Crisis Standards of Care

I. PURPOSE:

A. To provide a transparent, fair, equitable, and consistent approach to allocation of scarce resources during a declared emergency in which Crisis Standards of Care (CSC) has been implemented at Memorial Community Health Inc (MCHI).

B. Ensure critical resources are conserved and distributed efficiently and ethically across the healthcare system.

C. To provide guidance during a sustained public health emergency, it is anticipated that limitations of resources, including staff, space, and/or material resources, may develop that would preclude the provision of the usual standard of care for patients. Crisis standards of care (CSC) describes attempts to deliver the best possible healthcare at a time when very severe resource constraints prohibit delivery of the usual standards of care. The CSC will only be initiated when there is no acceptable alternative and will be discontinued as soon as possible.

III. TRIAGE TEAM:

A. The Triage Team will consist of Triage Officers. Triage Officers are designated based on the most experienced providers with established expertise in the management of critically ill patients, leadership ability, and effective communication and conflict resolution skills. Triage Officers include:
   - Chief of Staff (if not the attending physician) or Vice Chief of Staff
   - Another physician as indicated
   - Incident Commander
   - Chief Operating Officer or designee
   - Director of Nursing or designee
   - Pharmacy Director or designee
   - Respiratory Support Staff (CRNA/ RT) as indicated
   - Social Worker or designee
   - Legal Representative for the Board of Directors, as indicated
   - Clergy Member as indicated
   - Lay Community Representative (Board Member) as indicated

B. Activation of the Triage Team will be determined by the Hospital Incident Commend System, and will be communicated clearly too appropriate staff.

C. The Triage Team will oversee the initial triage process, assess all patients, assign a level of priority for each, communicate with treating physicians, and direct attention to the highest-priority patients. The Triage Team will have the responsibility and authority to:
   - Make decisions about which patients will receive the highest priority for receiving critical care
   - Make decisions regarding reallocation of critical care resources when there is ongoing scarcity and patients

- Make determinations regarding the framework of a patient not receiving cardiopulmonary resuscitation or intubation.
- Communicate clearly with bedside nurses, physicians, and other clinicians the triage decisions
- Identify as soon as possible those patients who are at risk for decline and in need of CSC.
- Seek consultation with a clinician for appropriate age groups involved to determine respective priority levels
- Conduct reassessments of patients already receiving critical care to make decisions about continuation of critical care
- Review and report out to clinical leadership how triage is being conducted

D. Depending on available resources in small and critical access hospitals, some or all the following measures may be implemented related to staffing and surge:

Staffing & Surge:

- Just in time training for staff to assist in other areas of the facility (Surgery, Long Term Care, Medical Clinic, Assisted Living, etc)
- Telehealth with other facilities or providers
- Implementation of the regional triage team

E. To best mitigate implicit bias, to the greatest extent possible, MCHI has aimed to have the Triage Team reflect the diversity of the patient population served in terms of demographics such as race, ethnicity, disability, preferred language, sexual orientation and gender identity. Every attempt will be made to assemble a team that reflects the diversity of the community and population served by MCHI.

F. The Regional Triage Team will also help manage prioritization and placement of patients as described in the Healthcare Crisis Protocol in need of a scarce resource in the affected geographic region who cannot be managed within the specific hospital system.

The Regional Triage Team contact for MCHI is: Matt Larson: 402-469-2138

IV. DECISION-MAKING FRAMEWORK

A. The Triage Team will use the initial allocation framework to determine priority scores for all patients who require a scarce critical care resource. All patients already being supported by the scarce resource will be regularly reassessed as detailed below. The Triage Team will communicate with the clinical teams immediately after a decision is made regarding allocation or reallocation of a critical care resource.

B. The decision-making framework is composed of three steps:

- a calculation of each patient's **priority score**

- an assignment for each patient to a **color-coded priority group**
- a daily determination of how many priority groups can **receive the scarce resource**

Step 1a: Priority Scoring

Points are assigned for SOFA score category (1-4 points) and the presence of underlying conditions that make death likely within 1 year (4 points). These points are then added together to produce a total priority score, which ranges from 1 to 8. Lower scores indicate higher likelihood of benefiting from critical care; priority will be given to those with lower scores.

