
equitable execution of CSC is a pervasive lesson from the COVID-19 pandemic.
From its inception, a plethora of distinct legal issues arose surrounding CSC,
including documentation and reimbursement issues, privacy-related
concerns, waivers of existing legal requirements, informed consent
alterations, liability risks, and alleviating staff shortages. As the IOM
Committee forecasted in 2009, these types of issues could be addressed
through emergency declaratory powers, executive orders, and real-time agency
guidance.

Other law and policy issues, however, present significantly greater
challenges to CSC’s implementation, warranting explicit solutions. First, CSC
cannot be operationalized effectively without clearer understandings of its legal
triggers. Second, implementation of CSC necessitates regional coordination
across public and private sectors to promote uniformity, but such coordination
within and across states was often haphazard or foregone. Third, macro-
allocations underlying CSC exposed unlawful, discriminatory impacts among
certain populations. Finally, “tie-breaking” decisions concerning individual
patient access to critical scarce resources (e.g., ventilators, ICUs) demanded
resolution of thorny legal issues to avoid inequities in treatment and services.

221. Piatt & Hodge, Jr., Crisis Standards of Care, supra note 29, at 4.
222. N.Y. STATE TASK FORCE ON LIFE & L. & N.Y. STATE DEPT OF HEALTH, VENTILATOR
223. 1135 Waiver, PUB. HEALTH EMERGENCY (May 13, 2021), https://www.phe.gov/Preparedness/
legal/Pages/1135-waivers.aspx.
224. George J. Annas & Sondra S. Crosby, Standard Racism: Trying to Use “Crisis Standards of Care”
225. Donna Levin et al., FAQ: Crisis Standards of Care and Health Provider Liability, NETWORK FOR
and-health-provider-liability/.
226. Scott Aronson et al., Healthcare Provider Shortages: Resources and Strategies for Meeting
Demand, ASPR TRACIE, Nov. 2021, at 1, https://files.asprtracie.hhs.gov/documents/healthcare-work
force-strategies-for-managing-a-surge-in-healthcare-provider-demand.pdf (“Staff shortages have been a
primary challenge in the management of patient surge during the COVID-19 pandemic and other
disasters.”).
227. See supra Part I.B., Table 1.
228. CLARE STROUD ET AL., INST. OF MED., CRISIS STANDARDS OF CARE: SUMMARY OF A
WORKSHOP SERIES 62 (2010).
2022] Navigating Legalities in Crisis Standards of Care 205

As explicated below, the future of CSC hinges on resolving these legal conundrums.

A. Reconsidering Legal Triggers

Throughout the COVID-19 pandemic, repeated patient surges and fleeting resources amid changing legal dynamics obfuscated clear triggers for CSC implementation. HCWs, hospitalists, and public health personnel persistently asked, “have we shifted into CSC or not?” Lacking clear answers, HCWs were tepid in their emergency responses. A palpable need for clarity over legal triggers arose.

In its initial Letter Report, the IOM Committee expressly advocated that shifts to CSC would be “formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period.”229 COVID-19 clearly warranted extended emergency responses at all levels of government.230 Yet not every emergency declaration also necessitated CSC.231 During the pandemic, some hospital systems managed patient surges reasonably well to stave off crisis.232 Express invocations of state-level CSC plans emerged in only a select number of states (including Alaska,233 Arizona,234 Idaho,235 New Hampshire,236 and New Mexico237).

Other states did not follow suit in part because they lacked express CSC plans, were politically reticent,238 or deferred to health care facility efforts.239

229. IOM, CSC LETTER REP., supra note 1, at 18; see supra Part I.A.
230. See supra Part II.C.
231. See Hick et al., supra note 16, at 3 (describing variances in the extent and duration of formal declarations of emergency do not always align with resource scarcity warranting CSC).
232. See infra Part III.A.
234. Duda, supra note 157.
236. N.H. GOV. CHRISTOPHER T. SUNUNU, EMERGENCY ORDER #33 PURSUANT TO EXECUTIVE ORDER 2020-04 AS EXTENDED BY EXECUTIVE ORDER 2020-05 (2020).
237. Chacón, supra note 184.
239. See Knowles, supra note 196 (explaining that Arkansas is developing a CSC policy, but that, “[f]or now, hospitals have their own plans . . . [and that] each hospital’s situation is different”; the state health department’s medical director for health preparedness and response branch, Jerri Lynn Jones opined, “I don’t think it would be appropriate for us as a state to dictate what is happening at the bedside.”).
Utah’s CSC plan, for example, relied heavily on hospitals to invoke CSC as circumstances warrant. Even in Arizona and New Mexico, which formally triggered their CSC plans, state health authorities still deferred to specific hospitals’ assessments as to when they were in crisis depending on patient volume and dwindling resources. Maryland’s 2022 emergency proclamation instated certain emergency liability protections while acknowledging that some hospitals had already been operating under CSC. Consequently, hundreds of hospitals and tens of thousands of HCWs spontaneously operationalized patient triage efforts during the COVID-19 pandemic without formally invoking CSC.

Despite common misperceptions, however, CSC is not triggered solely by the declaration of an emergency, disaster, or PHE. Rather, shifts to CSC are justified by the sustained scarcity of resources coupled with patient surges in emergencies. Consequently, multiple legal triggers may signal shifts to CSC in addition to express state emergency declarations or invocations of CSC plans, as illustrated in Table 4.

### Table 4. Potential Legal Triggers for CSC

<table>
<thead>
<tr>
<th>TYPES</th>
<th>SOURCES</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td>Federal Guidance</td>
<td>• National Academies</td>
<td>December 18, 2020: NASEM and others expressly call for the</td>
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</tbody>
</table>

240. See Utah Hosp. A'ssn Crisis Standards of Care Workgroup, supra note 90, at 2 (explaining that guidelines may only apply in an affected area of the state and that “[i]ndividual healthcare facilities and organizations will manage their responses through their designated emergency operations plans and incident command structures”).

241. Arizona’s Department of Health Services officially activated CSC in June 2020 under the recognition that “an individual hospital’s status may fall within the continuum of contingency and crisis standards of care,” listing recommendations, but ultimately leaving determinations and actions to individual facilities. AzHHA member advisory – COVID-19: June 30, ARIZ. HOSP. & HEALTHCARE ASS’N (June 30, 2020), https://www.azhha.org/azhha_member_advisory_covid_19_june_30; see also John Ingold, Some Hospitals Resorted to Crisis Triage During the Pandemic. A Colorado Doctor Says More Should Have., COLO. SUN (Oct. 11, 2021, 4:01 AM), https://coloradosun.com/2021/10/11/coronavirus-hospitals-crisis-standards-of-care/?mc_cid=a9bb37d4d&mce_id=cd2672f1e0 (quoting Dr. Matt Wynia in discussing Arizona and New Mexico’s CSC declarations, explaining that “in both instances, the state basically said, ‘If you need to, you can do these triage protocols.’ But they were not required. No one said, You have to set up a triage team. You have to do load balancing across different hospital systems.”).

242. MD. OFF. OF THE GOVERNOR, supra note 186.

243. See supra Part II.B.

244. As the IOM Committee originally noted in 2009, “[t]he formal declaration that [CSC is] in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.” IOM, CSC LETTER REP., supra note 1, at 18 (emphasis added). Montana incorporates this into its’ state definition of CSC as a change “formally declared by a state government . . . [e]nabling[] specific legal/regulatory power and protections for healthcare providers in . . . allocating and using scarce medical resources and implementing alternate care facility operations.” MONT. DEP’T OF PUB. HEALTH & HUM. SERVS, supra note 89, at 1.

245. See Mehta & Wynia, supra note 23, at 55 (arguing for development of “automatic triggers” for CSC invocations based on observed medical trends instead of relying on political actors).
While CSC can be invoked on a facility, local, state, or regional basis under multiple legal foundations, uncertainties arise when CSC-related triggers
conflict. For example, federal health authorities may support the need for hospitals in areas of infectious disease to implement CSC via a PREP Act declaration while specific states in the region either fail to declare a PHE or reinstate a prior declaration.\(^{252}\) Hospitalists and HCWs in these jurisdictions may feel ill-equipped legally to shift to CSC even as patient levels surge and resources become scarce.

Assessing available legal options under any of the possible triggers is dispositive. Federal PREP Act declarations, for example, provide an array of powers enabling effective CSC implementation.\(^{253}\) First, the PREP Act authorizes federal supremacy over the allocation, use, and administration of MCMs in emergency circumstances.\(^{254}\) Second, it contains strong preemptive language blocking contrary or conflicting state laws.\(^{255}\) Third, the federal government can affect scope of practice or licensure reciprocity limitations and provide for expanded telehealth practices to facilitate CSC implementation when staff are in short supply.\(^{256}\) Fourth, the PREP Act\(^{257}\) immunizes HCWs and entities for losses relating to or resulting from administration of covered MCMs.\(^{258}\) Each of these PREP Act powers supports CSC implementation, even in states where emergency declarations are lacking.

\(^{252}\) See supra Part II.C.

\(^{253}\) 42 U.S.C. § 247d-6d.

\(^{254}\) Id.

\(^{255}\) Id. § 247d-6d(b)(8); see also Barbara J. Evans & Ellen W. Clayton, Federal COVID-19 Response Unlawfully Blocks State Public Health Efforts, PETRIE-FLOM CTR. HARV. L. (Oct. 22, 2020), https://blog.petrieflom.law.harvard.edu/2020/10/22/federal-covid19-response-nevada-preemption/ (explaining that on October 8, 2020, HHS sent a letter informing Nevada officials that the state could not halt the use of certain EUA COVID-19 rapid tests, as the action was “inconsistent with and preempted by federal law, and, as such, must cease immediately or appropriate action will be taken against those involved”).


\(^{257}\) 42 U.S.C. § 247d-6d.

\(^{258}\) Id. § 247d-6d(a)(1), (i)(1). This protection is broad, providing immunity for death, injury, property damage, and more; however, willful misconduct is excluded. PREP Act Q&As, PUB. HEALTH EMERGENCY (Dec. 22, 2021), https://www.phe.gov/Preparedness/legal/prepact/Pages/prepqa.aspx#immun3. Litigation has emerged on the breadth of these liability protections. See Maglioli v. All. HC Holdings, 16 F.4th 393, 411 (3d Cir. 2021). On October 20, 2021, the Third Circuit Court of Appeals held that the PREP Act does not completely preempt state law, and that a state court would have to determine whether nursing facility negligence claims could be litigated. Id. Judicial interpretations may shape the extent of the Act’s liability protections for entities undertaking actions involving MCMs during emergencies. Id.
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B. Facilitating Regional Coordination

Regional cooperation and coordination among public and private sectors are imperative to advancing equitable outcomes and saving maximum lives during CSC. Yet, distinct legal challenges arise from widespread variations in jurisdictional definitions of emergency, CSC, and triggers for execution. Allocations of powers between federal and state governments complicate coordination within and across jurisdictions. Addressing these challenges is vital to cross-sectoral planning and response efforts.

In the early months of the COVID-19 pandemic, the lack of regional coordination in approaching patient surges and resulting health care responses across several U.S. jurisdictions was apparent. Deluged hospitals reported difficulties in transferring patients to nursing homes, hospice facilities, and even other hospitals with available bed capacity. In some cases, available hospital beds and other resources were in short supply. In other instances, bed availability data were unavailable, unclear, or simply wrong. In an example repeated across dozens of hospitals nationally, one hospital in Queens, New York was “besieged” by patients in May 2020, while roughly 3,500 beds were available in other facilities only twenty minutes away. New York State subsequently created a live map of conditions and available beds to facilitate transfer and avoid overwhelming conditions.

Additional coordination problems surfaced elsewhere. From May to June 2020, southern California health care facilities were stymied by unwarranted rejections or delays concerning “COVID-19 patients based on their insurance

259. See supra Parts I.C., Table 2, II.C, Figure 4, & III.A.
265. Dwyer, supra note 263.
status.”\textsuperscript{267} Long waits resulted in some patients “arriv[ing] at their destination with damaged lungs from poorly controlled ventilators.”\textsuperscript{268} One St. Louis physician explained in September 2020 that rural hospital transfers were to be rejected at her local hospital unless “absolutely medically necessary.”\textsuperscript{269} In July 2020, hospitals in Houston, Texas—which lacked information about available beds in neighboring facilities—sought assistance from the city’s disaster council to address surging case numbers.\textsuperscript{270}

Calls for federal assistance to help coordinate patient demands emerged. Real-time efforts to provide a federal data system via HHS, however, met resistance or proved ineffective at best and inoperable at worst.\textsuperscript{271} Two systems were devised in 2020, one through CDC’s existing National Healthcare Safety Network and another through HHS’ partnership with TeleTracking Technologies, Inc.\textsuperscript{272} Both systems tracked different kinds of information, including available beds and ICU beds,\textsuperscript{273} PPE status and availability,\textsuperscript{274} COVID-19 patient numbers,\textsuperscript{275} and therapeutics distribution.\textsuperscript{276} Yet, each system was cumbersome and utilized algorithms resulting in lists “filled with mistakes,” according to real-time assessments in June 2020.\textsuperscript{277} A lack of effective enforcement exacerbated the issues as some facilities did not report, citing staffing issues, or submitted the same data week-to-week.\textsuperscript{278} When enforcement of system reporting requirements was considered, a review of the federal lists illustrated numerous errors.\textsuperscript{279}

In July 2020, HHS indicated abruptly that hospitals should stop utilizing CDC’s reporting system and exclusively report through HHS instead, causing


\textsuperscript{270} Id.

\textsuperscript{271} Evans & Berzon, supra note 268.

\textsuperscript{272} Id.


\textsuperscript{274} Id.

\textsuperscript{275} U.S. DEP’T OF HEALTH & HUM. SERVS., COVID-19 GUIDANCE FOR HOSPITAL REPORTING & FAQS FOR HOSPITALS, HOSPITAL LABORATORY & ACUTE CARE FACILITY DATA REPORTING 4–9 (2022).


\textsuperscript{277} Evans & Berzon, supra note 268.

\textsuperscript{278} Id.

\textsuperscript{279} Id.
additional confusion. In September 2020, HHS threatened to terminate Medicare provider agreements for failing to timely report required information, spurring further concern from providers attempting to comply with shifting data standards while combating patient surges. Some speculated that the quick change would incentivize inaccurate reporting to maintain funding.

Hospital experiences and data challenges illustrate just how vital regional coordination, communication, and cooperation are in avoiding excess morbidity and mortality during emergencies. Under the U.S. federalist system, CSC implementation has largely been left to the states under national guidance provided by NASEM and other federal entities. Consequently, states defined and executed CSC on their own terms, resulting in mismatches in terminology, approaches, and implementation across geographical borders. Infectious diseases like COVID-19, however, do not respect jurisdictional borders, affecting persons indiscriminately.

To counter the reality of burgeoning public health threats, multiple efforts to improve regional operations are available at the state and federal levels, including state-wide implementation of standards for coordination and communication. During the pandemic, for example, Arizona’s Department of Health Services organized a 24/7 telephone “Surge Line,” enabling rapid transfers of over 4,000 COVID-19 patients to available beds state-wide between April and October 2020. Arizona Governor Doug Ducey’s Executive Order required hospitals to participate and develop internal protocols to “complete . . . bed placement within thirty minutes,” and mandated health insurers to provide in-network rate coverage for transfers and treatment. While Arizona’s load-


283. Huang & Simmons-Duffin, supra note 281.

284. See, e.g., ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 565 (5th ed. 2015) (explaining that “[s]tate and local governments possess the police power, which means that they can take any action unless there is a constitutional prohibition.”).

285. See Hick et al., supra note 16, at 5–7 (assessing alternative approaches to generating refined data and surveillance practices to better assess and respond to patient surges during the COVID-19 pandemic).


balancing approach to alleviate patient gridlocks was implemented on an emergency basis, states may preemptively engage in similar coordinative efforts in advance of future emergencies.

Cross-jurisdictional mechanisms such as Medical Operations Coordination Cells (MOCCs) may also facilitate load-balancing up to and during crises. At federal, regional, or state levels, MOCCs are intended to allocate COVID-19 patients “so that the highest possible level of care can be provided to all patients who need that care before transitioning hospitals toward crisis measures.” Washington State’s MOCC helped flatten its COVID-19 curve from March through June 2020 specifically concerning intrastate patient coordination.

Innovations like Arizona’s Surge Line and other proposed uniform communication approaches can facilitate enhanced regional coordination in implementing CSC in future PHEs. Yet, legal barriers remain. Jurisdictional differences in language framing emergencies, defining CSC, or facilitating patient transfers can stymie effective cooperation. Emergency declarations, utilization of existing options through the state-based Emergency Management Assistance Compact (EMAC), and executive orders may obviate barriers posed by differences or a lack of uniformity across states. State or local actions to legislate or regulate advance measures and options can help assure intrastate regional coordination. CMS has wide latitude in setting conditions for program participants. Data reporting requirements prioritizing the advance creation and continued utilization of a single uniform system help to avoid duplicative or

289. Id. at 13, 26, 34.
290. Steven H. Mitchell et al., Western Washington State COVID-19 Experience: Keys to Flattening the Curve and Effective Health System Response, 231 J. AM. COLL. SURGEONS 316, 317 (2020). Washington’s system enabled decompression services for acute care facilities, asked health providers for regular input of data, and established a set of principles that facilities were requested to abide by to ensure regional cooperation.
291. See 42 U.S.C. § 1395o(a)(9) (requiring that hospitals, for purposes of Medicare reimbursement, meet “requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution”); see also 42 C.F.R. § 482.1 (2018) (generally explaining conditions of participation for hospitals participating in Medicare).
unclear requirements inhibiting providers’ response efforts. The Federal Emergency Management Agency (FEMA) can set similar conditions on expenditures for emergency responses,\(^{295}\) enabling shared approaches and understanding of CSC across borders.

Federal legislation may also ameliorate regional coordination challenges. EMTALA\(^ {296}\) requires stabilization and treatment of individuals arriving at emergency departments. EMTALA also mandates that certain hospitals with higher capabilities accept transfers of persons with emergency medical conditions.\(^ {297}\) New legislation may further enhance uniformity. On March 1, 2021, Senator Elizabeth Warren (D-MA) and eleven co-sponsors\(^ {298}\) re-introduced the Equitable Data Collection and Disclosure on COVID-19 Act\(^ {299}\) to require surveillance systems to disaggregate information and demonstrate disparate impacts across different demographic categories.\(^ {300}\) Acknowledging the profound impacts of the COVID-19 pandemic on persons of color, people with disabilities, Indigenous Peoples, and low-income communities, Senator Warren called for “comprehensive national data on who is getting infected, who is getting treatment, and who is dying.”\(^ {301}\) Enhanced uniformity in data collection and utilization may not only improve regional coordination, but also help limit disparate impacts for certain populations in implementing CSC, as discussed below.


\(^{296}\) 42 U.S.C. §§ 1395cc, 1395dd.


\(^{299}\) S. 512.


\(^{301}\) Id.
C. Limiting Discriminatory Impacts in Implementation

Incomplete data, ignorance of existing systemic barriers, lack of effective CSC planning, and variances in CSC implementation contributed to a “perfect storm” that perpetuated disparate treatments and poor health outcomes among at-risk populations nationally. The future of CSC depends on assurances that plans and their execution do not perpetuate and exacerbate health disparities.

From the onset of the pandemic, several disability rights organizations identified the potential for discriminatory impacts in CSC plans and implementation. They corresponded directly with state leaders and filed complaints with HHS’ Office for Civil Rights (OCR) alleging that state CSC or triage plans incorporated discriminatory implementation criteria tending to screen out patients with disabilities or advanced age. Alabama’s 2010 ventilator allocation criteria, for example, deprioritized access for “[p]ersons with severe or profound mental retardation, moderate to severe dementia, or catastrophic neurological complications.” Utah’s CSC plan allegedly disqualified “persons with advanced neuromacular disease, dementia, Cystic Fibrosis, and other disabilities requiring assistance with daily living from receiving lifesaving care during a [PHE].”

OCR negotiated with these and other states to update their CSC plans and eliminate discriminatory language, including: (1) categorical exclusions of specific persons or populations and (2) CSC assessments utilizing long-term

302. See ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER 61–86 (2019) (describing various social and structural barriers to health, including factors such as access to health care, education, and employment).

303. See Catherine L. Aurieamma et al., Eliminating Categorical Exclusion Criteria in Crisis Standards of Care Frameworks, 20 AM. J. BIOETHICS 28, 32 (2020) (asserting that emergency circumstances compounded these unjustifiable outcomes through lack of planning and resort to emergency ad hoc decision-making, which can incorporate conscious and unconscious biases).

304. Manchanda et al., Inequity in Crisis Standards of Care, supra note 28, at 1.

305. See Hick et al., supra note 16, at 2 (arguing that CSC protocols “cannot be expected to remedy historic and structural inequity, however, they should not exacerbate underlying disparities”).


307. Id.


survivability. While OCR’s specific recommendations focused predominantly on age- and disability-based discrimination, consideration of long-term survivability underlying allocations can also result in racial disparities. Black populations historically have lower life expectancies on average than White populations. In July 2020, OCR clarified that civil rights protections prohibiting race, color, and national origin discrimination continued to fully apply during the COVID-19 pandemic.

Persons earning low wages also experienced disparate impacts as smaller, poorly funded hospitals typically serving Medicaid populations or people of color were tasked with treating exorbitant numbers of patients with COVID-19. In Los Angeles, one hospital predominantly serving low-income communities experienced heightened rates of death among patients with COVID-19 and “treated more Covid patients than some Los Angeles hospitals three to four times its size.” A July 2020 assessment found that COVID-19 patients admitted to hospitals with fewer ICU beds were more likely to die.

Equitable allocation of limited resources during PHEs was a central objective underlying CSC identified by the IOM Committee in 2009. Legally accomplishing it proved challenging during the COVID-19 pandemic especially given specific requirements or limits under equal protection principles as well as statutory antidiscrimination protections like the Americans with Disabilities Act, Civil Rights Act, Title VI, and the Age Discrimination Act. Avoiding discriminatory resource allocations through CSC requires careful legal

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313. See Civil Rights Protections Prohibiting Race, Color & National Origin Discrimination During COVID-19, U.S. DEP’T OF HEALTH & HUM. SERVS., OFF. FOR C.R. IN ACTION (July 20, 2020), https://www.hhs.gov/sites/default/files/title-vi-bulletin.pdf (explaining that recipients of federal financial assistance needed to ensure “that individuals from racial and ethnic minority groups are not rejected for hospital admissions[,] or denied access to intensive care units compared to similarly situated non-minority individuals”).
314. Caroline Kelly et al., Low-Income COVID-19 Patients Die Needlessly Because They Are Stuck in the Wrong Hospitals—While the Right Hospitals Too Often Shut Them Out, HEALTH AFFS. (Apr. 2, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210401.95800/full/ At least one hospital CEO disclosed a plan to try treating all patients who arrived, fearing the loss of revenue upon transfer. Id.
316. Shruti Gupta et al., Factors Associated with Death in Critically Ill Patients with Coronavirus Disease 2019 in the US, 180 JAMA INTERNAL MED. 1436, 1441 (2020).
321. Id. § 6102.
assessments and explicit incorporation of principles of health justice centered on the social determinants of health, as per the process illustrated in Figure 5, below.

**Figure 5. Incorporating Health Justice**

1. Identify (a) important health disparities that are of concern to key stakeholders, especially those affected and (b) social inequities in access to the resources and opportunities needed to be healthier that are likely to contribute to the health disparities.

2. Change policies, laws, systems, environments and practices to eliminate inequities in the opportunities and resources needed to be as healthy as possible.

3. Evaluate and monitor efforts using short-term and long-term measures.

4. Reassess strategies to plan next steps.

The goal: equity in health & its determinants

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322. Health justice encompasses “laws, policies, systems, and behaviors that are evenhanded with regard to and display genuine respect for everyone’s health and well-being.” TOBIN-TYLER & TEITELBAUM, supra note 302, at 167; see also Ruqaiijah Yearby & Seema Mohapatra, Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19, 70 EMORY L.J. 1419, 1431 (2021) (recommending adoption of the health justice framework to “eradicate racial inequities” that resulted during the COVID-19 pandemic).


325. PRESIDENTIAL COVID-19 HEALTH EQUITY TASK FORCE, FINAL REPORT & RECOMMENDATIONS 76 (2021), https://www.minorityhealth.hhs.gov/assets/pdf/HETF_Report_508_102821_9am_508Team%20WIP11.pdf (“The Federal Government should support research to better understand the ways in which states' [CSC] intersect with ableism and ageism, as well as how disproportionately impacted communities of color and other underserved populations should be supported.”).

326. See id. at 34 (encouraging the federal government to widely disseminate CSC, explain CSC benefits, and suggest their adoption).
incentivizing transfers to avoid limitations for persons experiencing lower incomes may promote health justice.\textsuperscript{327} CSC planners may also consider utilization of the Social Vulnerability Index (SVI)\textsuperscript{328} or Area Deprivation Index (ADI),\textsuperscript{329} both of which assess geographic deprivations nationally.\textsuperscript{330} ADI does not expressly prioritize persons on the basis of race, which may help it withstand potential equal protection-based challenges.\textsuperscript{331} Finally, planners may look to organizational actions prioritizing equity for help in shaping CSC plans.\textsuperscript{332}

D. Defending “Tie-Breaker” Decisions

Avoiding disparate health impacts through CSC allocations on the macro-level is essential, but policymakers and planners must also confront critical issues of micro-level decisions involving specific patients when lives are on the line. These are among the most controversial legal challenges hospitals and HCWs face in implementing CSC—the tough, “tie-breaking” choices that must be made when there are more patients than there are beds, treatments, or staff to assist them. As with any tie-breaker scenario, there are winners and losers. Consequences of these decisions in CSC, however, can be the difference between life or death.\textsuperscript{333}

Resource availability—including hospital staff and beds—statistically correlates with heightened COVID-19 mortality rates.\textsuperscript{334} It is a hard reality underlying CSC during the pandemic: some patients died directly from the effects of COVID-19; others expired from a lack of health care access or poor

\begin{itemize}
\item Kelly et al., \textit{supra} note 314.
\item At a Glance: CDC/ATSDR Social Vulnerability Index, AGENCY FOR TOXIC SUBSTANCES & DISEASE REGISTRY (Aug. 30, 2021), https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html ("CDC/ATSDR SVI is a database that helps emergency response planners and public health officials identify, map, and plan support for communities that will most likely need support before, during, and after a [PHE].")
\item “An area deprivation index (ADI) is a multidimensional evaluation of a region’s socioeconomic conditions, which have been linked to health outcomes (1–6).” Andrew R. Maroko et al., \textit{Integrating Social Determinants of Health with Treatment and Prevention: A New Tool to Assess Local Area Deprivation}, 13 PREVENTING CHRONIC DISEASE, Sept. 2016, at 1; see also James G. Hodge, Jr. et al., \textit{Diminishing Disparities in U.S. Crisis Standards of Care: Medical and Legal Challenges}, 34 ECLINICAL MED., Apr. 1, 2021, at 1 [hereinafter Hodge, Jr. et al., \textit{Diminishing Disparities}] (noting that decisions regarding interventions may be based on the ADI, “where most benefits accru to those in at-risk areas”).
\item Harald Schmidt et al., \textit{Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines?}, 324 JAMA 2023, 2024 (2020).
\item Id.
\item For example, NASEM developed guidance on how to allocate COVID-19 vaccinations incorporating equity as a crosscutting consideration for access, specifically indicating indices like SVI to help prioritization across geographic areas. NAT’L ACADS. OF SCI., ENG’G, & MED., FRAMEWORK FOR EQUITABLE ALLOCATION OF COVID-19 VACCINE 8–9 (2020). The plan also prioritized persons living in congregate settings (e.g., homeless shelters) and essential workers in the first and second phases of allocations. Id. at 10.
\item Hodge, Jr. & Piatt, \textit{Legal Decision-making}, \textit{supra} note 23.
\item Kadri et al., \textit{supra} note 188, at 1.
\end{itemize}
coordination. Hospital triage committees and clinicians responsible for tie-breaking decisions have the Herculean task of balancing an array of medical, ethical, and practical dynamics. They must also (1) consider critical “tripping points” regarding factors they may not legally take into account; and (2) address legal inconsistencies in CSC approaches across states.

As illustrated in Figure 6, a long list of considerations, including patients’ race, color, ethnicity, or sex, are legally forbidden as criteria for CSC tie-breaking decisions.\textsuperscript{335} Patients’ religious affiliations, ability to pay, social worth, vaccination status, and categorical exclusions based solely on age, disability, or long-term survivability are also “off the table” in multiple jurisdictions.\textsuperscript{336}

\textbf{Figure 6. Unlawful Legal Bases for CSC Tie-Breakers}

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<tr>
<th>Unlawful Legal Bases for CSC Tie-breakers</th>
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<td>• Race/Color</td>
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<td>• Gender</td>
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<td>• Age</td>
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<td>• Veteran Status</td>
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<td>• Marital Status</td>
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<tr>
<td>• Religious/Exercise of Conscience</td>
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<td>• Limited English Proficiency</td>
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<tr>
<td>• Long-term Mortality or Life Expectancy</td>
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<td>• Assumptions of Perceived Health Status</td>
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<td>• Disability – Physical or Mental</td>
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<td>• Quality of Life</td>
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<td>• Individual’s Relative Worth</td>
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<td>• Ineptible Clinical Assessment Scores</td>
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<td>• Resource Intensity Due to Disability/Age</td>
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<td>• Donation of Need Due to Disability/Age</td>
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<td>• Advanced Planning/Steering Decisions</td>
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<td>• Categorical Exclusions</td>
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<td>• Blanquet Applications</td>
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<td>• Stereotypes</td>
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CSC decision-makers cannot make real-time choices based on numerous legally prohibited factors, but often lack explicit or meaningful guidance concerning criteria they can use.\textsuperscript{337} A 2020 Johns Hopkins report noted how insufficient CSC guidelines in New York left bedside clinicians having “to make the least bad decision under extraordinary circumstances.”\textsuperscript{338} This is untenable. As NASEM observed on March 28, 2020, “[e]xtreme scarcity can necessitate difficult life-and-death decisions. [HCPs making] them must have adequate guidance . . . to follow the rule of law.”\textsuperscript{339}

Instead, CSC decision makers face a panoply of differing tie-breaking approaches across states. As documented in Table 4 below, select states’ CSC plans (1) define tie-breaking scenarios concerning scarcity generally (e.g., Montana, Washington) or related to specific resources (e.g., ventilators in

\textsuperscript{335} As noted above, HHS/OCR warned states to avoid unlawful discrimination across HHS-funded programs. Several states subsequently adjusted their CSC plans at OCR’s urging. See supra Part III.C.

\textsuperscript{336} Arizona law expressly prohibits resource allocations based on religion or veteran/income status.\textit{ARIZ. DEPT. OF HEALTH SERVS., ARIZ. CRISIS STANDARDS OF CARE PLAN 92} (2021).

\textsuperscript{337} Hodge, Jr. & Piatt, \textit{Legal Decision-making}, supra note 23.

\textsuperscript{338} TONER ET AL., \textit{supra} note 21, at 8.

\textsuperscript{339} NASEM, \textit{CSC RAPID CONSULTATION}, \textit{supra} note 22, at 5.
Colorado and ICUs in Utah) [column I], and then (2) provide explicit guidance for how to prioritize patients under such scenarios [column II].

Table 4. Select Tie-Breaker Criteria Among State CSC Plans

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<tr>
<th>I. State Tiebreakers</th>
<th>II. Tiebreaker Guidance</th>
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| **Colorado** – “Assign Limited Ventilators to Patients Most Likely to Benefit if No Other Options Are Available”341 | 1. “[A]ssess patient acuity using SOFA . . . scoring table and/or other parameters appropriate to the situation (agent-specific prognostic indicators, modifications based on agent involved).”
2. “Compared to other patient(s) requiring and awaiting external ventilation/oxygenation, does this patient have significant differences in prognosis or resource utilization in one or more categories [omitted] that would justify re-allocation of the ventilator/unit? . . . Injury/epidemiologic factors may have the highest predictive value in some cases and may also affect the predictive ability of the SOFA score.”
3. “Re-allocate ventilator/resource only if patient . . . with respiratory failure has significantly better chance of survival/benefit as compared to patient currently receiving ventilation.”342 |
| **Idaho** – “In the event that there are more patients in a Priority Category than there are critical care resources/ventilators . . .”343 | 1. “[C]hildren ages 0-17.”
2. “[P]regnant women with a viable pregnancy ≥ 28 weeks of gestation.”
3. “[P]atients based on lifecycle, prioritizing those patients who have lived through fewer lifecycles . . . .”
4. “[I]ndividuals who perform tasks that are vital to the public health response of the crisis at hand, including . . . those whose work directly supports the provision of acute care to others.”
5. “[L]ottery (i.e., random allocation). . . .”344 |
| **Kansas** – no explicit situational context provided345 | “Once a determination has been made that a patient qualifies for the resource under the SOFA score, and a patient’s priority category has been determined, |

341. COLO. DEP’T OF PUB. HEALTH & ENV’T, supra note 85, at 47.
342. Id. at 47–48.
344. Id.
345. KAN. DEP’T OF HEALTH & ENV’T, supra note 86, at 16.
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<td>within-category priority will be established on a first-come, first-served basis or on a random selection/lottery basis, depending on feasibility of implementation.</td>
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346. Id.
347. EXEC. OFF. OF HEALT & HUM. SERVS., COMMONWEALTH OF MASS., supra note 87, at 21–22.
348. Id. at 21–22.
349. MONT. DEP’T OF PUB. HEALTH & HUM. SERVS., supra note 89, at 37–38.
350. Id. at 50.
351. Id. at 40.
### I. State Tiebreakers

- cannot be distinguished relative to short term outcome after the individualized assessments [previously] conducted . . . , a tiebreaker may need to be used in order to determine which patient receives the limited resource.\(^3\)\(^5\)\(^2\)

### II. Tiebreaker Guidance

Accordingly, such patients with MSOFA scores above the Crisis MSOFA Cutoff should be considered for continued ICU/ventilator care, unless their clinical condition or expressed wishes indicate otherwise.”

1. “If one patient’s clinical trajectory is declining more rapidly than the other patient needing the same limited resource, the limited resource should be assigned to the patient with the less rapid rate of clinical decline, and thus the greatest prospect of short-term survival.”

2. “[A] judgment should be made of which patient has the greater prospect of short-term survival based on additional clinical judgment of patient’s record and overall presentation of relevant symptoms, combined with use of recommended assessment tools . . . , so long as this judgment is not based on any unlawful considerations of race, color, national origin, disability, age, or sex.”

3. “Assign the limited resource by randomization to lottery.”\(^3\)\(^5\)\(^3\)

### Washington –

- “When there are not enough medical resources for patients who have the same likelihood to survive to discharge (i.e., are in the same priority level in the prioritization scale).”\(^3\)\(^5\)\(^4\)

1. “The resource remains with the patient who already has the resource as long as the patient is not clinically worsening.”

2. “The resource goes to a pregnant patient.”

3. “The resource goes to the patient with the highest SVI score based on the following: i) SVI score (highest rank = 10, based on home address); and ii) Unhoused individuals will receive a score based on their last known address (i.e., shelter, hospital) or the current location of services.”

4. “Randomization using the Excel Randomization Tool.”\(^3\)\(^5\)\(^5\)

Consistent with the factors documented in Table 4, chances of survival over similarly-situated patients in CSC tie-breaking scenarios depend on an array of primary criteria including: (1) persons with sufficiently low Sequential Organ Failure Assessment (SOFA) scores (CO, MA), (2) minors (ID, MT), (3) pregnant women (UT), (4) patients who already received a limited resource (WA), and (5)

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352. UTAH HOSP. ASS’N CRISIS STANDARDS OF CARE WORKGROUP, supra note 90, at 7.
353. Id.
355. Id.
patients arriving on a “first-come, first-served” basis (KS). Stated simply, if patient X (a 38-year-old pregnant woman) and patient Y (a 16-year-old male) face similar medical prognoses absent immediate access to a single ventilator, patient X would gain access in Utah, while patient Y would win in Idaho.

When initial prioritizations do not completely resolve tie-breakers for access to limited resources, additional sub-criteria in states’ CSC plans diverge further. These secondary factors include epidemiological considerations (CO), life-cycle assessments (ID), lotteries (KS), patients contributing to the “maintenance of social order,” (MA), patients who brought their vents to their facilities (MT), patients’ “rate of clinical decline,” (UT), and SVI scores (WA). Thus, if patient A and patient B are medically-similar pregnant women in Washington State, patient A would gain access to the limited resource if her SVI score is higher than patient B’s score.

Facing a smorgasbord of CSC tie-breaking options across states, it is hardly surprising that triage committees and clinicians struggle to assess the legalities of their decisions. In the context of the COVID-19 pandemic and future PHEs, tie-breaking quagmires should be resolved through effective, fair, and sound decisions that are medically, ethically, and legally defensible based on factors illustrated in Figure 7, below.

