



2222 West Braker Lane  
Austin, Texas 78758  
MAIN OFFICE 512.454.4816  
TOLL-FREE 800.315.3876  
FAX 512.454.3999

July 22, 2020

*Via Email and U.S. Priority Mail*

Roger Severino, Director  
Office for Civil Rights  
U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington D.C. 20201

**Re: Complaint Regarding North Texas Mass Critical Care Guidelines for Adults and Children**

Dear Mr. Severino:

Disability Rights Texas (DRTx), along with the seventeen undersigned state and national advocacy organizations and individual complainants, submit this Complaint against the North Central Texas Trauma Regional Advisory Council (North Central Texas Trauma RAC)—responsible for overseeing the provision of emergency medical services for almost eight million Texans who reside in the Dallas-Fort Worth metro area and the surrounding eighteen counties representing nearly 30% of the entire state—challenging the North Texas Mass Critical Care Guidelines Document: Hospital and ICU Triage Guidelines for Adults (“Guidelines for Adults”)<sup>1</sup> and the North Texas Mass Critical Care Guidelines Document: Hospital and ICU Triage Guidelines for Pediatrics<sup>2</sup> (“Guidelines for Children”). This complaint is also filed against the Texas Department of State Health Services as the state agency that has delegated emergency services management to the North Central Texas Trauma RAC and retains oversight over the Council. The Guidelines jeopardize the lives of adults and children with disabilities, older adults, individuals from communities of color, prisoners, and others with co-morbid conditions during the COVID-19 pandemic in violation of Title II of the Americans with Disabilities Act (“ADA”), Section 504 of the Rehabilitation Act, Section 1557 of the Patient Protection and Affordable Care Act (“ACA”), and the Age Discrimination Act of 1975 (“Age Act”). We request that your Office take swift action to repudiate these Guidelines and ensure non-discriminatory access to life-saving medical care for North Texas residents during the pandemic.

The triage scoring system in both sets of Guidelines penalize patients with certain medical conditions, excluding some altogether from hospital admission, intensive care unit (ICU) admission, and ventilator access. Others are penalized based on predictions of long-term prognosis without regard to short-term survival or survival from COVID-19. The Guidelines contain no statements prohibiting discrimination based on disability, age, race, or ethnicity, thereby—at least implicitly – allowing for such discrimination. Finally, the rigid scoring systems relied upon in the Guidelines fail to require the provision of reasonable modifications to the triage process when necessary to accommodate an individual’s disability, as required

---

<sup>1</sup> Exhibit A.

<sup>2</sup> Exhibit B. Under the guidelines, “pediatrics” are individuals age thirteen and younger. Guidelines for Children at 1, “Scope.” The guidelines for adults apply to individuals aged fourteen and older. Guidelines for Adults, at 1, “Scope.”

by federal law. As a result, the Guidelines discriminate against adults and children with disabilities, prisoners, older adults, and communities of color in violation of federal law.

Texas coronavirus cases continue to set new records with each passing day, with Dallas County recently reporting over one thousand new cases for six days in a row.<sup>3</sup> Just a few weeks ago, a doctor with UT Southwestern in North Texas stated that hospitals in the Dallas-Fort Worth area could be at capacity in as little as three weeks, based on the rate of increased infections in the area.<sup>4</sup> While we understand that public officials and health care institutions are faced with the unenviable prospect of having to make difficult choices about how to allocate care, it is critical that OCR take immediate steps to ensure that life-saving care is not illegally withheld from North Texans with disabilities, older adults, prisoners, and others with co-morbid conditions, due to discriminatory triage criteria.

As is evident from daily statistical and media reports, the situation for Texans with COVID-19 is dire. The urgency of this situation requires urgent action by HHS. For this reason, we request a finding by your Office that the triage factors in the Guidelines that deny life-saving treatment to individuals based on underlying disabilities, co-morbidities, and age must be eliminated so as to comply with federal law.

### **Complainants**

The below named individuals and organizations file this complaint on behalf of themselves and their constituents, Texans with disabilities who will likely die if medical professionals are allowed to withhold health care services from them in the discriminatory manner dictated by the Guidelines.

DRTx is the organization designated pursuant to the federal Protection and Advocacy Acts<sup>5</sup> by the State of Texas as the Protection and Advocacy system for residents of this State with physical, mental, and developmental disabilities. DRTx is charged under these laws with investigating incidents of abuse and neglect committed against persons with disabilities, advocating for such individuals to ensure protection of their rights, and pursuing legal remedies in furtherance of these rights. DRTx files this Complaint on behalf of itself and its constituents, individuals with disabilities who are at risk of harm from the Guidelines' rationing scheme, together with our co-complainants, advocacy organizations from across the state and individuals with disabilities who live in the catchment area of the North Central Texas Trauma RAC.

ADAPT of Texas, based in Austin, Texas, is a grassroots statewide nonprofit disability rights organization that has groups throughout the state. ADAPT of Texas advocates for the rights of people with disabilities to live in the Community and have access to the same services, amenities, and programs as everyone else. ADAPT believes people with disabilities to be of equal value to any other person, to have the same right

---

<sup>3</sup> Allie Morris and Robert T. Garrett, *Texas sets new COVID-19 records Wednesday in key metrics*, THE DALLAS MORNING NEWS, July 8, 2020, available at <https://www.dallasnews.com/news/public-health/2020/07/08/texas-sets-new-covid-19-records-wednesday-in-key-metrics/>.

<sup>4</sup> Reese Oxner, et. al., *Texas is heading down a dangerous path, local leaders warn as coronavirus cases and hospitalizations surge*, THE TEXAS TRIBUNE, June 22, 2020, available at <https://www.texastribune.org/2020/06/22/texas-coronavirus-cases-hospitalizations-austin-houston-dallas/>.

<sup>5</sup> Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15041 *et seq.*; The Protection and Advocacy for Individuals with Mental Illness Act, as amended, 42 U.S.C. § 10801, *et seq.*; the Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e.

to live as anyone else, to have the same right to treatment as anyone else, and that the value of the lives of people with disabilities is not tied to their abilities or impairments. People with disabilities should not have to fear those who purport to heal them.

The Arc of Texas promotes, protects, and advocates for the human rights and self-determination of Texans with intellectual and developmental disabilities (IDD). As a statewide membership organization, The Arc of Texas works alongside and for Texans with IDD and their families to identify barriers to and solutions for inclusive education, competitive integrated employment, quality community-based services and supports, and access to civil rights and justice. The Arc of Texas supports its members in various ways, from informing state-level policies to training members to advocate for themselves at state agencies and the Texas Capitol. In addition to direct policy and advocacy work, The Arc of Texas organizes and facilitates numerous programs that train, educate, and connect diverse stakeholders. In its more than 65 years of existence, The Arc of Texas continuously proves that Texans with IDD are valuable members of their communities and can make decisions for themselves, particularly when proper supports and services are available. Unfortunately, The Arc of Texas must also work tirelessly to dispel harmful myths against Texans with IDD, including that they do not have a high quality of life. Rationing healthcare for individuals with disabilities is unacceptable, and The Arc of Texas joins others to demand that harmful and discriminatory practices are prohibited during the COVID-19 pandemic and all future emergencies.

The Coalition for Texans with Disabilities (CTD) is a statewide, non-profit, cross-disability advocacy organization founded in 1978 and directed by people with disabilities. In its policy work, CTD consistently advocates for access to health care in an environment that rejects discrimination based on disability.

Protect TX Fragile Kids (PTFK) is a nonprofit organization founded and run by parents of medically fragile Texas children. PTFK's stated mission is to give a voice to Texas' most fragile citizens; to inform, educate, and support families of children with disabilities; to fight for what is right for children with special medical needs and disabilities; to champion public policy which supports and protects the well-being of children with disabilities and complex medical needs; to monitor existing and proposed legislation impacting children with disabilities; and to empower families with children who have disabilities and complex medical needs to connect with elected officials in order to promote understanding of this life.

Texas Appleseed's mission is to promote social and economic justice for all Texans by leveraging the skills and resources of volunteer lawyers and other professionals to identify practical solutions to difficult, systemic problems. As a 501(c)(3) public interest justice center, Texas Appleseed works to change unjust laws and policies by conducting data-driven research that uncovers inequity in laws and policies and identifies solutions for meaningful change, policy advocacy, impact litigation, and working closely with grassroots community organizing groups. Texas Appleseed projects include those focused on Criminal Justice, Juvenile Justice and Homeless Youth, Education Justice, Fair Financial Services, Foster Care Reform, and Disaster Recovery and Fair Housing. Texas Appleseed's work focuses on people involved in the criminal justice system, children involved in the juvenile justice and foster care systems, homeless youth, people with disabilities, and communities of color, all of whom are disproportionately at risk of contracting COVID-19 and, therefore, disproportionately affected by the Guidelines.

In addition to these organizations, this Complaint is brought by the following individuals:

Blake Pyron, 24, lives with Down Syndrome, a heart condition, and sleep apnea. He resides at home with his parents in Denton County. After graduating from high school, Blake started his own business, Blake's Snow Shack, in Sanger, Texas. Blake is a Texas Ranger's fan and loves country music. As a self-advocate, Blake lobbied the Texas Legislature for fair wages for persons with disabilities, which culminated in the passage of a minimum wage bill for persons with disabilities. As a National Down Syndrome Society Ambassador, Blake spoke at a United Nations conference on the employment of persons with disabilities and rang the opening bell at the New York Stock Exchange. Recently, on behalf of Blake and other persons with disabilities, his mother participated in a public service announcement called "Coronavirus: Loved Ones of Those at Risk."<sup>6</sup> Blake is worried about what will happen to him if he is admitted to the hospital during the COVID-19 pandemic especially given the North Texas Guidelines. He wants to be treated the same as everyone else and wants to make sure that other people with disabilities are also treated the same. Blake and his family have a reasonable fear that he will be denied life-saving medical care under the Guidelines for Adults due to his disabilities.

Julie Espinoza, 55, is a grandmother and resident of Collin County with multiple disabilities. She was diagnosed with juvenile rheumatoid arthritis which has caused permanent damage, despite her being the first child to ever receive an artificial hip replacement. She is a two-time cancer survivor, has severe scarring in her lungs, and has relearned how to speak and use the left side of her body after a stroke. She uses an electric wheelchair and works as a social worker at her local Center for Independent Living, helping people with disabilities accommodate their limitations and have control over the lives they wish to live.<sup>7</sup> Based on her life experience and her experience with institutional care during her stroke recovery, Julie reasonably believes that the medical system has a low opinion of her quality of life, though she finds great enjoyment in her life with her husband, daughters, and grandsons. Julie has a reasonable fear of being denied life-saving medical care under the Guidelines for Adults due to her multiple disabilities.

Katie<sup>8</sup> is 23 years old and has spastic cerebral palsy due to an anoxic brain injury from a placental abruption at 35 weeks gestation and delayed delivery. She also has seizure disorder, chronic lung disease, legal blindness, dysphagia, and gastrostomy tube dependence. Katie lives with her parents in Collin County. Her parents have a reasonable fear of Katie being denied life-saving care under the Guidelines for Adults due to Katie's pre-existing conditions and neurological status.

Matthew is 22 years old and has muscular dystrophy. His respiratory status is compromised, he is nonverbal, and he requires a wheelchair for mobility. Matthew lives at home in Collin County with his parents. His parents have a reasonable fear of Matthew being denied life-saving care under the Guidelines for Adults due to his pre-existing conditions and neurological status.

Hannah, 9, lives with hypoxic-ischemic encephalopathy due to a placental abruption at 32 weeks gestation. Hannah, who is Black, also has epilepsy, chronic lung disease, and developmental delays. Hannah lives

---

<sup>6</sup> The video is available at <https://youtu.be/uEKqjQVdyKg>.

<sup>7</sup> Julie recently recorded a video report on the impact of COVID-19 on individuals with disabilities. The video can be found at <https://www.facebook.com/watch/?v=303839744151845>.

<sup>8</sup> Pseudonyms are being used to protect the identities of Katie, Matthew, and Hannah.

with her mother in Tarrant County. Hannah’s mother has a reasonable fear of Hannah being denied life-saving care under the Guidelines for Children due to her pre-existing conditions and neurological status.

This Complaint follows similar actions filed with the Office of Civil Rights against state crisis standards of care in Washington, Alabama, Tennessee, Utah, Kansas, New York, Pennsylvania, North Carolina, Oregon, and Oklahoma and incorporates by reference the legal arguments set forth in the Washington complaint.<sup>9</sup>

### **North Texas Guidelines for Adults and Children**

#### *A. The Development and Use of the Guidelines in North Texas*

In Texas, the Department of State Health Services (DSHS) has delegated the development, implementation, and maintenance of regional trauma and emergency healthcare systems to Regional Advisory Councils (“RACs”).<sup>10</sup> 25 TEX. ADMIN. CODE § 157.123(a)-(b). DSHS’s Bureau of Emergency Management is responsible for recognizing a RAC and approving of the RAC’s emergency medical services and trauma services plan, including trauma treatment guidelines. *Id.* The Bureau is likewise responsible for oversight of a RAC, including reviewing and evaluating a RAC’s performance. *Id.* at § (b)(3)(Y). There are twenty-two RACs in the state, each of which is responsible for developing, implementing, and monitoring the provision of emergency medical services under their trauma services plan in their geographic area.<sup>11</sup> The membership of RACs generally consists of healthcare entities like hospitals, physicians, nurses, EMS providers, and other individuals interested in trauma care and injury prevention.<sup>12</sup> Organizations and individuals representing the rights of persons with disabilities or older adults are not typically members.

The North Central Texas Trauma RAC is the largest RAC in the state and is responsible for almost eight million Texans who reside in the Dallas-Fort Worth and Denton metro areas and the surrounding eighteen counties.<sup>13</sup> Since 2017, the North Central Texas Trauma RAC has also provided services to two neighboring RACs—the North Texas RAC (comprised of ten additional counties<sup>14</sup>) and the Big Country RAC (comprised of sixteen additional counties<sup>15</sup>).<sup>16</sup> Its members include many, if not most, of the emergency medical services providers in the area, including but not limited to the City of Dallas Fire & Rescue and Fort Worth Fire Department, and large hospital systems, including Baylor and Baylor Scott & White, Cook Children’s, Medical City, Methodist, and Texas Health Resources hospitals. In all, the

---

<sup>9</sup> These OCR complaints are available at <https://www.centerforpublicrep.org/covid-19-medical-rationing/>

<sup>10</sup> See also Texas Department of State Health Services, *Regional Advisory Councils*, <https://www.dshs.texas.gov/emstraumasystems/etrarac.shtm>.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> The counties included in the North Central Texas Trauma RAC are Dallas, Tarrant, Denton, Kaufman, Cooke, Grayson, Fannin, Wise, Collin, Hunt, Palo Pinto, Parker, Rockwall, Erath, Somervell, Wood, Johnson, Ellis, and Navarro. North Central Texas Trauma RAC, *About NCTTRAC*, <https://ncttrac.org/about-us/>.

<sup>14</sup> This area includes the city of Wichita Falls and Hardeman, Foard, Wilbarger, Wichita, Clay, Archer, Montague, Jack, Young, and Baylor counties.

<sup>15</sup> This area includes the city of Abilene and Knox, Stonewall, Haskell, Throckmorton, Fisher, Jones, Shackelford, Stephens, Mitchell, Nolan, Taylor, Callahan, Eastland, Coleman, Brown, and Comanche counties.

<sup>16</sup> North Central Texas Trauma RAC, *About NCTTRAC*, <https://ncttrac.org/about-us/>.

North Central Texas Trauma RAC serves more than 26% of the population of Texas, or approximately 2% of the entire population of the United States.<sup>17</sup>

The Guidelines for Adults and the Guidelines for Children were developed between 2010 and 2014 by the North Texas Mass Critical Care Task Force,<sup>18</sup> a taskforce independent of the RAC. The Task Force membership that developed both sets of Guidelines overlaps with the North Central Texas Trauma RAC membership and includes representatives from Baylor, Methodist, Children’s Medical Center, and UT Southwestern hospitals; Dallas County Health and Human Services Department; and members of the Dallas and Tarrant county medical societies.<sup>19</sup> The North Central Trauma RAC contributed to and/or explicitly endorsed the Guidelines after their publication in 2014.<sup>20</sup> In March, 2020 in the face of the coronavirus pandemic, the North Texas Mass Critical Care Task Force reaffirmed both Guidelines with no modifications as the triage framework to use when demand for medical services outstrips supply.<sup>21</sup>

Based on their contributions to and/or explicit endorsement of the Guidelines, it is Complainants’ belief that the North Central Trauma RAC and its members are following or will soon begin following the Guidelines when rationing of healthcare resources begins in the forty-four counties served or assisted by the North Central Texas Trauma RAC. It is clear that these Guidelines have already been activated, that hospitals and healthcare facilities are authorized to apply them, and that Texans with disabilities and co-morbid conditions are at imminent risk of being denied life-saving treatment pursuant to them.<sup>22</sup>

---

<sup>17</sup> *Id.*

<sup>18</sup> Steven Harrell, *In Case of Emergency: The North Texas Mass Critical Care Task Force Presents Guidelines for Resource Management During Medical Emergencies*, DALLAS MEDICAL JOURNAL, January 2014 at 6-7, available at [https://www.dallas-cms.org/tmimis/dcms/assets/files/communityhealth/MCC/DMJ\\_JAN14\\_NTXMCC.pdf](https://www.dallas-cms.org/tmimis/dcms/assets/files/communityhealth/MCC/DMJ_JAN14_NTXMCC.pdf).

<sup>19</sup> *Id.* at 7.

<sup>20</sup> *Id.*

<sup>21</sup> Dallas County Medical Society, *North Texas Mass Critical Care Guidelines*, <https://www.dallas-cms.org/tmimis/DCMS/PublicHealth/MassCriticalCare/DCMS/PublicHealth/MassCriticalCare.aspx>.

<sup>22</sup> Under the plain language of the Guidelines, they are “activated in the event the governor declares a pandemic respiratory crisis or other public health emergency that has the potential to overwhelm available intensive care resources.” Guidelines for Adults at 1; Guidelines for Children at 1. On March 13, 2020, Governor Abbott issued a disaster proclamation declaring COVID-19 poses an imminent threat of disaster. PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, March 13, 2020, [https://gov.texas.gov/uploads/files/press/DISASTER\\_covid19\\_disaster\\_proclamation\\_IMAGE\\_03-13-2020.pdf](https://gov.texas.gov/uploads/files/press/DISASTER_covid19_disaster_proclamation_IMAGE_03-13-2020.pdf). This proclamation has been renewed each subsequent month since. PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, April 12, 2020, <https://gov.texas.gov/news/post/governor-abbott-extends-disaster-declaration-for-covid-192>; PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, May 12, 2020, [https://gov.texas.gov/uploads/files/press/DISASTER\\_renewing\\_covid19\\_disaster\\_proclamation\\_No\\_2\\_IMAGE\\_05-12-2020.pdf](https://gov.texas.gov/uploads/files/press/DISASTER_renewing_covid19_disaster_proclamation_No_2_IMAGE_05-12-2020.pdf); PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, June 11, 2020, [https://gov.texas.gov/uploads/files/press/DISASTER-Renewing-Covid19-Disaster-Proclamation\\_06-11-2020.pdf](https://gov.texas.gov/uploads/files/press/DISASTER-Renewing-Covid19-Disaster-Proclamation_06-11-2020.pdf); PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, July 10, 2020, <https://gov.texas.gov/news/post/governor-greg-abbott-renews-covid-19-disaster-declaration>. On June 25, 2020 the Governor issued an executive order regarding hospital capacity, postponing all not medically necessary procedures at all hospitals in Dallas County. Tex. Exec. Order GA-27, [https://gov.texas.gov/uploads/files/press/EO-GA-27\\_hospital\\_capacity\\_COVID-19.pdf](https://gov.texas.gov/uploads/files/press/EO-GA-27_hospital_capacity_COVID-19.pdf). On July 9, Governor Abbott issued a proclamation suspending elective surgeries in 11 out of 22 RACs in the State, including in the North Central Texas Trauma RAC. PROCLAMATION OF THE GOVERNOR OF THE STATE OF TEXAS, July 9, 2020 [https://gov.texas.gov/uploads/files/press/DISASTER\\_amending\\_GA-27\\_adding\\_more\\_counties.pdf](https://gov.texas.gov/uploads/files/press/DISASTER_amending_GA-27_adding_more_counties.pdf).

B. *The Need for Non-Discriminatory Guidelines in Texas and the Use of the Guidelines during the COVID-19 Pandemic*

On March 28, 2020, your Office issued a Bulletin on Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19). This Bulletin directed that civil rights laws prohibiting discrimination on the basis of disability and age in HHS-funded health programs or activities “remain in effect,” including as they apply to the delivery of life-saving care and treatment during the COVID-19 outbreak.<sup>23</sup> In light of this, on April 6, 2020, DRTx, joined by seventeen organizations and a medical doctor, wrote to Governor Greg Abbott asking that state officials take specific steps to ensure that life-saving care is not illegally withheld from individuals with disabilities due to discriminatory resource allocation or standards of care.<sup>24</sup> Advocates urged the Governor to immediately issue mandatory statewide guidance detailing what Texas health care providers must do to care for the lives of all Texans, consistent with the obligations placed on healthcare providers by the ADA and Section 504 as detailed in the OCR Bulletin. On July 1, 2020, faced with a rapidly worsening pandemic in Texas and the continued lack of statewide guidance governing healthcare rationing, DRTx renewed its call to the Governor to issue statewide guidance that prohibited discrimination against persons with disabilities.<sup>25</sup> As of the date of this Complaint, the Governor has not responded to either of these letters. As a result, Texas still has no statewide guidance, leaving the Guidelines in effect in North Texas.

C. *Legal Standards*

Title II of the ADA prohibits public entities (such as state and local governments) from excluding people with disabilities from their programs, services, or activities, denying them the benefits of those services, programs, or activities, or otherwise subjecting them to discrimination. 42 U.S.C. §§ 12131-12134. Implementing regulations promulgated by the United States Department of Justice (“DOJ”) define unlawful discrimination under Title II to include, *inter alia*: using eligibility criteria that screen out or tend to screen out individuals with disabilities, failing to make reasonable modifications to policies and practices necessary to avoid discrimination, and perpetuating or aiding discrimination by others. 28 C.F.R. §§ 35.130(b)(1)-(3), 35.130(b)(7)-(8). Moreover, DOJ has explicitly instructed that Title II of the ADA applies to emergency preparedness efforts of state and local governments, writing:

One of the primary responsibilities of state and local governments is to protect residents and visitors from harm, including assistance in preparing for, responding to, and recovering from emergencies and disasters. State and local governments must comply with Title II of the ADA in the emergency- and disaster-related programs, services, and activities they provide.<sup>26</sup>

---

<sup>23</sup> HSS Office for Civil Rights, Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) at 1, (March 28, 2020); available at <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>.

<sup>24</sup> Available at <https://media.disabilityrightstx.org/wp-content/uploads/2020/04/07195541/C19-Request-for-Guidance-Letter-public-doc-1.pdf>.

<sup>25</sup> Available at <https://media.disabilityrightstx.org/wp-content/uploads/2020/07/01024349/20200701-Letter-to-Texas-Officials-to-Issue-Guidance-on-Rationing.pdf>.

<sup>26</sup> See, DOJ, Emergency Management Under Title II of the Americans with Disabilities Act at 1 (July 26, 2007), available at <https://www.ada.gov/pcatoolkit/chap7emergencymgmt.htm>.

Section 504 of the Rehabilitation Act similarly bans disability discrimination by recipients of federal financial assistance, including the North Central Texas Trauma RAC,<sup>27</sup> Texas agencies, and most hospitals and health care providers. 29 U.S.C. § 794(a). The breadth of Section 504’s prohibition on disability discrimination is co-extensive with that of the ADA. *See, e.g., Frame v. City of Arlington*, 657 F.3d. 215, 223 (5<sup>th</sup> Cir. 2011) (“The ADA and the Rehabilitation Act are generally interpreted *in pari materia*.”).

The Age Discrimination Act of 1975 (the Age Act), prohibits discrimination on the basis of age in programs or activities that receive federal financial assistance. 42 U.S.C. §§ 6101-6107. No person in the United States shall, on the basis of age, be excluded from participation, in be denied the benefits of, or be subjected to discrimination under such a program. 34 C.F.R. § 110.10(a).

Section 1557 of the ACA provides that no health program or activity that receives federal funds may exclude from participation, deny the benefits of their programs, services or activities, or otherwise discriminate against a person protected under Section 504 of the Rehabilitation Act. 42 U.S.C. § 18116; 45 C.F.R. §§ 92.101(a), 92.101(b)(2)(i). This includes an obligation to make reasonable modifications in policies, practices, and procedures necessary to avoid discrimination. 45 C.F.R. § 92.205. It also incorporates the Age Act’s prohibition of discrimination on the basis of age in health programs and activities. 42 U.S.C. § 18116.

Section 1557 also forbids discrimination on the basis of race, color, or national origin in the delivery of health care through its incorporation of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, *et seq.* 42 U.S.C. § 18116. Pursuant to 28 C.F.R. § 42.104, Title VI makes illegal any criteria or methods of administration that screen out persons on the basis of race, color, or national origin. The law also certainly prohibits intentional discrimination, which includes deliberate indifference to anticipated impacts.

### **The Guidelines’ Triage Assessment Process Violates Federal Law**

Both Guidelines are based on three “basic premises”<sup>28</sup> to which each health care organization will adhere. Though they were reaffirmed in March, 2020 after the COVID-19 pandemic had begun, neither set of Guidelines mentions or incorporates the principles of the OCR Bulletin nor any applicable federal civil rights law. There are no safeguards against unconscious bias nor guidance on how to avoid discriminatory application of triage principles against persons with disabilities, older adults, or persons with underlying, co-morbid conditions. The deliberate omission of these principles suggests, or at least allows, healthcare providers to make life-saving treatment decisions without guidance or even consideration of applicable federal law. The likely results, in contravention to the OCR Bulletin, are discriminatory decisions that severely prejudice persons with disabilities and co-morbidities, older adults, and people of color. In fact, some provisions of the Guidelines, like the exclusionary criteria discussed below, explicitly do so.

---

<sup>27</sup> The North Central Texas Trauma RAC is the recipient of federal grant funds. North Central Texas Trauma RAC, *About NCTTRAC*, <https://ncttrac.org/about-us/>.

<sup>28</sup> The premises are (1) “Graded guidelines should be used to control resources more tightly as the severity of a pandemic increases;” (2) “Priority should be given to patients for whom treatment most likely would be lifesaving...”; and (3) “Under a declared state of emergency, the governor maintains the authority to supersede healthcare regulations or statutes that may come into conflict with these guidelines.” Guidelines for Adults at 1; Guidelines for Children at 1. The second “basic premise” is the one at the heart of this Complaint.



The alleged “major goal” of the Guidelines is to “save as many lives as possible”<sup>29</sup> or, as the Guidelines themselves say, to give “priority...to patients for whom treatment most likely would be lifesaving and whose functional outcome most likely would improve with treatment.” Guidelines for Adults at 1; *see also* Guidelines for Children at 1.<sup>30</sup> The priority system is implemented by an Algorithm, which on its face and as applied, is plainly discriminatory.

As noted *supra*, under Governor Abbott’s June 25, 2020 and July 9, 2020 executive orders, the counties of the North Central Texas Trauma RAC are already at Triage Level 1.<sup>31</sup> With rapidly growing rates of COVID-19 cases in the area, hospitals may move to Triage Level 2 shortly. Under the allocation Algorithm in the Guidelines, individuals who meet certain “exclusionary criteria” are “excluded from hospital admission or transfer to critical care.” *Id.* at 2, 4-5. These same exclusionary criteria additionally apply to restrict access to Intensive Care Units (ICUs) and to ventilators. *Id.* at 5. As explained in more detail *infra*, the exclusionary criteria under both sets of Guidelines explicitly discriminate against individuals with disabilities and co-morbid medical conditions, with disparate impacts on older adults as well as Black and Hispanic people. Individuals with even one exclusionary criteria are automatically assigned the lowest priority and assumed to have the “lowest chance of survival even with treatment.” Guidelines for Adults at 4. Individuals in this group are automatically discharged to their homes or to palliative care. *Id.*; Guidelines for Children at 4. Even if a child or adult does not present at the hospital with an exclusionary criterion, if one develops during the admission, the same consequences are imposed. *Id.* In effect, the presence of even one exclusionary criterion is equivalent to a death sentence, or at least a total prohibition on receiving any life-saving care.

For adults who are not excluded outright at the beginning of the triage process, the Algorithm additionally sorts individuals into three priorities—Low Priority (presumed lowest chance of survival even with treatment<sup>32</sup>), Intermediate Priority (higher chance of survival than those in “Low” group with treatment, but lower than those in “Highest Priority” group); and Highest Priority (presumed highest chance of survival with treatment). Guidelines for Adults at 4. This sorting is done using the Modified Sequential Organ Failure Assessment (MSOFA) Score. *Id.* As with the Exclusionary Criteria and as discussed in more detail *infra*, the MSOFA scoring system also discriminates against individuals with disabilities and

---

<sup>29</sup> Dallas County Medical Society, North Texas Mass Critical Care Guidelines, *available at* <https://www.dallas-cms.org/tmimis/DCMS/PublicHealth/MassCriticalCare/DCMS/PublicHealth/MassCriticalCare.aspx>.

<sup>30</sup> The Guidelines for Children express the premise as “Priority should be given to patients for whom treatment would most likely be lifesaving” and do not mention functional outcomes. Guidelines for Children at 1.

<sup>31</sup> There are three Triage Levels under the Guidelines:

- Triage Level 1 where outpatient procedures are cancelled but the Algorithm: Hospital and ICU/Ventilator Admission Triage (“Algorithm”) is not yet being used; Guidelines for Adults at 2; Guidelines for Children at 2.
- Triage Level 2 during which hospitals have “surged to maximum bed capacity, and emergency departments are overwhelmed. There are not enough beds to accommodate all patients needing hospital admission and not enough ventilators to accommodate all patients with respiratory failure.” Physician Offices, Clinics, EMS, institutional staff, and hospitals begin using the Algorithm. *Id.* 2-5;
- Triage Level 3: Hospitals are implementing “altered standards of care regarding nurse/patient ratios and have expanded capacity by adding patients to occupied hospital rooms.” Healthcare professionals are continuing to use the Algorithm. *Id.*

<sup>32</sup> This group also includes those who have the highest chance of survival without any treatment and are thus also sent home without hospitalization. For purposes of this Complaint, when the “Low Priority” group is discussed, this subgroup is excluded from the discussion since the determination that they have the highest likelihood of survival without treatment largely does not indicate disability, race, or age-related discrimination against members of this group.

co-morbid medical conditions, resulting in these individuals being excluded from receiving care or given a lower priority for receiving care.

*A. Categorical Exclusions Unaccompanied by Individualized Review of the Patient's Current, Objective Medical Evidence Constitute Discrimination*

The Guidelines' rigid reliance on the exclusion criteria and the MSOFA scores without providing for reasonable modifications for pre-existing conditions and disabilities dramatically increase the likelihood that individuals with disabilities, older adults, and individuals from communities of color will be denied life-saving care based on discriminatory assumptions about their quality of life or structural inequities that may impact overall life expectancy.

*1. Exclusionary Criteria under the Guidelines for Adults*

The exclusionary criteria included in the Guidelines constitute impermissible disability discrimination since they are based on diagnoses and broad functional impairments rather than an individualized assessment that a person is unlikely to benefit from treatment. Under the Guidelines, only one exclusionary criterion need be present before an individual is denied further life-sustaining or life-saving treatment.<sup>33</sup> Guidelines for Adults at 4. There are three significant, discriminatory impacts of these criteria.

First, many, if not, all of the criteria explicitly target certain disabling, pre-existing, or co-morbid conditions that are facially discriminatory and violate federal law. For instance, persons with certain neuromuscular conditions, like ALS, are wholly excluded from access to life-saving care.

Second, the scoring system for determining the severity of a disabling, pre-existing, or co-morbid condition is itself discriminatory, by negatively weighting (and thus de-prioritizing) certain conditions and their impacts on long-term functioning,

Finally, none of the exclusionary criteria allow for accommodations for persons with disabilities and many, if not most, of the scoring systems are based on "survivability" that is unrelated to COVID-19.

For example, the Guidelines for Adults, automatically exclude persons with "severe" dementia, which the guidelines indicate is dementia that is being medically treated and requires assistance with activities of daily living, as well as advanced untreatable neuromuscular disease (such as ALS or end-state MS), requiring assistance with activities of daily living or chronic ventilatory support.<sup>34</sup> *Id.* at 5. Exclusionary criteria based solely on the existence of a diagnosis like dementia, ALS, or MS, combined with needing assistance to complete a motor task like walking or brushing one's teeth, illegally disadvantages people with disabilities and older adults. In fact, given the documented higher rates of dementia among older

---

<sup>33</sup> The Guidelines serve to exclude individuals from accessing not only COVID-19 treatment but any treatment that would require hospitalization, placement in an ICU, or a ventilator in order to "preserve" these resources for other individuals who may need them. Thus an individual with a disability could present to a hospital with a survivable but acute care need unrelated to COVID-19 and be turned away under these guidelines.

<sup>34</sup> "Activities of daily living" is an umbrella term encompassing everything from eating and walking to basic hygiene.

adults of color, such criteria engage in intersectional discrimination on the basis of age and race.<sup>35</sup> In addition, by failing to require individualized assessments about their ability to benefit from treatment, the application of the criteria reflect generalized assumptions about categories of persons with disabilities and diagnostic conditions. Similarly, the exclusion of individuals with neuromuscular disease who are on ventilators clearly discriminates against individuals whose disability requires use of this medical equipment, without requiring an analysis of how it may impact their ability to benefit from treatment.

The Guidelines rely heavily on other assessment instruments which themselves are problematic and reflect generalized assumptions about categories of disabilities, including the New York Heart Association (“NYHA”) Functional Classification System and Pugh Scores. *Id.* The NYHA system is based on perceived “quality of life.” *Id.* at 7. The NYHA classification system has been criticized for being subjective,<sup>36</sup> with significant variations based on what an individual healthcare professional interprets “ordinary physical activity” and “slight or marked limitations.”<sup>37</sup> In addition, the classification system disadvantages individuals with circulatory and/or cardiac conditions and mobility impairments and results in decision-making based on disabilities or co-morbidities rather than whether the individual will survive in the short-term or survive COVID-19. The other evaluation instruments and classification systems similarly disadvantage and discriminate against persons with respiratory conditions,<sup>38</sup> organ dysfunctions,<sup>39</sup> acute or traumatic conditions,<sup>40</sup> and other diagnoses and disabilities.

---

<sup>35</sup> Cynthia Chen and Julie M. Zissimopoulos, *Racial and ethnic differences in trends in dementia prevalence and risk factors in the United States*, 4 ALZHEIMER’S & DEMENTIA 510-520 (2018), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6197734/>.

<sup>36</sup> J.A. Bennett *et al.*, *Validity and reliability of the NYHA classes for measuring research outcomes in patients with cardiac disease*. 31 HEART LUNG 262-270 (2002), cited in Milton Severo, *et al.*, *Indirect calibration between clinical observers-application to the New York Heart Association functional classification system*, 4 BMC RES NOTES 276 (2011), available at <https://doi.org/10.1186/1756-0500-4-276>.

<sup>37</sup> Under the Guidelines, individuals are excluded from care when they are in Class III or higher in the NYHA system. Guidelines at 5. Class III simply requires that the person be “comfortable at rest, but less than ordinary activity causes fatigue, palpitations, or dyspnea.” *Id.* at 7.

<sup>38</sup> The exclusionary lung criteria include specific medical test scores; however, an individual is excluded from hospital admission, ICU admission, and access to a ventilator *only* if they have that score *and* Chronic Obstructive Pulmonary Disease (“COPD”), Cystic Fibrosis, pulmonary fibrosis, and primary pulmonary hypertension. *Id.* at 5. Individuals with these disorders are thus singled-out for denial of care. Because primary pulmonary hypertension is more common in individuals who are Black or Hispanic compared to those who are white, this exclusionary criteria may also disproportionately disadvantage individuals from these groups. Nadine Al-Naamani, *et al.*, *Racial and ethnic differences in pulmonary arterial hypertension*, 7 PULM. CIRC. 793-796 (Dec. 2017), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5703127/>. Similarly, the COPD exclusion may discriminate against older adults, as they are disproportionately misdiagnosed with COPD. See David P. Johns, *et al.*, *Diagnosis and early detection of COPD using spirometry*, 6 J. THORAC. DIS. 1557-1569 (Nov. 2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255165/> citing C.A. Vaz Fragoso, *et al.*, *The ratio of FEV<sub>1</sub> to FVC as a basis for establishing chronic obstructive pulmonary disease*, 181 AM. J. RESPIR. CRIT. CARE MED. 446-51 (2010).

<sup>39</sup> The last organ failure score is the Pugh Score, under which hospital admission, ICU admission, and ventilators are denied to anyone whose score is higher than 7 on the scale. *Id.* at 5. Individuals with a score of 7 on the Pugh scale are considered to have moderate liver damage and have a life expectancy greater than three years but less than 15. *Id.*

<sup>40</sup> In addition to excluding individuals based on their current disabilities and co-morbidities, the Guidelines also deny hospital admission and life-saving care to certain more acute conditions—like burns and traumatic injuries—and thus illegally discriminate against people with disabilities or co-morbidities and older adults who suffer these acute injuries. The Guidelines for Adults automatically exclude individuals with “traumatic injury” where the individual has a Trauma Score below 2 under the Revised Trauma Score (“RTS”) range provided on page 6 of the Guidelines. The RTS includes the Glasgow Coma Scale which disadvantages individuals with communication and mobility impairments who may not be able to give the appropriate response to the examination. *Id.* at 6. Individuals with certain disabilities are thus predisposed to score lower on the RTS;

These exclusionary criteria are not based upon a one-time analysis. Rather, adults who are hospitalized under the Algorithm are reassessed daily to determine whether they have developed one of the exclusionary criteria. *Id.* at 4. If they do, they are automatically discharged from receiving continued medical treatment and either sent home or provided only palliative care. *Id.*

## 2. Exclusionary Criteria under the Guidelines for Children

The exclusionary criteria under the Guidelines for Children, while fewer, are no less problematic than those in their adult counterpart. Under the Guidelines for Children, children with certain diagnoses<sup>41</sup> are automatically excluded from treatment based on their “short anticipated duration of benefit,” i.e., the overall predicted life expectancy of a child with a particular disorder. Even without regard to COVID-19, the “anticipated duration of benefit” determination is based entirely on diagnosis and overall predicted life expectancy; as the Guidelines for Children state, the exclusionary diagnoses chosen as examples are ones where eighty percent of children do not survive past two years.<sup>42</sup> These automatic exclusions, however, do not take into account the actual characteristics or medical condition of a given child. At least one recent study has suggested that children with the excluded conditions of Trisomy 13 and 18 are living longer, with ten percent of hospitalizations of children with these disorders being children over the age of eight.<sup>43</sup> It is not unheard of for children with Trisomy 18 to reach age twenty.<sup>44</sup> Of additional concern, some of these genetic conditions have statistically higher occurrence in populations of color—for example, Trisomy 18 is statistically more prevalent in Black and Native American communities<sup>45</sup>—raising concerns that these exclusionary criteria will not only discriminate against children with disabilities but also children from communities of color. Finally, the entire discussion of estimated “anticipated duration of

---

without accommodations, they are more likely to be determined ineligible for hospitalization to treat their acute injury and thus be left to die in order to preserve medical resources for someone else. The Guidelines also exclude individuals from hospitalization who have suffered from a severe burn based on a Triage Table that is based solely on age and percentage of the body that has been burned. *Id.* at 5, 7. Age alone can thus be the determining factor for whether or not someone is denied treatment under the Guidelines, running afoul of federal civil rights requirements.

<sup>41</sup> The listed disorders are provided as examples but are a non-exhaustive list. The disorders include Trisomy 13 and 18, metabolic diseases like Zellweger syndrome, spinal muscular atrophy type 1, progressive neuromuscular disorder, cystic fibrosis, and severe end-stage pulmonary hypertension. Guidelines for Children at 5.

<sup>42</sup> Automatically excluding children based on diagnoses that have an 80% mortality rate after the age of two begs the question of why the 20% who, due to their individual medical characteristics, have survived and/or will survive past the age of two are automatically excluded from life-sustaining and life-saving care during the pandemic.

<sup>43</sup> Carrie Gann, *Trisomy 18 and 13: More Children Like Bella Santorum Survive*, ABC News (April 6, 2012), available at <https://abcnews.go.com/Health/trisomy-18-kids-bella-santorum-rick-santorums-daughter/story?id=16090571> (Of note, the article emphasizes that “the children's ability to survive may depend on how they are treated and cared for within the medical system.”) quoting Katherine E. Nelson, *et. al.*, *Inpatient Hospital Care of Children with Trisomy 13 and Trisomy 18 in the United States*, 129 PEDIATRICS 869-76 (May 2012), abstract available at <https://pubmed.ncbi.nlm.nih.gov/22492767/> (“Conclusions...Despite the conventional understanding of these syndromes as lethal, a substantial number of children are living longer than 1 year....”);

<sup>44</sup> See e.g., Ricki Lewis, PhD, *A Very Special Birthday for a Young Man with Trisomy 18*, PLOS Blogs: DNA Science (September 5, 2013), available at <https://dnascience.plos.org/2013/09/05/a-very-special-birthday-for-a-young-man-with-trisomy-18/>.

<sup>45</sup> Centers for Disease Control and Prevention, *Differences in Major Birth Defects*, available at <https://www.cdc.gov/ncbddd/birthdefects/features/raciaethnicdifferences.html> (summarizing a study published in 2014 from the *American Journal of Public Health* examining the occurrence of major birth defects across racial and ethnic groups.)

benefit” is unrelated to any considerations of whether a child will survive COVID-19 and is instead solely limited to predictions about overall life expectancy.

As with the Guidelines for Adults, hospitalized children are reassessed daily “to determine continued priority for hospitalization.” *Id.* at 4. A child who develops even one exclusionary criterion is automatically discharged to home or palliative care. *Id.*

### 3. *Prioritization of Adult Care using MSOFA*

For adults who are not initially excluded from hospitalization under the exclusionary criteria, the Algorithm provides they be sorted into priority groupings based on their MSOFA scores.<sup>46</sup> Like the initial exclusionary criteria, the reliance on MSOFA without providing modifications for disability disproportionately and negatively impacts individuals with disabilities, older adults, and individuals with co-morbid conditions, because these individuals are more likely to receive higher MSOFA scores and thus be sorted into a lower priority category for treatment. Without providing reasonable modifications, the Guidelines will inevitably lead to the denial of life-saving care to people with disabilities, older adults, and individuals from communities of color based on levels of impairment occurring prior to the acute care episode. Each of the five variables that constitute the MOSFA can each be impacted by disabilities or co-morbid medical conditions, yet do not factor in any accommodations, the stability of any underlying condition, or what bearing the measurement has on short-term or COVID-19 survival.<sup>47</sup>

Taken as a whole, the MSOFA disadvantages individuals with certain disabilities and/or co-morbidities, including older adults and people of color, who are more likely to score higher than others without that disability. These measures are not specific to COVID-19 but inappropriately factor in the overall physical condition of the individual without providing accommodations for disabilities to the rigid scoring system.

---

<sup>46</sup> The MSOFA relies upon five variables—certain respiratory scores, the presence of jaundice, hypotension measurements, the Glasgow Coma Score, and creatinine level. Guidelines for Adults at 5. The score an individual receives for each variable is added together to obtain an overall MSOFA score. *Id.* Scores ranging from 1 to 7 are assigned the highest priority for receiving care and hospitalization and are presumed to have the highest chance of survival with treatment. *Id.* at 4. Individuals with scores between 8 and 11 are assigned intermediate priority. *Id.* During a severe pandemic, these individuals receive secondary priority to those in the highest priority group. *Id.* Individuals with scores over 11 are assigned lowest priority, presumed to have the lowest chance of survival generally, and are automatically excluded from care—they are sent home or to palliative care only. *Id.* For those in the highest and intermediate priority groups who are admitted to the hospital (either into an ICU or to a general floor), these individuals are reassessed daily. *Id.* If they develop one of the exclusionary criterion or their MSOFA score increases, they can move from the highest priority group to the intermediate group or from the intermediate group to lowest, where they are discontinued from life-saving care and transferred home or to palliative care. *Id.* For those who are admitted to the ICU and receive ventilator support in the intermediate priority group, when the pandemic reaches Triage Level 3, these individuals may be discontinued from their ventilators and moved out of the ICU. *Id.*

<sup>47</sup> For example, the respiratory variable assigns higher scores to individuals who receive oxygen via nasal cannula or mask, with the score increasing as more oxygen per minute is required. *Id.* at 5. This calculation is without regard to whether the need for oxygen is based on a pre-existing but stable respiratory condition or whether the increased need for oxygen is based on COVID-19. Individuals who already require oxygen to manage their medical condition are automatically disadvantaged under this variable; indeed, the more oxygen one requires without COVID-19, the more disadvantaged one is. *Id.* Creatinine levels, another of the five variables, correspond to kidney function, which means that consideration of this score without accommodations may also disproportionately impact Black and Hispanic individuals who are more likely to have kidney disease than whites. See National Kidney Foundation, Race, Ethnicity, & Kidney Disease, available at <https://www.kidney.org/atoz/content/minorities-KD>. Finally, one of the five measures is the Glasgow Coma Scale which disadvantages individuals with communication and mobility impairments as discussed *supra* at footnote 40.

Appropriate modifications missing from the Guidelines include an explicit directive that baseline comorbidities should not increase a patient's MSOFA scores unless objective medical evidence demonstrates the conditions directly impact an individual's short-term survivability with treatment. Alternatively, if the MSOFA score is used to place individuals in different priority categories, the scoring thresholds for each category could be increased for a particular patient in order to hold the patient harmless for underlying impairments that do not impact short-term survivability

4. *The Guidelines' Exclusionary Criteria and Prioritization using MSOFA Violate Federal Law*

Under the Guidelines for Adults and Guidelines for Children, triage teams automatically exclude individuals with chronic but stable underlying conditions, including individuals with disabilities, older adults, and members of communities of color when scoring individuals under the various systems. Some adults with disabilities are automatically excluded based solely on the existence of a degenerative diagnosis and the mere fact that they need assistance with a simple motor task, thus discriminating against individuals with these medical conditions and mobility impairments in addition to disproportionately excluding older adults who may be more likely to need simple assistance with activities of daily living. Certain children with disabilities are automatically excluded based on underlying diagnoses that generally have a low survivability rate without regard to the individual child's condition or short-term survivability of COVID-19.

The ADA and Rehabilitation Act bar the use of eligibility criteria that screen out or tend to screen out individuals with disabilities from access to services. *See, e.g.*, 42 U.S.C. § 12182(b)(2)(A)(i); 28 C.F.R. § 36.301 (ADA public accommodations); 28 C.F.R. § 35.130(b)(8) (ADA public entities). The Age Act also services to prevent the exclusion of older adults from receiving crucial services. *See, e.g.*, 42 U.S.C. § 6102. Persons with disabilities, older adults, and persons of color are more than likely to be excluded from accessing care altogether or screened out of high priority categories under the Guidelines because they have conditions that will automatically add points to their MSOFA score. This is true even if their underlying conditions are stable and have no impact on their ability to benefit from intensive care services, including ventilation.

Another core tenet of the ADA and Rehabilitation Act is that decisions by covered entities must not be based on myths, stereotypes, and unfounded assumptions about people with disabilities; rather, they must be based on individualized determinations using objective evidence. *See School Bd. of Nassau County v. Arline*, 480 U.S. 273, 284-85, 287 (1987). Your Office confirmed the need for individualized assessments in the March 28, 2020 bulletin.<sup>48</sup> The use of co-morbid diagnoses in instances in which a person's immediate-term survivability is not negatively impacted as a result of the diagnosis is directly contrary to this tenet.

---

<sup>48</sup> HSS Office for Civil Rights, Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) at 1 (March 28, 2020), available at <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>; *see also* HHS Office for Civil Rights, OCR Resolves Complaint with Tennessee After it Revises its Triage Plans to Protect Against Disability Discrimination (June 26, 2020), available at <https://www.hhs.gov/about/news/2020/06/26/ocr-resolves-complaint-tennessee-after-it-revises-its-triage-plans-protect-against-disability.html>.

Triage protocols cannot treat adults and children with disabilities as unqualified for life-saving care when those disabilities do not affect their ability to benefit from the treatment sought. “Long standing and authoritative interpretations of the law bar the use of such circular techniques to insulate disability discrimination from legal challenge.”<sup>49</sup>

Baseline levels of impairment prior to the acute episode, whether it is COVID-19 related or not, should not increase one’s score on any of these exclusionary scales unless objective medical evidence, interpreted by a medical professional with expertise necessary to exercise professional judgment under usual standards of care, demonstrates that those conditions directly impact an individual’s short-term survivability with treatment.

The Guidelines do not make reasonable accommodations to ensure that underlying disabilities or other co-morbid conditions not associated with COVID-19 infection or short-term survivability are not captured in the scoring process of these assessments. Examples of such appropriate accommodations may include specifically excluding consideration of underlying impairments where no compelling evidence exists that those conditions will impact short-term survivability.

Because the Guidelines for Adults and the Guidelines for Children exclude otherwise eligible individuals with disabilities from accessing necessary medical care during the pandemic without regarding to their anticipated short-term survival with treatment, they violate federal anti-discrimination laws and directives from the Office of Civil Rights.

*B. Lowering Patients’ Priority For Care Based on Underlying Co-morbid Conditions Exacerbates Underlying Inequities in the Health Care System.*

Reliance on criteria like co-morbidity and projected longevity increase the likelihood that individuals with disabilities and those more likely to have underlying chronic conditions, including older adults and people of color, will be denied life-saving care. The Guidelines reinforce current and historical inequities in access to health care and risk importing quality of life criteria and unconscious bias into the triage process. Similarly, attempts to predict and score patients based on long-term prognosis will lead to inconsistent and subjective decision-making, higher rates of clinical error, and discriminatory allocation of care.

People with disabilities and persons of color have long experienced discrimination in their access to medical and preventative health care.<sup>50</sup> Over time, this discriminatory treatment leads to more co-morbid conditions and lower than average longevity. For instance, people with psychiatric disabilities are among those with lower life expectancies due to co-morbidities associated with years of antipsychotic medication and related side-effects, a history of segregation and substandard treatment, and marginalization in access to health care.<sup>51</sup>

---

<sup>49</sup> Samuel R. Bagenstos, *May Hospitals Withhold Ventilators from COVID-19 Patients with Pre-Existing Disabilities? Notes on the Law and Ethics of Disability-Based Medical Rationing*, 130 YALE L. J. FORUM \_\_\_\_ (2020, Forthcoming); available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3559926](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3559926).

<sup>50</sup> See, e.g., Nat’l Council on Disability, *Organ Transplant Discrimination Against People with Disabilities* (Sept. 25, 2019), available at [https://ncd.gov/sites/default/files/NCD\\_Organ\\_Transplant\\_508.pdf](https://ncd.gov/sites/default/files/NCD_Organ_Transplant_508.pdf).

<sup>51</sup> World Health Organization, *Information Sheet: Premature death among persons with severe mental disorders* available at [https://www.who.int/mental\\_health/management/info\\_sheet.pdf\\_\(reporting\\_10-25\\_year\\_life\\_expectancy\\_reduction\)](https://www.who.int/mental_health/management/info_sheet.pdf_(reporting_10-25_year_life_expectancy_reduction)); Thomas

Likewise, communities of color have also experienced discrimination and marginalization in the delivery of health care, issues that continue in various forms today.<sup>52</sup> People of color are more likely to experience co-morbid medical conditions like asthma, diabetes, hypertension, and heart conditions<sup>53</sup> as a result of structural racism, environmental factors, occupational safety and health, and lack of access to health care.<sup>54</sup> These health conditions can directly or indirectly factor into the various scoring systems underpinning the Guidelines and result in their exclusion from care altogether or de-prioritization for hospitalization and receipt of intensive care under the Guidelines.

Data reported from states around the country illustrate the disproportionate impact of COVID-19 on communities of color.<sup>55</sup> In Texas, statewide and region-wide data is largely unavailable, with race unknown for many COVID-19 related fatalities in the state.<sup>56</sup> Even with limited data, COVID-19 rates among Black Texans is at least one-third higher than their share of the Texas population, and may be worse if and when accurate data is obtained.<sup>57</sup> In Tarrant County, one of the counties served by the North Central Texas Trauma RAC, Hispanic communities have been disproportionately affected—they account for at least 39% of reported cases in the county,<sup>58</sup> despite accounting for less than 30% of the population.<sup>59</sup>

---

Insel, Post by Former NIMH Director Thomas Insel: No Health Without Mental Health (September 6, 2011) *available at* <https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2011/no-health-without-mental-health.shtml> (Citing studies that “Americans with major mental illness die 14 to 32 years earlier than the general population.”); M. De Hert, *et al.*, *Physical Illness in Patients with Severe Mental Disorders*, 10 *WORLD PSYCHIATRY* 52 (2011) (people with serious mental illness (SMI) receive inadequate treatment by health care providers; “...stigmatization, discrimination, erroneous beliefs and negative attitudes associated with SMI will have to be eliminated to achieve parity in health care access and provision.”); and N. Liu, *et al.*, *Excess Mortality in Persons with Severe Mental Disorders: A Multilevel Intervention Framework and Priorities for Clinical Practice, Policy and Research Agendas*, 16 *WORLD PSYCHIATRY* 30 (2017) (Although persons with serious mental illness have two times as many health care contacts, they receive fewer physical check-ups and screenings, fewer prescriptions and less treatment for physical ailments than other patients.).

<sup>52</sup> For instance, African American women are three to four times more likely to die during or after child birth than are white women. Amy Roeder, *America is Failing its Black Mothers*, *HARVARD PUBLIC HEALTH MAGAZINE* (Winter 2019) *available at* [https://www.hsph.harvard.edu/magazine/magazine\\_article/america-is-failing-its-black-mothers/](https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/).

<sup>53</sup> U.S. Dep’t Health & Human Services, Office of Minority Health, Profile Black/African American *available at* <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61> (“The death rate for African Americans is generally higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.”)

<sup>54</sup> Jamila Taylor, *Racism, Inequity and Health Care for African Americans*, (The Century Foundation 2019) *available at* <https://tcf.org/content/report/racism-inequality-health-care-african-americans/?agreed=1>.

<sup>55</sup> See, Reis Thebault *et al.*, *The Coronavirus is Infecting and Killing Black Americans at an Alarming Rate*, *WASHINGTON POST*, April 7, 2020, *available at* <https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmpingly-high-rate-post-analysis-shows/?arc404=true>.

<sup>56</sup> Octavio N. Martinez Jr. and Andy Deller, *Opinion: Why we need race and ethnicity data in the COVID-19 fight*, *THE STATESMAN*, May 11, 2020, *available at* <https://www.statesman.com/opinion/20200511/opinion-why-we-need-race-and-ethnicity-data-in-covid-19-fight>.

<sup>57</sup> *Id.*

<sup>58</sup> Bryan Mena, *Hispanics most affected by coronavirus in Tarrant County as leaders call for action*, *FORT WORTH STAR-TELEGRAM*, July 6, 2020, *available at* <https://www.star-telegram.com/article243939712.html>.

<sup>59</sup> United States Census Bureau, Quick Facts: Tarrant County, Texas, *available at* <https://www.census.gov/quickfacts/fact/table/tarrantcountytexas/RHI125219> (data as of July 1, 2019).



Similarly, in Dallas County, 60% of reported COVID-19 cases were Hispanic,<sup>60</sup> though data from just last year estimated the county at less than 41% Hispanic.<sup>61</sup>

Incarcerated persons, many of whom have co-morbid conditions, are also at significant risk of contracting COVID-19.<sup>62</sup> COVID-19 is already running rampant in Texas prisons and jails.<sup>63</sup>

Finally, people with disabilities and older adults are at high risk of contracting COVID-19, particularly those who receive hand-on personal care, live in congregate residential programs, or are served in institutional settings, or long-term care facilities. These individuals also are at greater risk of requiring hospital level of care and, therefore, finding their access to treatment determined by discriminatory Guidelines.<sup>64</sup> The discriminatory impact of these guidelines on people with disabilities and older adults impermissibly denies lifesaving treatment to the populations at greatest risk of contracting COVID-19.

*C. The Guidelines' Basic Premise of Giving Priority to Patients Based on Life Expectancy Discriminates against Older Adults and Individuals with Disabilities and Individuals from Communities of Color.*

In addition to outright excluding certain individuals with disabilities and/or co-morbid conditions, the Guidelines rely heavily on maximization of efficiency in allocating life-saving resources and take into account, under several of the exclusionary criteria and metrics, projected life expectancy. As discussed *supra*, the Guidelines for Children automatically exclude children with diagnoses that have less than an 80% survival rate after the age of two. Guidelines for Children at 5. Similarly and as discussed *supra*, the Guidelines for Adults disproportionately exclude older Americans and Americans who have conditions assumed to have a shorter life-expectancy. The basic principles underlying the Guidelines exclusionary criteria—efficiency and life-expectancy—discriminate against people with disabilities and other protected classes.

Importantly, the American College of Physicians has rejected the use of long-term prognosis, instead recommending that hospitals make resource allocation decisions

based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment) and effectiveness (i.e., the likelihood that the therapy will help

---

<sup>60</sup> League of United Latin American Citizens, Letter to Texas Governor Greg Abbott (July 2, 2020), available at [https://lulac.org/news/pr/Letter\\_to\\_Texas\\_Governor\\_Greg\\_Abbott/](https://lulac.org/news/pr/Letter_to_Texas_Governor_Greg_Abbott/).

<sup>61</sup> United States Census Bureau, Quick Facts: Tarrant County, Texas, *supra* fn 59.

<sup>62</sup> Emma Grey Ellis, *Covid-19 Poses a Heightened Threat in Jails and Prisons*, WIRED, March 24, 2020, available at <https://www.wired.com/story/coronavirus-covid-19-jails-prisons/>.

<sup>63</sup> Bryce Newberry, *State prisons remain a hot spot for COVID-19 in Texas*, KVUE News, June 18, 2020, available at <https://www.kvue.com/article/news/health/coronavirus/state-prisons-remain-a-hotspot-for-covid-19-in-texas/269-279fd28f-391b-4d95-8a14-819d8723eae8>.

<sup>64</sup> See, e.g., Melanie Barden, *Data shows one-third of Texas COVID-19 deaths come from cases in long-term care facilities*, CBS Austin, April 14, 2020, available at <https://cbsaustin.com/news/local/data-shows-one-third-of-texas-covid-19-deaths-come-from-cases-in-long-term-care-facilities>; Tricia L. Nadolny, et al., *"The damage was done": 89 test positive for coronavirus at Texas facility*, USA Today, April 3, 2020, available at <https://www.usatoday.com/story/news/2020/04/03/coronavirus-outbreak-denton-texas-center-for-disabilities-delayed-response/5116826002/> (detailing the early coronavirus outbreak at the Denton State Supported Living Center, a large facility for individuals with intellectual and developmental disabilities.)

the patient recover). Allocation of treatments must maximize the number of patients who will recover, not the number of “life-years,” which is inherently biased against the elderly and the disabled.<sup>65</sup>

Likewise, the misplaced focus on life-expectancy results in intersectional discrimination on the basis of age and race and jeopardizes communities of color such as African American<sup>66</sup> and Native American<sup>67</sup> communities who have lower life expectancies due to well-documented social disparities and systemic health inequities.

Even Dr. Douglas White, prominent author of the much-cited “Pittsburgh Model” for altered standards of care, has publicly rejected factoring long-term prognosis and overall life expectancy into the triage assessment process. Instead, Dr. White advocates for considering prognosis in the near term.<sup>68</sup>

Risks of error and unconscious bias may be even greater in high-pressured triage decisions during this crisis. Medical innovations such as new pharmaceuticals, surgical techniques and other interventions can shift the long-term prognosis for many conditions, radically altering the life-expectancy of any given disability or condition.

In contrast to the Guidelines, other states have charted a different course. New York’s ventilator guidelines eliminate any consideration of co-morbidity or long-term prognosis.<sup>69</sup> Instead, they assess “the short-term likelihood of survival of the acute medical episode,” and not “whether a patient may survive a given illness or disease in the long-term (e.g., years after the pandemic). By adopting this approach, every patient is held to a consistent standard. Triage decision-makers should not be influenced by subjective determinations of long-term survival, which may include biased personal values or quality of life opinions.”<sup>70</sup> In California, the state’s SARS-CoV-2 Crisis Care Guidelines explicitly list as a factor to consider during triage that “[m]ore time, skill, and resources may be required to care for people with disabilities....”<sup>71</sup> In contrast to the Texas Guidelines’ Algorithm, the California flow chart questions whether the individual is “actively dying or certain to die” or has a “poor immediate survival prognosis”

---

<sup>65</sup> American College of Physicians, Internists Say Prioritization, Allocation of Resources and Stewardship Must Not Result in Discrimination During COVID-19 Emergency (March 27, 2020), available at <https://www.acponline.org/acp-newsroom/internists-say-prioritization-allocation-of-resources-must-not-result-in-discrimination>.

<sup>66</sup> See, Allan S. Noonan, et al., *Improving the Health of African Americans in the USA: An Overdue Opportunity to for Social Justice*, 37 OUB. HEALTH REV. 12 (2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5810013/>.

<sup>67</sup> Indian Health Service, Fact Sheet: Disparities (October 2019), available at <https://www.ihs.gov/newsroom/factsheets/disparities/>.

<sup>68</sup> This April 8, 2020 interview on WBUR is available at <https://www.wbur.org/hereandnow/2020/04/08/hospitals-ethically-ration-ventilators>.

<sup>69</sup> New York State Department of Health, “Ventilator Allocation Guidelines” by the New York Taskforce on Life and the Law, November 2015, 34, available at [https://www.health.ny.gov/regulations/task\\_force/reports\\_publications/docs/ventilator\\_guidelines.pdf](https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf).

<sup>70</sup> Elios Rivera-Segarra, et al., “That’s All Fake”: Health Professionals, Stigma and Physical Healthcare of People Living with Serious Mental Illness, 14 PLOS ONE, 12, (2019) available at <https://doi.org/10.1371/journal.pone.0226401>.

<sup>71</sup> California Department of Public Health, California SARS-CoV-2 Pandemic Crisis Care Guidelines, p 13, June 2020, available at <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/California%20SARS-CoV-2%20Crisis%20Care%20Guidelines%20-June%208%202020.pdf>

and directs resource allocation decisions around those guiding questions.<sup>72</sup> Finally, New Hampshire’s Crisis Standards of Care Plan expressly dictate that

[r]ationing should NOT be based on the following: age, race, ethnicity, socioeconomic status, sexual orientation, disability, citizenship, ability to pay, or religion, ...judgments that people have greater quality of life than others, predictions about baseline life expectancy (i.e., life expectancy if the patient were not facing the pervasive or catastrophic public health crisis), unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities.<sup>73</sup>

As these examples demonstrate, ethical triage consistent with the requirements of federal non-discrimination laws is both possible and necessary to avoid the discrimination present in North Texas under the Guidelines.

*D. Assessments of Long-term Prognosis Based on “Significant Life Limiting Co-morbidities” Are Prone to Discriminatory Assumptions, Unconscious Bias, and Clinical Error.*

The Guidelines provide no objective, reliable, or consistent means of informing decisions on intermediate or long-term prognosis, relying instead, on rigid adherence to imperfect scoring systems. Additionally, populations whose health and longevity are already negatively impacted by inequities in access to care (e.g., people with psychiatric disabilities; communities of color; LGBTQ+ individuals, and incarcerated people) will be doubly harmed by these criteria.<sup>74</sup>

The Guidelines use criteria that will lead to discriminatory assumptions or unconscious bias in the provision of lifesaving care.<sup>75</sup> Further, they fail to include safeguards against such influences in the decision-making process. Specifically, incorporating co-morbidities that do not reduce a patient’s short-term survival prospects into the triage assessment creates a substantial risk that quality of life and other subjective value judgments will also be improperly incorporated into the process, reducing the likelihood persons with disabilities and chronic health conditions will receive medically indicated care.<sup>76</sup> Because

---

<sup>72</sup> *Id.* at 15.

<sup>73</sup> New Hampshire Department of Health & Human Services, New Hampshire Crisis Standards of Care Plan at 36, available at <https://www.dhhs.nh.gov/documents/nh-csc-plan.pdf> (emphasis in original).

<sup>74</sup> See, Joseph Stramondo, PhD, COVID-19 Triage and Disability: What Not to Do, Bioethics.net, March 30, 2020, available at <http://www.bioethics.net/2020/03/covid-19-triage-and-disability-what-not-to-do/>.

<sup>75</sup> The prevalence of unconscious bias in the provision of health care generally is well documented. See Cholë FitzGerald & Sania Hurst, *Implicit Bias in Healthcare Professionals: A Systemic Review*, 18 BMC MED. ETHICS (2017) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/> (meta-analysis of 49 articles on the impact of implicit race and gender bias in the provision of medical care concludes that “healthcare professionals exhibit the same levels of implicit bias as the wider population” and that bias is “likely to influence diagnosis and treatment decisions and levels of care in some circumstances”); see also Clarissa Kripke, *Patients with Disabilities: Avoiding Bias When Discussing Goals of Care*, 93 AM. FAM. PHYSICIAN 192 (2017) available at <https://www.aafp.org/afp/2017/0801/p192.html> (“[f]alse assumptions about patients’ quality of life can affect prognosis” and even “result in premature withdrawal of life-preserving care.”).

<sup>76</sup> The Department of Health and Human Services rejected Oregon’s plan to ration Medicaid services in the early 1990s that included criteria based upon quality of life and likelihood of treatment returning the patient to an asymptomatic state, concluding that such criteria violate the ADA based on stereotypical assumptions about people with disabilities’ quality of life. Timothy B. Flanagan, *ADA Analyses of the Oregon Health Plan*, 9 ISSUES IN LAW & MEDICINE 397 (1994) (reprinting federal analyses that Oregon’s proposals to ration health care violated the ADA).

the criteria in the Guidelines effectively constitute a proxy for quality of life, they directly contravene OCR's Bulletin and federal civil rights laws.

People with disabilities and older adults can outlive the prognoses doctors ascribe to them, often by decades<sup>77</sup> making any consideration of "projected" life expectancy discriminatory.

Instead of the discriminatory process in the Guidelines, triage decisions should be governed by individualized assessments of the patient's potential for survivability to discharge if provided treatment.

*E. The Guidelines Fail to Require the Provision of Reasonable Accommodations to an Individual's Disability and Reasonable Modifications of the Triage Process.*

The Guidelines do not mention requirements under the ADA or Section 504 to make reasonable accommodations for people with disabilities. Nor do they remind health care facilities of their federal and state anti-discrimination obligations to make reasonable modifications to their policies and practices when necessary to allow persons with disabilities to enjoy the benefits and services they provide. For instance, certain triage criteria, such as de-prioritizing individuals with an MSOFA score in the intermediate priority range from continuing to receive ICU care and/or ventilators during Triage Level 3, may have a disproportionate, negative impact on individuals who are no less likely to recover, but may do so more slowly due to a pre-existing disability.<sup>78</sup> Similarly, individuals who are admitted to the hospital with a personal ventilator should not have them reallocated or removed for another individual.

Patients with disabilities may require specific accommodations in communicating their needs and preferences regarding treatment, including access to interpreters and specialized assistive technology. It is critical that all reasonable steps be taken to ensure guardians, supported decision makers, family members, and health care agents are afforded an equal opportunity to communicate with the individual with the disability, their treating clinicians, and the triage assessment team. If necessary, this communication should be facilitated through specialized interpreters and/or telephonic or video technology that is effective for and accessible to the person and their supporters.

Finally, if a patient with a disability requires an accommodation that involves the presence of a family member, personal care assistant, or similar disability service provider knowledgeable about the management of their care to physically or emotionally assist them during their hospitalization, this accommodation should be allowed with proper precautions taken to contain the spread of infection.<sup>79</sup>

---

<sup>77</sup> See Selby, Chakraborty, Lilien, et. al., *Clinical Accuracy When Estimating Survival Duration: The Role of the Patient's Performance Status and Time-Based Prognostic Categories*, 587 J. OF PAIN AND SYMPTOM MANAGEMENT at 588 (use of SOFA scores may not accurately predict short term survivability patients with comorbidities).

<sup>78</sup> See Kripke, *Patients with Disabilities*, supra, fn 75, 96 AM. FAMILY PHYSICIAN at 192 (patient with cognitive limitations and chronic conditions "recovering slowly from an acute, temporary illness" mistakenly referred to hospice due to undue concerns reflecting stereotypical assumptions).

<sup>79</sup> See, e.g., COVID-19 visitor policy of Rush University Medical Center, Illinois, available at <https://www.rush.edu/patients-visitors/covid-19-resources/rush-coronavirus-covid-19-patient-and-visitor-updates>.

## **OCR Must Protect All North Texas Residents From Discrimination**

In the forty-four North Texas counties served or assisted by the North Central Texas Trauma RAC, residents with disabilities, parents of children with disabilities, older adults, incarcerated people, and communities of color with co-morbid conditions are experiencing intense fear and anxiety, not only because they are at heightened risk of contracting the COVID-19 virus, but because they expect to be denied life-saving care in the event health care rationing goes into effect under the attached Guidelines.

For this reason, the individual and organizational Complainants request that your Office immediately investigate and issue a finding that the Guidelines for Adults and the Guidelines for Children unlawfully discriminate against these individuals in violation of federal law. Urgent action is needed given the pace at which the pandemic is spreading and the rising demand on health care resources.

We further request that your Office advise the North Central Texas Trauma RAC that it must eliminate triage criteria based on life limiting co-morbidities and long-term prognosis, and suggest that it develop revised, mandatory, non-discriminatory Crisis Standards of Care. Those revised Guidelines must:

- 1) Prohibit consideration of disability or age independent of its impact on short term survival from COVID-19 or any other medical condition requiring hospitalization during the pandemic;
- 2) Prohibit any implementation of the Guidelines that would result in discriminatory treatment or impact on populations protected by Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973;
- 3) Include an explicit assurance that all individuals are qualified for and eligible to receive life-saving care, regardless of diagnosis, functional impairment, or activities of daily living needs;
- 4) Ensure that all triage decisions must result from individualized assessments based on objective medical evidence;
- 5) Eliminate “life-limiting co-morbidities” or “long term prognosis” as factors in triage scoring protocols;
- 6) Require that the standards include reasonable accommodations/modifications of the triage protocol for people with disabilities;
- 7) Include necessary accommodations to assist persons with communication, mobility, or other conditions to effectively participate in healthcare treatment decisions;
- 8) Guarantee that individuals who enter a hospital with their own ventilators or other support equipment are not at risk of having that equipment removed or reallocated;<sup>80</sup>

---

<sup>80</sup> The current Guidelines do not provide any assurances that individuals with ventilators will not have them removed. This is a fear that has been expressed to numerous protection and advocacy agencies like DRTx nationally. The Tennessee resolution incorporated this requirement into that state’s triage plans. See HHS Office for Civil Rights, OCR Resolves Complaint with Tennessee After it Revises its Triage Plans to Protect Against Disability Discrimination (June 26, 2020), *available at*

9) Require disability-specific training (online) for triage teams to review how any updated crisis standards of care are applied to individual patients; and

10) Require an appeals process, oversight, and grievance/complaint procedure to ensure disability discrimination does not occur under updated crisis standards of care.

Thank you for your attention. We look forward to your response.

Respectfully,

Richard LaVallo  
Disability Rights Texas  
2222 W. Braker Lane  
Austin, Texas 78758  
(512) 454.4816  
[rlavallo@drtx.org](mailto:rlavallo@drtx.org)  
[lsnead@drtx.org](mailto:lsnead@drtx.org)

Steven Schwartz  
Center for Public Representation  
22 Green Street  
Northampton, MA 01060  
(413) 586-6024  
[sschwartz@cpr-ma.org](mailto:sschwartz@cpr-ma.org)  
[krucker@cpr.-ma.org](mailto:krucker@cpr.-ma.org)  
[ccostanzo@cpr-ma.org](mailto:ccostanzo@cpr-ma.org)

Regan Bailey  
Denny Chan  
Gelila Selassie  
Justice in Aging  
1101 I Street NW, Suite 1100  
Washington, DC 20036  
(202) 683-1990  
[rbailey@justiceinaging.org](mailto:rbailey@justiceinaging.org)  
[dchan@justiceinaging.org](mailto:dchan@justiceinaging.org)  
[gselassie@justiceinaging.org](mailto:gselassie@justiceinaging.org)

Shira Wakschlag  
The Arc of the United States  
1825 K Street NW, Suite 1200  
Washington, DC 20006  
(202) 534-3708  
[wakschlag@thearc.org](mailto:wakschlag@thearc.org)

Samuel Bagenstos  
625 South State Street  
Ann Arbor, Michigan 48109  
(734) 647-7584  
[sbagen@gmail.com](mailto:sbagen@gmail.com)

Jennifer Mathis  
The Bazelon Center for Mental Health Law  
1090 Vermont Ave NW, Suite 220  
Washington, DC 20005  
[jenniferm@bazelon.org](mailto:jenniferm@bazelon.org)

Claudia Center  
Disability Rights Education & Defense Fund  
3075 Adeline Street, Suite 210  
Berkeley, CA 94703  
[ccenter@dredf.org](mailto:ccenter@dredf.org)

Samantha Crane  
Autistic Self Advocacy Network  
P.O. Box 66122  
Washington, DR 20035  
[scrane@autisticadvocacy.org](mailto:scrane@autisticadvocacy.org)

---

<https://www.hhs.gov/about/news/2020/06/26/ocr-resolves-complaint-tennessee-after-it-revises-its-triage-plans-protect-against-disability.html>

# North Texas Mass Critical Care Guidelines Document Hospital and ICU Triage Guidelines for ADULTS

Prepared by NORTH TEXAS MASS CRITICAL CARE TASK FORCE

VERSION 1.0 — JANUARY 2014

## Purpose:

To provide a triage protocol to allocate scarce healthcare resources (intensive care services, including ventilators) to those who are most likely to benefit medically during a **pandemic respiratory crisis or other emergency situation** that has the potential to overwhelm available intensive care resources. Application of these guidelines will require physician judgment at the point of patient care.

## Basic premises:

- ☞ **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- ☞ **Priority should be given to patients for whom treatment most likely would be lifesaving** and whose functional outcome most likely would improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.
- ☞ Under a declared state of emergency, the governor maintains the authority to supersede healthcare regulations or statutes that may come into conflict with these guidelines.

## Scope:

- ☞ **These triage guidelines apply to all healthcare professionals, clinics, and facilities in North Texas.**
- ☞ **The guidelines apply to all patients 14 years and older.** Please see *Hospital and ICU Triage Guidelines for Pediatrics* for patients 13 years and younger.

## When activated:

Guidelines should be activated in the event the governor declares a pandemic respiratory crisis or other public health emergency that has the potential to overwhelm available intensive care resources.

## Hospital and medical staff planning:

- ☞ **Each hospital should:**
  - **Establish a triage committee** for the review and support of compliance with this policy when implemented. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, a member of the hospital ethics committee, a pastoral care representative, a social worker, and 1 or more independent physicians.
  - **Institute a supportive and/or palliative care team** to provide symptom management, counseling, and care coordination for patients, and support for families of patients who do not receive intensive care unit services.
- ☞ **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

## Contents:

<b>OVERVIEW OF PANDEMIC TRIAGE LEVELS</b> .....	<b>2</b>
<b>PRE-HOSPITAL SETTINGS</b> .....	<b>2</b>
Telephone Triage.....	2
Physician Offices and Clinics.....	2
Long-term Care and Other Institutional Facilities .....	2
<b>HOSPITAL SETTINGS</b> .....	<b>3</b>
Hospital Administrative Roles — General.....	3
Emergency Department, Hospital and ICU — Clinical Triage.	3
<b>ALGORITHM: HOSPITAL AND ICU ADMISSION TRIAGE</b> ....	<b>4</b>
<b>TRIAGE TOOLS AND TABLES</b> .....	<b>5</b>
<b>(a) EXCLUSION CRITERIA</b> for Hospital Admission .....	5
<b>(b) Modified Sequential Organ Failure Assessment (MSOFA)</b> .....	5
<b>(c) INCLUSION CRITERIA</b> for ICU/Ventilator .....	5
<b>(d) GLASGOW COMA SCORE (GCS)</b> .....	6
<b>(e) REVISED TRAUMA SCORE (RTS)</b> .....	6
<b>(f) TRIAGE DECISION TABLE FOR BURN VICTIMS</b> .....	7
<b>(g) NYHA FUNCTIONAL CLASSIFICATION SYSTEM</b> .....	7
<b>(h) PUGH SCORE</b> .....	7
<b>DEFINITIONS USED IN THIS DOCUMENT</b> .....	<b>8</b>
<b>REFERENCES</b> .....	<b>8</b>
<b>ACKNOWLEDGMENTS</b> .....	<b>8</b>
<b>APPENDICES (separate files)</b>	
<b>Appendix A</b> — <i>Initial Triage Tool for Pandemic Influenza</i> (for <b>ADULT</b> and <b>PEDIATRIC</b> patients)	
<b>Appendix B</b> — <b>Patient worksheets</b> B1: <b>ADULT</b> <i>Pandemic Influenza Triage Worksheet</i> B2: <b>PEDIATRIC</b> <i>Pandemic Influenza Triage Worksheet</i>	
<b>Appendix C</b> — <b>Patient handouts / Home care instructions</b> For <b>ADULT</b> and <b>PEDIATRIC</b> patients expected to recover: C1: <i>Caring for Someone with Influenza</i>	

# EXHIBIT A

## OVERVIEW OF PANDEMIC TRIAGE LEVELS

Triage Level 1 Early in the pandemic	Triage Level 2 Worsening pandemic	Triage Level 3 Worst-case scenario
<ul style="list-style-type: none"> <li>As the threat of the activation of the triage protocol increases, each hospital will cancel outpatient procedures, including elective surgeries that require a back-up option of hospital admission and ventilator support if complications arise.</li> <li>Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed.</li> <li>There are not enough beds to accommodate all patients needing hospital admission and not enough ventilators to accommodate all patients with respiratory failure.</li> <li>Hospital staff absenteeism is 20% to 30%.</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals have implemented altered standards of care regarding nurse/patient ratios and have expanded capacity by adding patients to occupied hospital rooms.</li> <li>Hospital staff absenteeism is 30% to 40%.</li> </ul>

## PRE-HOSPITAL SETTINGS

### Initial Triage

**Applies to:** Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments

**Implemented by:** Physicians, clinic staff, pre-screening staff

**Other uses:** Publish in newspapers, place on Web sites for self-use by public

**ALL Triage Levels:** Use **INITIAL TRIAGE TOOL** (*Appendix A*) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

### EMS, Physician Offices and Clinics

**Applies to:** Patients who present for care or call for guidance for where to go or how to care for ill family members

**Implemented by:** Primary care staff, hospital help lines, community help lines, and health department help lines

#### Triage Level 1:

- Use **INITIAL TRIAGE TOOL** (*Appendix A*) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

#### Triage Levels 2 and 3:

- Continue to use **INITIAL TRIAGE TOOL** (*Appendix A*).
- Initiate **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with care instructions (*Appendices pending*).

### Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g., mental health, correctional, handicapped)

**Applies to:** Patients in institutional facilities

**Implemented by:** Institutional facility staff

#### ALL Triage Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection.

#### Triage Levels 2 and 3:

- Use **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
- Give palliative and supportive care in place.

# EXHIBIT A



# HOSPITAL SETTINGS

## Hospital Administrative Roles — General

(Refer to page 8 for definitions of elective surgery categories.)

### Triage Level 1:

**1) Preserve bed capacity** by:

- Canceling all Category 2 and 3 elective surgeries, and advising all Category 1 elective surgery patients of the risk of infection.
- Canceling any elective surgery that would require postoperative hospitalization.
- **Note:** Use standard operation and triage decision for admission to ICU because resources are adequate to accommodate the most critically ill patients.

**2) Preserve oxygen capacity** by:

- Phasing out all non-acute hyperbaric medicine treatments.
- Ensuring that all liquid oxygen tanks are full.

**3) Improve patient care capacity**

by transitioning space in ICUs to accommodate more patients with respiratory failure.

**4) Control infection** by limiting visitation (follow hospital infection control plan).

### Triage Level 2:

**1) Preserve bed capacity** by:

- Canceling all elective surgeries unless necessary to facilitate hospital discharge.
- Evaluating hospitalized Category 1 elective surgery patients for discharge using same criteria as medical patients.

**2) Improve patient care capacity** by

implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.

**3) Institute a supportive and/or**

**palliative care team** to provide symptom management, counseling and care coordination for patients, and support for families of patients who do not receive intensive care unit services.

### Triage Level 3:

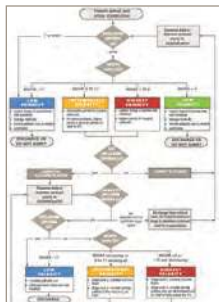
**1) Preserve bed capacity** by limiting

surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

## Emergency Department, Hospital and ICU — Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** ALGORITHM AND TOOLS (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the *lowest* priority for admission is given to patients with the lowest chance of survival with *or* without treatment, and to patients with the highest chance of survival *without* treatment.

Physician judgment should be used in applying these guidelines.



See pages 4 and 5 for triage algorithm and supporting tools.

### Triage Level 2:

- Initiate **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment daily after 48–72 hours of ICU care.

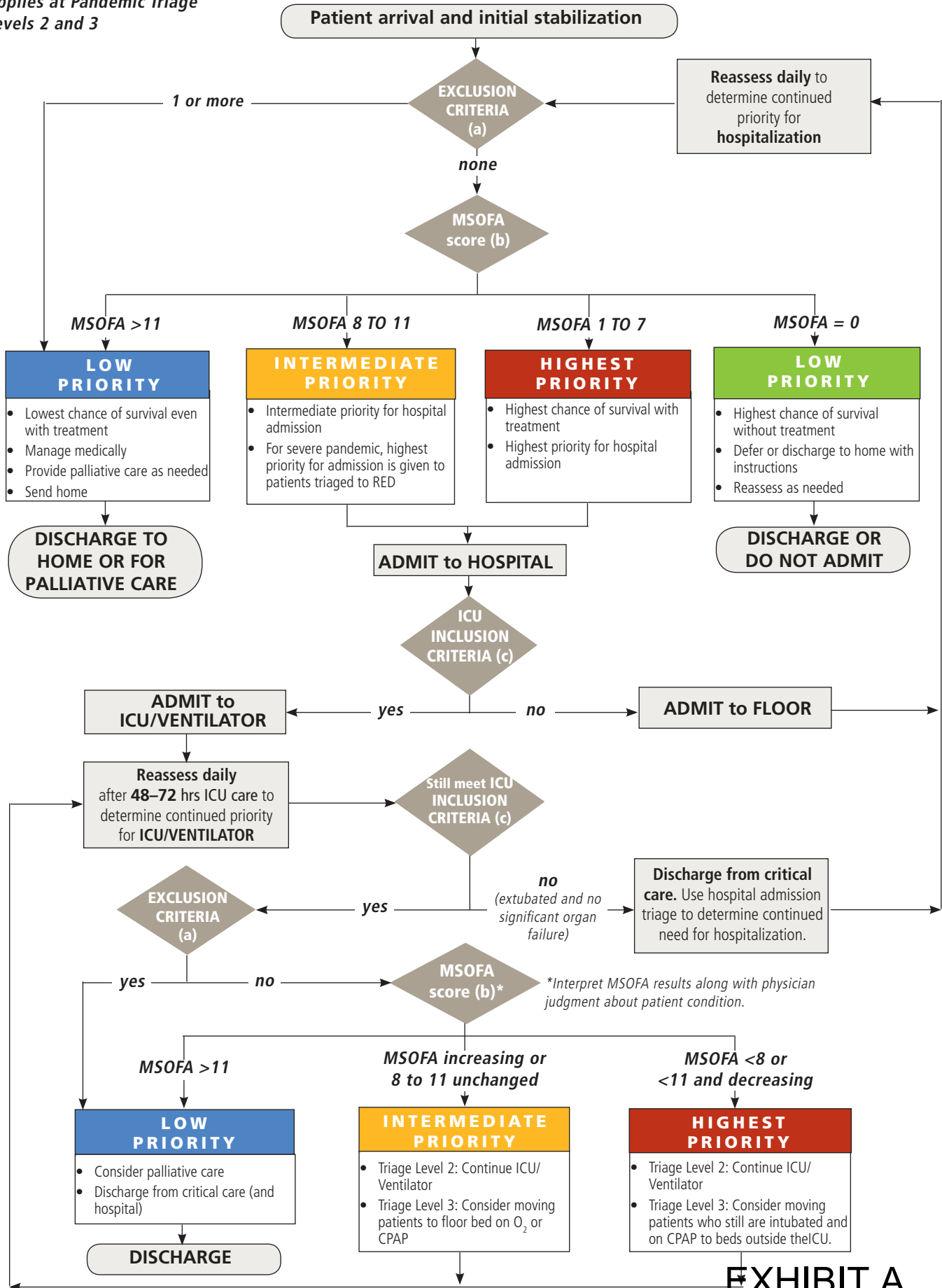
### Triage Level 3:

- Continue to use **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation and/or mechanical ventilation.
- Triage more **yellow** patients to floor on oxygen or CPAP.
- Triage more **red** patients who are intubated and on CPAP to floor.

# EXHIBIT A

# ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



**EXHIBIT A**

## TRIAGE TOOLS AND TABLES

### (a) EXCLUSION CRITERIA for

#### Hospital Admission:

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known Do Not Attempt Resuscitation (DNAR) or Out of Hospital-DNR (OOH-DNR) status.**
- (2) **Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state.
- (3) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke and intracranial hemorrhage.
- (4) **Traumatic injury:** Severe traumatic brain injury, hemodynamically unstable traumatic injuries requiring more than 10 units of blood transfusion, or more than one pressor, ARDS requiring high peep >15 or HFOV; Revised Trauma Score <2 [see (e)]. Revised Trauma Score: \_\_\_\_\_
- (5) **Severe burns with anticipated survival “Low,” “Low/Expectant” or “Expectant”** as indicated by age and burn size on the Triage Decision Table For Burn Victims (f). Burns not requiring critical care resources may be cared for at the local facility. Score \_\_\_\_\_
- (6) **Cardiac arrest not responsive to ACLS interventions within 20–30 minutes.**
- (7) **Known severe dementia** medically treated and requiring assistance with activities of daily living.
- (8) **Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or chronic ventilatory support.
- (9) **Incurable metastatic malignant disease.**
- (10) **End-stage organ failure** meeting the following criteria:
  - Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g). Class:** \_\_\_\_\_
  - Lung** (any of the following):
    - Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV<sub>1</sub>) <25% predicted baseline, PaO<sub>2</sub> <55 mm Hg, or severe secondary pulmonary hypertension.
    - Cystic fibrosis with post-bronchodilator FEV<sub>1</sub> <30% or baseline PaO<sub>2</sub> <55 mm Hg.
    - Pulmonary fibrosis with VC or TLC <60% predicted, baseline PaO<sub>2</sub> <55 mm Hg, or severe secondary pulmonary hypertension.
    - Primary pulmonary hypertension with NYHA class III or IV heart failure (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
  - Liver: MELD SCORE >20 or Pugh Score > 7 (h),** when available. Includes bili, albumin, INR, ascites, encephalopathy. MELD score calculators available online. PUGH Score table on page 7. MELD: \_\_\_\_\_ PUGH: \_\_\_\_\_

### (b) Modified Sequential Organ Failure Assessment (MSOFA) Score

MSOFA scoring guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
<b>SpO<sub>2</sub>/FIO<sub>2</sub> ratio*</b> <i>or</i> nasal cannula or mask O <sub>2</sub> required to keep SpO <sub>2</sub> >90%	SpO <sub>2</sub> /FIO <sub>2</sub> >400 <i>or</i> room air SpO <sub>2</sub> >90%	SpO <sub>2</sub> /FIO <sub>2</sub> 316-400 <i>or</i> SpO <sub>2</sub> >90% at 1–3 L/min	SpO <sub>2</sub> /FIO <sub>2</sub> 231-315 <i>or</i> SpO <sub>2</sub> >90% at 4–6 L/min	SpO <sub>2</sub> /FIO <sub>2</sub> 151-230 <i>or</i> SpO <sub>2</sub> >90% at 7–10 L/min	SpO <sub>2</sub> /FIO <sub>2</sub> ≤150 <i>or</i> SpO <sub>2</sub> >90% at >10 L/min	
<b>Jaundice</b>	no scleral icterus			clinical jaundice/scleral icterus		
<b>Hypotension†</b>	None	MABP <70	dop <5	dop 5–15 <i>or</i> epi ≤0.1 <i>or</i> norepi ≤0.1	dop >15 <i>or</i> epi >0.1 <i>or</i> norepi >0.1	
<b>Glasgow Coma Score</b>	15	13–14	10–12	6-9	<6	
<b>Creatinine level, mg/dL</b> (use ISTAT)	<1.2	1.2–1.9	2.0–3.4	3.5-4.9 <i>or</i> urine output <500 mL in 24 hours	>5 <i>or</i> urine output <200 mL in 24 hours	
<b>MSOFA score = total scores from all rows:</b>						