Table 1: **Multi-principle Strategy to Allocate Critical Care to Adult Patients During a Public Health Emergency**

Specification	Point System*			
	1	2	3	4
Prognosis for survival of the acute illness	SOFA score <6	SOFA score 6-9	SOFA score 1012	SOFA score > 12
Prognosis for survival beyond the acute illness				Severely life limiting conditions; death likely within 1 year regardless of whether patient survives the acute illness

SOFA = Sequential Organ Failure Assessment

Table 2: Multi-principle Strategy to Allocate Critical Care to Pediatric Patients During a Public Health Emergency

Specification	Point System			
	1	2	3	4
Prognosis for survival of the acute illness	75-100% chance of short-term survival	50-75% chance of short-term survival	25-50% chance of short-term survival	0-25% chance of short-term survival
Presence of underlying conditions			Severe co-morbid conditions; death likely within 1 year	Conditions expected to be non-survivable during this admission

Step 1b. Adjustment to SOFA for patients with chronic kidney disease

Use of SOFA scoring has the potential to compound existing structural inequities. For example, use of SOFA scoring will have a disproportionately negative impact on patients with chronic kidney disease, who are disproportionately persons of color. To mitigate this effect, any patient with known chronic kidney disease should be assigned no more than 2 points in the SOFA score for elevated creatinine.

Step 2: Assign patients to color-coded priority groups

Once a patient's priority score is calculated using the multi-principle scoring system described in Tables 1 or 2 for adult and pediatric patients respectively, each patient will be assigned to a color-coded triage priority group (Table 3), which should be noted clearly in their chart/electronic medical record.

Color-coded assignment of priority groups is designed to allow Triage Officers to create operationally clear priority groups to receive critical care resources, according to their score on the multi-principle allocation framework. For example, individuals in the Red group both require and have the best chance to benefit from critical care interventions and should therefore receive priority over all other groups in the face of scarcity. The Orange group has intermediate priority and should receive critical care resources if there are available resources after all patients in the Red group have been allocated critical care resources. The Yellow group has lowest priority and should receive critical care resources if there are available resources after all patients in the Red and Orange groups have been allocated critical care resources. The priority scoring process should be consistent across organizations, although specific color codes used to designate priority group may vary.

Table 3: Color-coded Priority Groups Use Priority Score from Multi-principle Scoring System to Assign Priority Category

Level of Priority and Code Color	Priority score from Multi-principle Scoring System

RED **Highest priority**	**Priority score 1-2**
ORANGE **Intermediate priority** (reassess as needed)	Priority score 3-5
YELLOW **Lowest priority** (reassess as needed)	Priority score 6-8
GREEN **Do not manage with scarce critical care resources** (reassess as needed)	No significant organ failure or no requirement for critical care resources

Step 3: Make daily determination of how many priority groups can receive the scarce resource

The Triage Team should make determinations daily, or more frequently if needed, about what priority groups will have access to critical care services. These determinations will be based on real-time knowledge of the degree of scarcity of the critical care resources, as well as information about the predicted volume of new cases that will be presenting for care over the following several days. For example, if there is clear evidence that there is an imminent shortage of critical care resources (i.e. few ventilators available and large numbers of new patients daily), only patients in the highest priority group (Red group) should receive the scarce critical care resource. As scarcity subsides, additional priority groups (e.g. first Orange group, then Yellow group) should have access to critical care interventions.

V. <u>DOCUMENTATION</u>

A. All triage decisions made through the Triage Team will be documented in the medical record. As long as the allocation framework is in effect, the overall allocation of critical care resources within the institution will be documented and reported to promote transparency. When the appeals process is conducted, the Triage Review and Oversight Committee will document in sufficient detail to demonstrate that the outcome reflects a well-considered decision. A reporting mechanism will be developed to monitor the results of the triage

process by race, ethnicity, preferred language, gender, disability and other patient demographic characteristics.

B. Record all patients presented to the Regional Triage Team in a Regional Triage Team Log, to include:

- Date and time of referral.
- Name of referring clinician and contact information.
- Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification but should not be made available to Triage Team.
- All clinical information presented to the Triage Team at the time of decision.
- Triage Team decision date and time and all supporting documentation.
- Patient outcome (if known).

REFERENCES AND RESOURCES

Department of Health and Human Services. *Crisis Standards of Care-Small and Critical Access Hospitals a Guidance Document for the State of Nebraska*. 23 Nov. 2020.

https://nwhrn.org/wp-content/uploads/2019/07/Scarce-Resource-Management-and-CrisisStandards-of-Care-Overview-and-Materials.pdf

Table resource https://www.sanctuaryvf.org/

SOFA Score Calculator: https://clincalc.com/IcuMortality/SOFA.aspx

Original Policy Date: *1/19/2022*	Policy Owner: *COO/CEO*
Revised Effective Date:	Revised By: