



UPDATED GUIDANCE – June 29, 2020: COVID-19 Standards of Care for Vulnerable Populations

In response to input received from Ohioans with developmental disabilities and their families, the Ohio Department of Developmental Disabilities, the Ohio Department of Health, and the Ohio Department of Medicaid collaborated to create this guidance about standards of care for vulnerable populations in hospital settings.

Hospitals and clinicians play a significant role in protecting the most vulnerable Ohioans as they are charged with making important decisions around treatment for patients. This becomes particularly challenging when health care systems face surges and scarce medical resources. As part of the coronavirus (COVID-19) response, hospitals must have crisis standards of care and resource allocation guidelines in place, and medical professionals must be well-informed about how to implement these protocols. All hospitals should ensure that their policies align with legislation and best practice, particularly around issues concerning vulnerable populations.

- A person's disability status, presence of underlying health conditions, race, or ethnicity cannot be determining factors to exclude them from lifesaving medical treatment or prioritization for scarce medical resources.
- Decisions around care and allocation of resources must be based upon individualized clinical assessment, based on the best objective medical evidence, and the patient's ability to respond to treatment and short-term survivability from COVID-19. All decisions pertaining to scarce resource allocation should be made in concert with the hospital's ethics committee. Projections on "long-term survivability" or maximization of "life-years" is difficult to predict and may lead to discriminatory treatment of older adults and people with disabilities.
- Patient survivability indices, such as the Sequential Organ Failure Assessment (SOFA) and Glasgow Coma Score, have not proven to be reliable indicators of survivability of COVID-19. Relying on these indices can lead clinicians to underestimate the survivability of patients with disabilities based on underlying conditions that are unrelated to their ability to respond to treatment. Thus, it is imperative that clinicians evaluate baseline levels of impairment before an acute care episode (including communication limitations, or a need for assistance with activities of daily living).
- Patients must be informed of their rights and be included in decision-making about their care. Crisis standards of care and scarce resource allocation protocols should be transparent, accessible, and made available. Documents should be easy to read and accessible to the populations served (i.e., multilingual, plain language, Braille, etc.). Hospitals should establish an appeals process for transparency and accountability.
- Systems and medical professionals cannot use disability status, pre-existing medical conditions, race, ethnicity, age, or quality of life perceptions as factors for determining or deprioritizing treatment or allocation of resources for a person or group of people. Hospital protocols that prioritize "young" or "healthy" individuals over those who are "older" or "sicker" cannot be used in lieu of individual assessments of short-term survivability.
- Decisions pertaining to scarce resource allocation should not penalize people with disabilities or older adults who may require more use of treatment resources or greater time to recover than others.



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- Personally-owned ventilators or other durable medical equipment cannot be reallocated by hospitals or medical providers from the owner to another patient due to projected or actual equipment shortages.
- A family member or caregiver (i.e., patient care assistant, direct support professional, patient advocate, etc.) should be allowed bedside access for patients who may require assistance with making important medical decisions, activities of daily living, behavioral support needs, or to facilitate communication. In situations where this is not possible or that pose a significant barrier to infection control, alternate arrangements should be made to meet the patient's unique needs. A caregiver's active role is essential to the patient's health outcomes.
- Telemedicine should be considered, where appropriate, to facilitate continuity of care while implementing social distancing measures. Delivery of telemedicine services should incorporate appropriate accommodations to meet the unique needs of each patient.
- The U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) enforces the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act which prohibits discrimination in HHS-funded health programs or activities. As such, people with disabilities should not be denied medical care based on stereotypes, quality of life, or judgments about a person's relative "worth" based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether a person is a candidate for treatment should be guided by an individualized assessment of the patient and his or her circumstances, based on the best available objective medical evidence.