\* SpO<sub>2</sub>/FIO<sub>2</sub> ratio:

SpO<sub>2</sub> = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO<sub>2</sub> = Fraction of inspired oxygen; e.g., ambient air is 0.21

Example: if SpO<sub>2</sub> = 95% and FIO<sub>2</sub> = 0.21, the SpO<sub>2</sub>/FIO<sub>2</sub> ratio is calculated as 95/0.21 = 452

† Hypotension:

MABP = mean arterial blood pressure in mm Hg [diastolic + 1/3(systolic - diastolic)]

dop = dopamine in micrograms/kg/min

epi = epinephrine in micrograms/kg/min

norepi = norepinephrine in micrograms/kg/min

### (c) ICU/Ventilator INCLUSION CRITERIA

Patient must have **NO EXCLUSION CRITERIA (a)** and at least one of the following **INCLUSION CRITERIA:**

- (1) **Requirement for invasive ventilatory support**
  - Refractory hypoxemia (SpO<sub>2</sub> <90% on non-rebreather mask or FIO<sub>2</sub> >0.85)
  - Respiratory acidosis (pH <7.2)
  - Clinical evidence of impending respiratory failure
  - Inability to protect or maintain airway
- (2) **Hypotension\* with clinical evidence of shock\*\* refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.**
  - \*Hypotension = Systolic BP <90 mm Hg or relative hypotension
  - \*\*Clinical evidence of shock = altered level of consciousness, decreased urine output or other evidence of end-stage organ failure

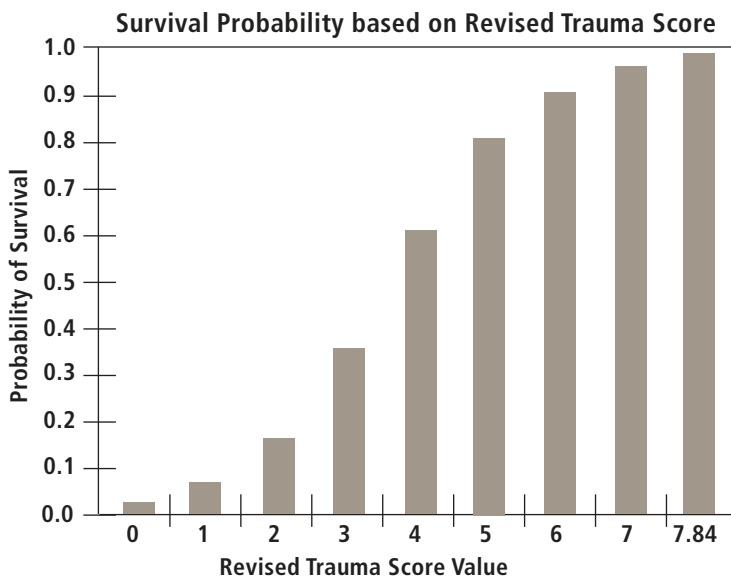
**(d) GLASGOW COMA SCORE (GCS)**

The GCS is used as part of the REVISED TRAUMA SCORE (RTS) in determining exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Glasgow Coma Scoring Criteria			
Criteria		Score	Criteria Score
<b>Best Eye Response</b> (4 possible points)	No eye opening	1	_____
	Eye opens to pain	2	
	Eye opens to verbal command	3	
	Eyes open spontaneously	4	
<b>Best Verbal Response</b> (5 possible points)	No verbal response	1	_____
	Incomprehensible sounds	2	
	Inappropriate words	3	
	Confused	4	
	Oriented	5	
<b>Best Motor Response</b> (6 possible points)	No motor response	1	_____
	Extension to pain	2	
	Flexion to pain	3	
	Withdraws from pain	4	
	Localizes to pain	5	
	Obeys commands	6	
<b>Total Score</b> (add 3 subscores; range 3 to 15):			_____

**(e) REVISED TRAUMA SCORE (RTS)**

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted toward the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic flu at triage levels 2 and 3.



Revised Trauma Score Calculation				Adjusted Score
Criteria	Score	Coded value	Weighting	
<b>Glasgow Coma Score</b>	3	0	x 0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 15	4		
<b>Systolic Blood Pressure (SBP)</b>	0	0	x 0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
<b>Respiratory Rate (RR) in breaths per minute (BPM)</b>	0	0	x 0.2908	_____
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
<b>Revised Trauma Score</b> (add 3 adjusted scores):				_____

**EXHIBIT A**

**(f) TRIAGE DECISION TABLE FOR BURN VICTIMS**

A burn score of “Low” or worse on this table is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0–10%	11–20%	21–30%	31–40%	41–50%	51–60%	61–70%	71–80%	81–90%	91%+
0 – 1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/expectant
2.0 – 4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0 – 19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0 – 29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0 – 39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0 – 49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0 – 59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/expectant	Low/expectant
60.0 – 69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/expectant	Low/expectant	Low/expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/expectant	Expectant	Expectant	Expectant	Expectant

**Outpatient:** Survival and good outcome expected, without requiring initial admission; **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14–21 days, 1-2 surgical procedures); **High:** Survival and good outcome expected (survival ≥90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14–21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50–90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14–21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival ≤10% even with unlimited aggressive treatment.

**(g) NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM**

The NYHA functional classification system relates symptoms to everyday activities and the patient’s quality of life. NYHA Class III or IV heart failure are exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

NYHA Classes	
Class	Patient Symptoms
<b>Class I</b> (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnea.
<b>Class II</b> (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitations or dyspnea.
<b>Class III</b> (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations or dyspnea.
<b>Class IV</b> (Severe)	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

Used with permission from www.abouthf.org.

**(h) PUGH SCORE**

A total PUGH SCORE ≥7 is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Scoring Criteria			
Criteria	Value	Points	Total for criteria
<b>Total Serum Bilirubin</b>	<2 mg/dL	1	_____
	2–3 mg/dL	2	
	>3 mg/dL	3	
<b>Serum Albumin</b>	>3.5 g/dL	1	_____
	2.8–3.5 g/dL	2	
	<2.8 g/dL	3	
<b>INR</b>	<1.70	1	_____
	1.71–2.20	2	
	>2.20	3	
<b>Ascites</b>	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
<b>Encephalopathy</b>	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
<b>Total Pugh Score</b>			_____
Score interpretation			
Total PUGH SCORE	Class		
5 to 6	A	Life expectancy 15–20 years Abdominal surgery perioperative mortality 10%	
7 to 9	B	Liver transplant evaluation indicated Abdominal surgery perioperative mortality 30%	
10 to 15	C	Life expectancy 1–3 years Abdominal surgery perioperative mortality 82%	

**EXHIBIT A**

## DEFINITIONS USED IN THIS DOCUMENT

- Ⓒ **Emergency patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- Ⓒ **Elective surgery:**
  - **Category 1:** Urgent patients who require surgery within 30 days.
  - **Category 2:** Semi-urgent patients who require surgery within 90 days.
  - **Category 3:** Non-urgent patients who need surgery at some time in the future.
- Ⓒ **Long-term care facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- Ⓒ **Palliative care:** In the setting of an overwhelming medical crisis, palliative care helps improve patient symptoms such as shortness of breath, pain and anxiety. Palliative care teams also support patient and family spiritual and/or emotional pain.

## REFERENCES

This document was developed following review and partial adaptation of the following articles:

- Ⓒ Christian MD, Hawryluck L, Wax RS, et al. Development of a triage protocol for critical care during an influenza pandemic. *CMAJ*. 2006;175(11):1377–1381.
  - *Commentary:* Melnychuk RM, Kenny NP. Pandemic triage: the ethical challenge. *CMAJ*. 2006;175(11):1393.
- Ⓒ Devereaux, A. V., and J. R. Dichter. "Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care: From a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL." *Chest* 133.5 Suppl (2008): 515–665. Print.
- Ⓒ Hick JL, O'Laughlin DT. Concept of operations for triage of mechanical ventilation in an epidemic. *Acad Emerg Med*. 2006;13(2):223–229.
- Ⓒ Grissom CK, Orme JF, Jensen RL, Jephson AR. A modified sequential organ failure assessment (SOFA) score to predict mortality in critically-ill patients (abstract). *Crit Care Med* 2007;35(12):A9.
- Ⓒ Champion HR, Sacco WJ, Carnazzo AJ, Copes W, Fouty WJ. Trauma score. *Crit Care Med*. 1981;9(9):672–676.
- Ⓒ Champion HR, Sacco WJ, Copes WS, Gann DS, Gennarelli TA, Flanagan ME. A revision of the Trauma Score. *J Trauma*. 1989;29(5):623–629.
- Ⓒ Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet*. 1974;2(7872):81–84.
- Ⓒ "Interim Pre-Pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions." Flu.gov. Web. 11 Feb. 2007. <<http://www.pandemicflu.gov/>>
- Ⓒ Kinlaw, Kathy, and Robert Levine, comps. United States. Ethics Subcommittee of the Advisory Committee to the Director, Centers for Disease Control and Prevention. Cong. Rept. Print.
- Ⓒ New York Heart Association. The stages of heart failure – NYHA classification. Heart Failure Society of America Web site. [http://www.heartfailure.org/questions\\_stages.htm](http://www.heartfailure.org/questions_stages.htm). Published 2002. Updated September 28, 2006. Accessed December 5, 2007.
- Ⓒ Pugh RNH, Murray-Lyon M, Dawson JL, Pietroni MC, Williams R. Transection of the oesophagus for bleeding oesophageal varices. *Br J Surg*. 1973;60(8):646–649.

# North Texas Mass Critical Care Guidelines Document Hospital and ICU Triage Guidelines for PEDIATRICS

Prepared by NORTH TEXAS MASS CRITICAL CARE TASK FORCE

VERSION 1.0 — JANUARY 2014

## Purpose:

To provide a triage protocol to allocate scarce healthcare resources (intensive care services, including ventilators) to those who are most likely to benefit medically during a **pandemic respiratory crisis or other emergency situation** that has the potential to overwhelm available intensive care resources. Application of these guidelines will require physician judgment at the point of patient care.

## Basic premises:

- ☞ **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- ☞ **Priority should be given to patients for whom treatment would most likely be lifesaving.** Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.
- ☞ Under a declared state of emergency, the governor maintains the authority to supersede healthcare regulations or statutes that may come into conflict with these guidelines.

## Scope:

- ☞ **These triage guidelines apply to all healthcare professionals, clinics, and facilities in North Texas.**
- ☞ **The guidelines apply to all patients 13 years and younger.** Please see *Hospital and ICU Triage Guidelines for Adults* for patients 14 years and older.

## When activated:

Guidelines should be activated in the event the governor declares a pandemic respiratory crisis or other public health emergency that has the potential to overwhelm available intensive care resources.

## Hospital and medical staff planning:

- ☞ **Each hospital should:**
  - **Establish a triage committee** for the review and support of compliance with this policy when implemented. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, a member of the hospital ethics committee, a pastoral care representative, a social worker, and 1 or more independent physicians.
  - **Institute a supportive and/or palliative care team** to provide symptom management, counseling, and care coordination for patients, and support for families of patients who do not receive intensive care unit services.
- ☞ **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

## Contents:

<b>OVERVIEW OF PANDEMIC TRIAGE LEVELS.....</b>	<b>2</b>
<b>PRE-HOSPITAL SETTINGS.....</b>	<b>2</b>
Telephone Triage .....	2
Physician Offices and Clinics .....	2
Long-term Care and Other Institutional Facilities .....	2
<b>HOSPITAL SETTINGS.....</b>	<b>3</b>
Hospital Administrative Roles — General .....	3
Emergency Department, Hospital, and ICU — Clinical Triage ..	3
<b>ALGORITHM: HOSPITAL AND ICU ADMISSION TRIAGE.....</b>	<b>4</b>
<b>TRIAGE TOOLS AND TABLES .....</b>	<b>5</b>
(a) <b>EXCLUSION CRITERIA</b> for Hospital Admission.....	5
(b) <b>INCLUSION CRITERIA</b> for ICU/Ventilator.....	5
(c) <b>GLASGOW COMA SCORE (GCS)</b> .....	6
(d) <b>REVISED TRAUMA SCORE (RTS)</b> .....	6
(e) <b>TRIAGE DECISION TABLE FOR BURN VICTIMS</b> .....	7
<b>DEFINITIONS USED IN THIS DOCUMENT .....</b>	<b>8</b>
<b>REFERENCES.....</b>	<b>8</b>
<b>ACKNOWLEDGMENTS .....</b>	<b>8</b>
<b>APPENDICES (separate files)</b>	
<b>Appendix A — Initial Triage Tool for Pandemic Influenza</b> (for <b>ADULT</b> and <b>PEDIATRIC</b> patients)	
<b>Appendix B — Patient worksheets</b>	
B1: <b>ADULT</b> Pandemic Influenza Triage Worksheet	
B2: <b>PEDIATRIC</b> Pandemic Influenza Triage Worksheet	
<b>Appendix C — Patient handouts / Home care instructions</b> For <b>ADULT</b> and <b>PEDIATRIC</b> patients expected to recover:	
C1: <i>Caring for Someone with Influenza</i>	

## OVERVIEW OF PANDEMIC TRIAGE LEVELS

### Triage Level 1

#### Early in the pandemic

- As the threat of the activation of the triage protocol increases, each hospital will cancel outpatient procedures, including elective surgeries that require a back-up option of hospital admission and ventilator support if complications arise.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

### Triage Level 2

#### Worsening pandemic

- Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission and not enough ventilators to accommodate all patients with respiratory failure.
- Hospital staff absenteeism is 20% to 30%.

### Triage Level 3

#### Worst-case scenario

- Hospitals have implemented altered standards of care regarding nurse/patient ratios and have expanded capacity by adding patients to occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.

## PRE-HOSPITAL SETTINGS

### Initial Triage

**Applies to:** Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments

**Implemented by:** Physicians, clinic staff, pre-screening staff

**Other uses:** Publish in newspapers, place on Web sites for self-use by public

**ALL Triage Levels:** Use **INITIAL TRIAGE TOOL** (*Appendix A*) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

### EMS, Physician Offices and Clinics

**Applies to:** Patients who present for care or call for guidance for where to go or how to care for ill family members

**Implemented by:** Primary care staff, hospital help lines, community help lines, and health department help lines

#### Triage Level 1:

- Use **INITIAL TRIAGE TOOL** (*Appendix A*) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

#### Triage Levels 2 and 3:

- Continue to use **INITIAL TRIAGE TOOL** (*Appendix A*).
- Initiate **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with care instructions (*Appendices pending*).

### Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g., mental health, correctional, handicapped)

**Applies to:** Patients in institutional facilities

**Implemented by:** Institutional facility staff

#### ALL Triage Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection.

#### Triage Levels 2 and 3:

- Use **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
- Give palliative and supportive care in place.

## EXHIBIT B



# HOSPITAL SETTINGS

## Hospital Administrative Roles — General

(Refer to page 8 for definitions of elective surgery categories.)

### Triage Level 1:

#### 1) Preserve bed capacity by:

- Canceling all Category 2 and 3 elective surgeries, and advising all Category 1 elective surgery patients of the risk of infection.
- Canceling any elective surgery that would require postoperative hospitalization.

**Note:** Use standard operation and triage decision for admission to ICU since there are still adequate resources to accommodate the most critically ill patients.

#### 2) Preserve oxygen capacity by:

- Phasing out all non-acute hyperbaric medicine treatments.
- Ensuring that all liquid oxygen tanks are full.

#### 3) Improve patient care capacity

by transitioning space in ICUs to accommodate more patients with respiratory failure.

#### 4) Control infection by limiting

visitation (follow hospital infection control plan).

### Triage Level 2:

#### 1) Preserve bed capacity by:

- Canceling all elective surgeries unless necessary to facilitate hospital discharge.
- Evaluating hospitalized Category 1 elective surgery patients for discharge using same criteria as medical patients.

#### 2) Improve patient care capacity by

implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.

#### 3) Institute a supportive and/or

palliative care team to provide symptom management, counseling and care coordination for patients, and support for families of patients who do not receive intensive care unit services.

### Triage Level 3:

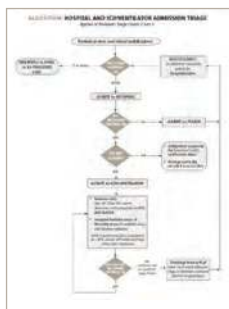
#### 1) Preserve bed capacity by limiting

surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

## Emergency Department, Hospital and ICU — Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm and tools (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the *lowest* priority for admission is given to patients with the lowest chance of survival with *or* without treatment, and to patients with the highest chance of survival *without* treatment.

Physician judgment should be used in applying these guidelines.



See pages 4 and 5 for triage algorithm and supporting tools.

### Triage Level 2:

- Initiate **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment daily after 48–72 hours of ICU care.

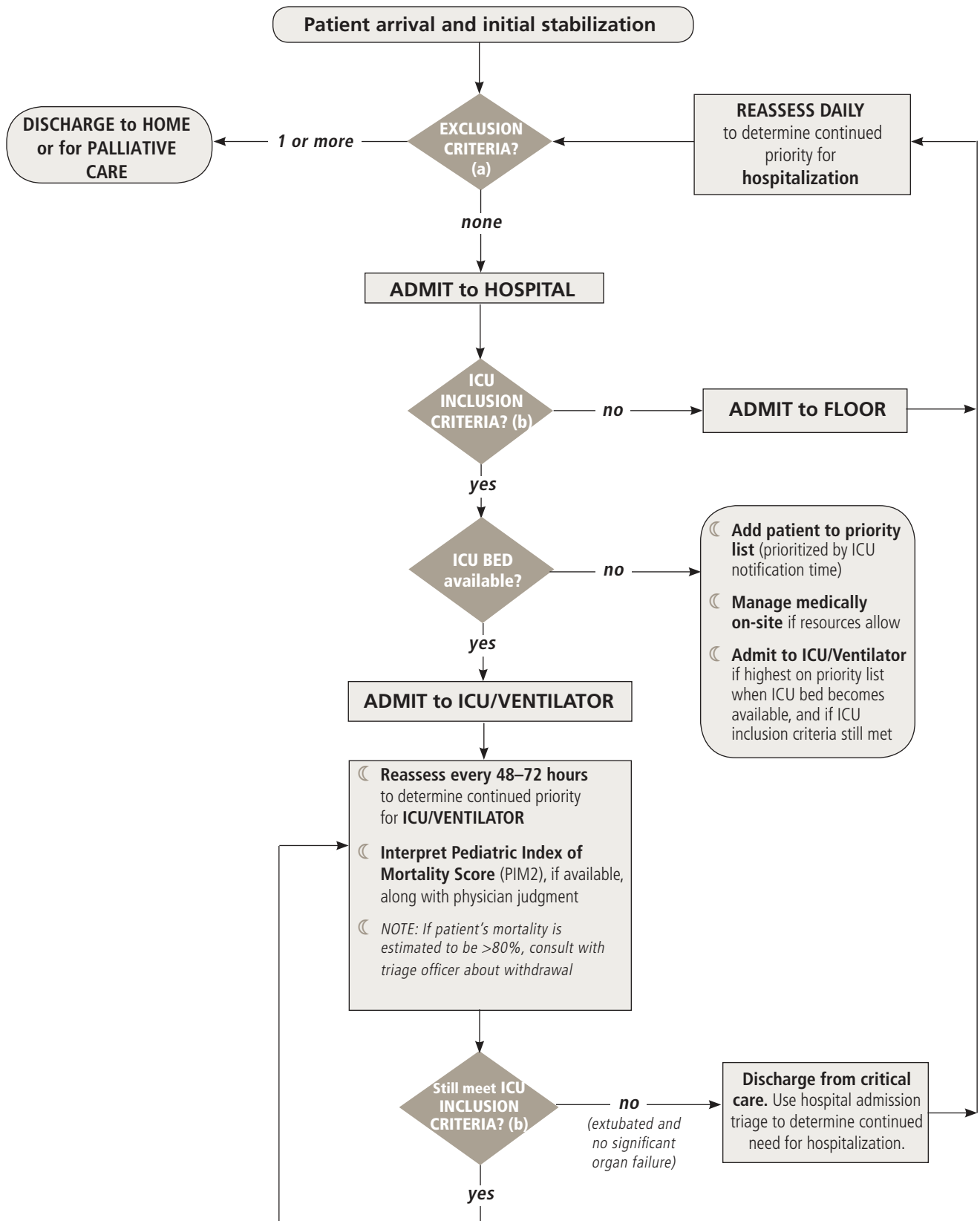
### Triage Level 3:

- Continue to use **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation and/or mechanical ventilation.

# EXHIBIT B

# ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



## EXHIBIT B

## TRIAGE TOOLS AND TABLES

### (a) EXCLUSION CRITERIA for Hospital Admission:

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Persistent coma or vegetative state.**
- (2) **Severe acute trauma with a REVISED TRAUMA SCORE <2 [see (d) and (e) on following pages].**  
GCS: \_\_\_\_ SBP: \_\_\_\_ RR: \_\_\_\_  
Revised trauma score: \_\_\_\_
- (3) **Severe burns with <50% anticipated survival** [patients identified as “Low” or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)]. Burns not requiring critical care resources may be cared for at the local facility.
- (4) **Cardiac arrest not responsive to PALS interventions within 20–30 minutes.**
- (5) **Short anticipated duration of benefit, e.g.,** underlying condition with >80% mortality rate at 18–24 months:
  - a) Known chromosomal abnormalities such as Trisomy 13 or 18
  - b) Known metabolic diseases such as Zellweger syndrome
  - c) Spinal muscular atrophy (SMA) type 1
  - d) Progressive neuromuscular disorder, e.g., muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
  - e) Cystic fibrosis with post-bronchodilator  $FEV_1 < 30\%$  or baseline  $PaO_2 < 55$  mm Hg
  - f) Severe end-stage pulmonary hypertension

#### OTHER CONSIDERATIONS:

- Resuscitation of extremely premature infants with anticipated mortality rates greater than 80% should not be offered. See [http://www.nichd.nih.gov/about/org/cdbpm/pp/prog\\_epbo/](http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/)
- The use of ECMO will be decided on an individual basis by the Chief Medical Officer (with input from attending physician, nursing supervisor and ECMO representative) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7–10 days.

### (b) ICU/Ventilator INCLUSION CRITERIA

- Applies to all patients except those infants not yet discharged from the NICU
- Patients must have NO EXCLUSION CRITERIA (a) and at least one of the following INCLUSION CRITERIA:

#### (1) Requirement for invasive ventilatory support:

- Ⓢ Refractory hypoxemia ( $SpO_2 < 90\%$  on non-rebreather mask or  $FIO_2 > 0.85$ )
- Ⓢ Respiratory acidosis ( $pH < 7.2$ )
- Ⓢ Clinical evidence of impending respiratory failure
- Ⓢ Inability to protect or maintain airway

#### (2) Hypotension\* with clinical evidence of shock\*\* refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.

- \* **Hypotension** = Systolic BP < 90 mm Hg for patients age > 10 years old, <  $70 + (2 \times \text{age in years})$  for patients ages 1 to 10, < 60 for infants < 1 year old, or relative hypotension
- \*\* **Clinical evidence of shock** = altered level of consciousness, decreased urine output or other evidence of end-stage organ failure

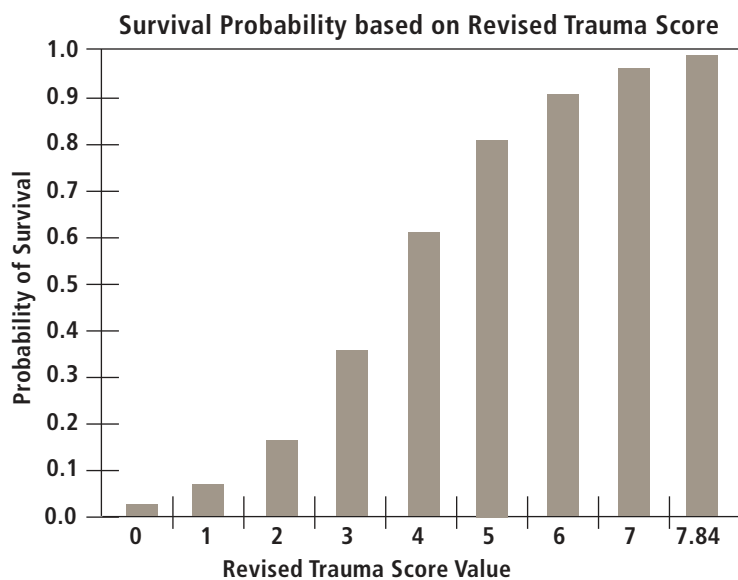
### (c) GLASGOW COMA SCORE (GCS)

The GCS is used as part of the REVISED TRAUMA SCORE (RTS) in determining exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Glasgow Coma Scoring Criteria				
Criteria	Adults and Children	Infants and Young Toddlers	Score	Criteria Score
<b>Best Eye Response</b> (4 possible points)	No eye opening	No eye opening	<b>1</b>	_____
	Eye opens to pain	Eye opens to pain	<b>2</b>	
	Eye opens to verbal command	Eye opens to speech	<b>3</b>	
	Eyes open spontaneously	Eyes open spontaneously	<b>4</b>	
<b>Best Verbal Response</b> (5 possible points)	No verbal response	No verbal response	<b>1</b>	_____
	Incomprehensible sounds	Infant moans to pain	<b>2</b>	
	Inappropriate words	Infant cries to pain	<b>3</b>	
	Confused	Infant is irritable and continually cries	<b>4</b>	
	Oriented	Infant coos or babbles (normal activity)	<b>5</b>	
<b>Best Motor Response</b> (6 possible points)	No motor response	No motor response	<b>1</b>	_____
	Extension to pain	Extension to pain	<b>2</b>	
	Flexion to pain	Abnormal flexion to pain	<b>3</b>	
	Withdraws from pain	Withdraws from pain	<b>4</b>	
	Localizes to pain	Withdraws from touch	<b>5</b>	
	Obeys commands	Moves spontaneously or purposefully	<b>6</b>	
<b>Total Score</b> (add 3 subscores; range 3 to 15):				_____

### (d) REVISED TRAUMA SCORE (RTS)

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted toward the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic flu at triage levels 2 and 3.



Revised Trauma Score Calculation				
Criteria	Score	Coded value	Weighting	Adjusted Score
<b>Glasgow Coma Score</b>	3	0	x 0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 15	4		
<b>Systolic Blood Pressure (SBP)</b>	0	0	x 0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
<b>Respiratory Rate (RR) in breaths per minute (BPM)</b>	0	0	x 0.2908	_____
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
<b>Revised Trauma Score</b> (add 3 adjusted scores):				_____

## EXHIBIT B

**(e) TRIAGE DECISION TABLE FOR BURN VICTIMS**

A burn score of “Low” or worse on this table is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0–10%	11–20%	21–30%	31–40%	41–50%	51–60%	61–70%	71–80%	81–90%	91%+
0–1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/expectant
2.0–4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0–19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0–29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0–39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0–49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0–59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/expectant	Low/expectant
60.0–69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/expectant	Low/expectant	Low/expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/expectant	Expectant	Expectant	Expectant	Expectant

**Outpatient:** Survival and good outcome expected, without requiring initial admission; **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14–21 days, 1–2 surgical procedures); **High:** Survival and good outcome expected (survival ≥90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14–21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50–90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14–21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival ≤10% even with unlimited aggressive treatment.

## DEFINITIONS USED IN THIS DOCUMENT

- ☞ **Emergency patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- ☞ **Elective surgery:**
  - **Category 1:** Urgent patients who require surgery within 30 days.
  - **Category 2:** Semi-urgent patients who require surgery within 90 days.
  - **Category 3:** Non-urgent patients who need surgery at some time in the future.
- ☞ **Long-term Care Facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- ☞ **Palliative care:** In the setting of an overwhelming medical crisis, palliative care helps improve patient symptoms such as shortness of breath, pain and anxiety. Palliative care teams also support patient and family spiritual and/or emotional pain.

## REFERENCES

This document was developed following review and partial adaptation of the following articles:

- ☞ Christian MD, Hawryluck L, Wax RS, et al. Development of a triage protocol for critical care during an influenza pandemic. *CMAJ*. 2006;175(11):1377–1381.
  - *Commentary:* Melnychuk RM, Kenny NP. Pandemic triage: the ethical challenge. *CMAJ*. 2006;175(11):1393.
- ☞ Hick JL, O’Laughlin DT. Concept of operations for triage of mechanical ventilation in an epidemic. *Acad Emerg Med*. 2006;13(2):223–229.
- ☞ Champion HR, Sacco WJ, Carnazzo AJ, Copes W, Fouty WJ. Trauma score. *Crit Care Med*. 1981;9(9):672–676.
- ☞ Champion HR, Sacco WJ, Copes WS, Gann DS, Gennarelli TA, Flanagan ME. A revision of the Trauma Score. *J Trauma*. 1989;29(5):623–629.
- ☞ Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet*. 1974;2(7872):81–84.
- ☞ Slater A, Shann F, Pearson F. PIM2: a revised version of the Paediatric Index of Mortality. *Intensive Care Med*. 2003; 29:278–285.