**Figure 7. Lawful Bases for CSC Tie-Breakers**

<table>
<thead>
<tr>
<th>Lawful Bases for CSC Tie-breakers</th>
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<tr>
<td>• Specific Resource Limitations or Suitability</td>
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<tr>
<td>• Current Medical/Public Health Information</td>
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<td>• Individualized Patient Assessments</td>
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<tr>
<td>• Objective Medical Evidence</td>
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<tr>
<td>• Equitable Clinical Assessment Scores</td>
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<tr>
<td>• Short-term Survival</td>
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<tr>
<td>• Age (as a limited prognostic factor)</td>
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<tr>
<td>• Patient/Surrogate Consent and Choices</td>
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<tr>
<td>• Health Care Worker Status</td>
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<tr>
<td>• Reasonable Modifications to Assure Equal Access for Disabled or Aged Patients</td>
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<tr>
<td>• Appeals</td>
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357. UTAH HOSP. ASS’N CRISIS STANDARDS OF CARE WORKGROUP, supra note 90, at 7; IDAHO DEP’T OF HEALTH & WELFARE, supra note 343, at 8.


Defensible legal criteria to render tie-breaking decisions involving patient care in crises include determinations of specific resource limits or suitability (e.g., medical equipment solely available for use among pediatric/neonatal patients) as well as current medical or public health trends or information. Additional considerations include:

1. **Individualized medical assessments** – assessments based on individualized prognostics concerning patient benefits to limited resources guided by the best available medical and public health evidence are permissible and preferable in lieu of categorical exclusions prohibited by law.

2. **Equitable use of clinical scores** – clinical assessment scores are controversial, but can be considered if they do not disparately impact specific groups. Massachusetts’ CSC tie-breaking criteria, for example, recommend limiting the number of points assigned to patients via SOFA scoring to help correct demonstrable inequities.

3. **Short-term survivability** – patient survivability up to hospital discharge (or immediately afterward) may be considered as contrasted with long-term survivability, which can perpetuate age-, disability-, or race-based discrimination.

4. **Age** (as a prognostic factor) – in limited circumstances, age may be a clinical factor relevant to individualized assessments, and thus lawfully permissible as a distinguishing factor.

5. **Patient/surrogate informed consent and choices** – respect for individual autonomy includes the freedom to decline medical treatment so long as patients or their surrogates are not steered or coerced into deleterious choices.

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361. See Hick et al., supra note 16, at 10–11 (describing how many healthcare providers “relied heavily on [SOFA] scores. Limitations of the SOFA score have been recognized and publicized prior to COVID-19.”).
362. Hodge, Jr. et al., Diminishing Disparities, supra note 329, at 1.
364. See infra Part III.C.
365. See National Organizations Call for Action, supra note 246 (recommending that hospitals “[m]ake resource allocation decisions based on individualized assessments of each patient, using the best available objective medical evidence concerning likelihood of death prior to or imminent after hospital discharge, including clinical factors relevant and available to such determinations, which may include age under limited circumstances”).
366. TOM BEAUCHAMP & JAMES R. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 58 (5th ed. 2001); Hick et al., supra note 16, at 9–10 (“Patients that voluntarily raise the possibility of foregoing services or resources that are in shortage have the legal and ethical right to decline services, but extreme caution must be exercised not to pressure patients into “altruistic” acts that are not consistent with their underlying values.”).
(6) **HCW status** – prioritizing HCWs on the frontlines who face risks in treating patients with COVID-19 or other infectious conditions is based on ethical principles of reciprocity, employment contracts, and duties of HCWs pursuant to their licensure;

(7) **reasonable modifications to assure equal access for disabled or aged persons** – blatant discrimination in CSC decision-making based on disability, age, or other unlawful factors is rare or difficult to uncover. What can emerge from repeated decisions, however, are unintended impacts on persons with disabilities or advanced age. In such cases, as authorized by OCR, reasonable modifications to tie-breaking criteria can help assure equitable access to limited resources;367 and

(8) **appeals** – CSC tie-breaking decisions invariably must be made, and often on an expedited basis. “Winners” are entitled to access scarce resources. “Losers” deserve a second chance. While the shifting nature of CSC implementation in the throes of PHEs may sustain constant adjustments in decision-making, revisiting key decisions, allowing appeals by patients or their doctors, and reconsidering specific persons for access to limited resources, are essential to the integrity of the process.

**CONCLUSION**

Initial conceptions of CSC in 2009 sought to ensure that plans would be in place to save as many lives as possible during PHEs. Unprecedented conditions experienced throughout the COVID-19 pandemic, however, exposed significant law and policy challenges in operationalizing CSC, principally: (1) uncertainty over legal triggers; (2) inadequate regional coordination; (3) emergence of discriminatory impacts; and (4) divergent “tie-breaker” decisions. Each of these legal conundrums is solvable. To the extent CSC is triggered when extended resource shortages combined with sustained patient surges during PHEs necessitate shifts in how care is allocated, supporting legal mechanisms extend well beyond state-based emergency declarations. Improving regional coordination relies on advance uniform understandings of CSC, alongside governmental surveillance and other efforts to facilitate shared operations in PHEs. Limiting discriminatory impacts in CSC implementation requires adherence to principles of health justice in CSC plans, as well as real-time adaptations based on new information. Tie-breaking decisions over patient access to specific limited resources must avoid legally prohibited factors in favor of equitable, defensible criteria. Future applications of CSC must ensure that real-time allocations and decisions during emergencies are fair, effective, and essential toward reducing morbidity and mortality.

367. See Civil Rights and COVID-19, supra note 310 (encouraging “reasonable modifications” for patients with disabilities when using scoring systems or other clinical instruments to assess survival).